DEPARTMENT OF H	IEALTH AND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDICAID SERVICES
					AND TRANSMITTAL	ID: FEFF
	PART I -	TO BE COMPI	LETED BY T	THE STAT	<b>FE SURVEY AGENCY</b>	Facility ID: 00340
1. MEDICARE/MEDICAID I (L1) <b>245467</b> 2.STATE VENDOR OR MED		3. NAME AND AI (L3) <b>HENDRICK</b> (L4) <b>503 E LINC</b>	S COMMUNI OLN STREET	TY HOSP		4. TYPE OF ACTION:       7_(L8)         1. Initial       2. Recertification         3. Termination       4. CHOW
(L2) <b>204342400</b>		(L5) HENDRICK	S, MN		(L6) <b>56136</b>	5. Validation 6. Complaint 7. On-Site Visit 9. Other
5. EFFECTIVE DATE CHAN (L9)	NGE OF OWNERSHIP	7. PROVIDER/SU 01 Hospital	IPPLIER CATEG 05 HHA	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint
<ol> <li>DATE OF SURVEY</li> <li>ACCREDITATION STATE 0 Unaccredited 2 AOA</li> </ol>	07/24/2014 (L34) US: (L10) 1 TJC 3 Other	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF 0 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30
11LTC PERIOD OF CERTIN	FICATION	10.THE FACILITY	IS CERTIFIED	AS:		
From (a):		X A. In Complia	nce With		And/Or Approved Waivers Of	The Following Requirements:
To (b):			equirements e Based On:		2. Technical Personnel	
12. Total Facility Beds	<b>58</b> (L18)	-	cceptable POC		3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code	<ul> <li>7. Medical Director</li> <li>NF)8. Patient Room Size</li> <li>9. Beds/Room</li> </ul>
13.Total Certified Beds	<b>58</b> (L17)		pliance with Prog ents and/or Applie		* Code: A	(L12)
14. LTC CERTIFIED BED BI	REAKDOWN				15. FACILITY MEETS	
18 SNF 18/	/19 SNF 19 SNF 58	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
(L37)	(L38) (L39)	(L42)	(L43)			
16. STATE SURVEY AGEN	CY REMARKS (IF APPLICA	ABLE SHOW LTC CA	NCELLATION I	DATE):		
17. SURVEYOR SIGNATUR	RE	Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Kathryn Serie Unit	Supervisor I	0	7/29/2014	(L19)	Kamala Fiske-Downing, I	Enforcement Specialist 07/29/2014 (L20)
	PART II - TO BE	COMPLETED I	BY HCFA RE	GIONA	L OFFICE OR SINGLE S	TATE AGENCY
<ol> <li>DETERMINATION OF I</li> <li>_X_ 1. Facility is Elimination</li> </ol>			IPLIANCE WITH HTS ACT:	I CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) e :
2. Facility is no	t Eligible (L21)					
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEM	IENT	26. TERMINATION ACTION:	: (L30)
OF PARTICIPATION	BEGINNING	G DATE	ENDING DAT	ſΈ	VOLUNTARY 00	INVOLUNTARY
04/01/1987					01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	
25. LTC EXTENSION DAT	E: 27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER
	A. Suspension	n of Admissions:	<i>σ</i> . ( )		04-Other Reason for withdrawar	07-Provider Status Change 00-Active
(	L27) B. Rescind St	uspension Date:	(L44)			00-Active
			(L45)			
28. TERMINATION DATE:	29	9. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1	539 32	2. DETERMINATION	OF APPROVAL	DATE		
	(L32)	07/21/2014		(L33)	DETERMINATION APPI	ROVAL
	. ,					

DEPARTMENT OF HEALTH AND HUMAN SERVICES	<b>CENTERS FOR MEDICARE &amp; MEDI</b>	CAID SERVICES
MEDICARE/MEDICAID CERTIFICATION AN	D TRANSMITTAL	ID: FEFF
PART I - TO BE COMPLETED BY THE STATE	SURVEY AGENCY	Facility ID: 00340

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS



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,

Kumala 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



### 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,

Kumala 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

#### **Post-Certification Revisit Report**

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245467	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 7/24/2014
Name	e of Facility		Street Address, City, State, Zip Code	
HENDRICKS COMMUNITY HOSPITAL			503 E LINCOLN STREET HENDRICKS, MN 56136	

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

(Y4) Item		(Y5) Date	(Y4) Item		(Y5) Date	(Y4) Item		(Y5)	Date
ID Prefix Reg. # LSC	483.20(d)(3), 44	Correction Completed 07/14/2014 33.10(k)(2)	ID Prefix Reg. # LSC	F0318 483.25(e)(2)	Correction Completed 07/14/2014	ID Prefix Reg. # LSC	483.25(I)		Correction Completed 07/14/2014
ID Prefix Reg. # LSC	F0356 483.30(e)	Correction Completed 07/14/2014	ID Prefix Reg. # LSC	483.35(i)	Correction Completed 07/14/2014	ID Prefix Reg. # LSC	F0412 483.55(b)		Correction Completed 07/14/2014
	F0428 483.60(c)	Correction Completed 07/14/2014	Reg. #			Reg. #			
ID Prefix Reg. # LSC			ID Prefix Reg. # LSC			Reg. #			
ID Prefix Reg. # LSC			ID Prefix Reg. # LSC			Reg. #			
Reviewed I State Agen		eviewed By KS/KFD	Date: 07/29/202	•	e of Surveyor: 22	2113		Date: 07	/24/2014
Reviewed I CMS RO	Зу R	eviewed By	Date:	Signature	e of Surveyor:			Date:	
Followup t	o Survey Comp 6/5/20				y Uncorrected Defi ed Deficiencies (CM			YES	NO

DEPARTMENT OF HEALTH					CENTERS FOR MED	DICARE & MEDI	CAID SERVICES
					AND TRANSMITTAL		ID: FEFF
	PART I -	TO BE COMPL	LETED BY T	THE STAT	TE SURVEY AGENCY		Facility ID: 00340
<ol> <li>MEDICARE/MEDICAID PROVIDER         <ul> <li>(L1) 245467</li> </ul> </li> </ol>	NO.	3. NAME AND AD (L3) HENDRICK			ITAL	4. TYPE OF ACTI	ON: <u>2 (</u> L8)
2.STATE VENDOR OR MEDICAID NO		(L4) 503 E LINC				1. Initial	2. Recertification
(L2) <b>204342400</b>		(L5) HENDRICK			(L6) <b>56136</b>	3. Termination 5. Validation	4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OW	VNERSHIP	7. PROVIDER/SU	PPLIER CATEG	<b>JORY</b>	<u>02</u> (L7)	7. On-Site Visit	9. Other
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Survey Aft	er Complaint
6. DATE OF SURVEY 06/05/2	<b>2014</b> (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF		
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/III	0 15 ASC	FISCAL YEAR END	ING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30	
11. LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED	AS:		1	
From (a):		X A. In Complian	nce With		And/Or Approved Waivers Of	The Following Require	nents:
To (b):			equirements		2. Technical Personnel	6. Scope of S	
12. Total Facility Beds	58 (L18)		e Based On: cceptable POC		<ul> <li>3. 24 Hour RN</li> <li>4. 7-Day RN (Rural SN</li> </ul>	<ul> <li>7. Medical D</li> <li>F)8. Patient Room</li> </ul>	
12. Total Taoling Doub	50 (110)				5. Life Safety Code	9. Beds/Room	
13.Total Certified Beds	<b>58</b> (L17)	B. Not in Com Requireme	pliance with Prog ents and/or Appli	gram ied Waivers:	* Code: B	(L12)	
14. LTC CERTIFIED BED BREAKDOW	N				15. FACILITY MEETS		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
58							
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REMAN	RKS (IF APPLICA	ABLE SHOW LTC CA	NCELLATION I	DATE):			
See Attached Remarks							
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL	Date:
Connio Drody, LIEE ME II		0	7/09/2014		Kanala Fieles Descriptor	<b>F</b> - <b>f</b> - <b>m</b> - <b>m</b> +	-:-1:-+ 07/19/2014
Connie Brady, HFE NE II				(L19)	Kamala Fiske-Downing, 1	Enforcement Spe	(L20)
PAR	TII - TO BE	COMPLETED H	BY HCFA RE	EGIONAI	<b>COFFICE OR SINGLE S</b>	TATE AGENCY	
19. DETERMINATION OF ELIGIBILIT	Ϋ́		IPLIANCE WITH	H CIVIL	21. 1. Statement of Finar	ncial Solvency (HCFA-25 ol Interest Disclosure Stm	
1. Facility is Eligible to Par	ticipate	RIGH	ITS ACT:		<ol> <li>3. Both of the Above</li> </ol>		а (псра-1313)
2. Facility is not Eligible	(L21)						
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION:		(L30)
OF PARTICIPATION	BEGINNINC	<b>J</b> DATE	ENDING DA	TE	VOLUNTARY 00		
04/01/1987					01-Merger, Closure 02-Dissatisfaction W/ Reimburse		Meet Health/Safety
(L24)	(L41)		(L25)		03-Risk of Involuntary Terminatio	0014114	Meet Agreement
25. LTC EXTENSION DATE:		VE SANCTIONS			04-Other Reason for Withdrawal	OTHER	der Status Change
	A. Suspension	n of Admissions:	(L44)			00-Activ	-
(L27)	B. Rescind St	spension Date:	(211)				
			(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS		
		03001					
	(L28)			(L31)	Posted 07/21/2014 C	co.	
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	L DATE			

(L33)

DETERMINATION APPROVAL

(L32)

DEPARTMENT OF HEALTH AND HUMAN SERVICES	<b>CENTERS FOR MEDICARE &amp; ME</b>	DICAID SERVICES
MEDICARE/MEDICAID CERTIFICATION AN	JD TRANSMITTAL	ID: FEFF
PART I - TO BE COMPLETED BY THE STATE	2 SURVEY AGENCY	Facility ID: 00340

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.



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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable 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,

Kumala 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	í

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245467	B. WING			06/0	05/2014
NAME OF F	PROVIDER OR SUPPLIER		ſ		TREET ADDRESS, CITY, STATE, ZIP CODE		
HENDRIG	CKS COMMUNITY HO	SPITAL			D3 E LINCOLN STREET ENDRICKS, MN 56136		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	FC	000			
	as your allegation c Department's accept bottom of the first p be used as verificat	of correction (POC) will serve of compliance upon the otance. Your signature at the age of the CMS-2567 form will ion of compliance. acceptable POC an on-site					
F 280 SS=D	revisit of your facilit validate that substa regulations has bee your verification. 483.20(d)(3), 483.1	y may be conducted to ntial compliance with the on attained in accordance with 0(k)(2) RIGHT TO		280	0		
	incompetent or othe incapacitated under participate in planni changes in care an	e right, unless adjudged erwise found to be r the laws of the State, to ing care and treatment or d treatment.	2/9/14	ve 5 f	e		
	within 7 days after t comprehensive ass interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent p the resident, the re- legal representative	are plan must be developed the completion of the sessment; prepared by an m, that includes the attending red nurse with responsibility d other appropriate staff in mined by the resident's needs, tracticable, the participation of sident's family or the resident's e; and periodically reviewed am of qualified persons after					
					RECEIVE	D	
		NT is not met as evidenced			JUL 0721		
					Mancstoz Department of Marskall	Health	(X6) DATE
LABORATOR	y director's or provid	DER/SUPPLIER REPRESENTATIVE'S SIGN			NEO	7	3-14

Any deficiency statement ending with an asterick (\*) 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.

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

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		H AND HUMAN SERVICES			FORM	: 06/20/201 APPROVE
STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY IPLETED
		245467	B. WING _		06/	05/2014
NAME OF	PROVIDER OR SUPPLIER	3	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP C		03/2014
HENDRI	CKS COMMUNITY H	OSPITAL		503 E LINCOLN STREET HENDRICKS, MN 56136		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	by: Based on observa review the facility for the use of side reviewed for sider of care for 1 of 1 r appropriate splint the plan of care to interventions prior needed anti-anxiet residents (R60, R5 received as neede Findings include; R4 was observed as two half siderails in was resting in bed transferred with the was not observed transferring. R4 w Independently. R4's quarterly mini 3/5/14, identified di identified as needin with bed mobility al interview for menta due to R4 being se Review of the care 12/17/13 Identified activities of daily liv moderate risk for fa attempts to move of lies just as she is p assessment compl on 12/5/12 and rev resident has 2 half	ation, interview and document failed to revise the plan of care ralls for 1 of 3 residents (R4) all use; failed to revise the pan esident (R26) reviewed for device use; and failed to revise include non pharmacological to the administration of as ty medication for 3 of 3 59 & R61) reviewed who d anti-anxiety medications.	F 28	1. The Deliver for	d is current. ursing staff was 0 <sup>th</sup> to education , the need to c interventions reded" notropic for tracking nonitoring for vill be completed evented by: lents who have sidents per wee nent, placement lents on anti- completed on nine if non- s were tried pri- te care planning aviors and hourd. tinue for 90 day te Quality eview and to ter audits. conducted by: honitored by:	ed k s or g s
·	is nonambulatory, l 17(02-88) Previous Versions	s Unable to sit up without Obsolete Event ID:FEFF11	Fe	acility ID: 00340 If cr	ontinuation sheet i	age 2 of 27

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TATEMEN	OF DEFICIENCIES	E & MEDICAID SERVICES	(X2) MUL	TIPLE	E CONSTRUCTION	(X3) DAT	<u>. 0938-03</u> E SURVEY
		IDENTIFICATION NUMBER:	A. SUILD	ING_	•	COM	IPLETED
		245467	B. WING			06/	05/2014
NAME OF I	PROVIDER OR SUPPLIER			31	TREET ADDRESS, CITY, STATE, ZIP CODE		
HENDRI	CKS COMMUNITY H	OSPITAL			03 E LINCOLN STREET ENDRICKS, MN 56136		
(X4) ID		ATEMENT OF DEFICIENCIES	ai		PROVIDER'S PLAN OF CORRECT	ON	(X5)
PRÉFIX TAG	(EACH DEHICIENC REGULATORY OR I	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)		(X5) COMPLETI DATE
F 280	Continued From pa	age 2	F2	280	F280		
		assistance to arise. The			1. Corrective Action:		
	assessment also id	dentified that R4 had bilateral		İ	a. Resident R4 is havin	g her need	4
	contractures of up	per and lower extremities. The	>   		for side rails re-evaluated as she	cannot us	e
		evlewed on 3/5/14 with no	L F L		them on her own anymore.		
		ne care plan dated 6/15/12			b. Resident R26's appr		
1		obility and use of 2 half rails			splint with finger separators was		hd
	assist with bed mo	ity during care provision to bility			is currently care planned and in t c. Resident R 59 has ch		
		Sinty-			conditions of anxiety and psycho		<b>a</b>
	During interview or	16/5/14 at 8:32 a.m. registered			use of the anti-anxiety medicatio		C
	nurse (RN)-A state	d the side ralls are positioned			appropriate as deemed by the car		
	In the "up" position	for staff comfort, If they are			The resident's dose of anti-anxie		
	arraid to have an o	pen side of the bed while doing d that R4 does not move			medication is scheduled to be give		t
	independently while				1400. She does have a PRN dos	e as well,	
					but there are care planned non-		,
		th nursing assistant (NA)-В оп			pharmacological interventions th		
	6/4/14, at 1:32 p.m	. she stated that R4 does not			tried prior to administering. R60		
		hold onto the rail when			the anti-anxiety medication for h		
		. On 6/5/14 at 8:39 a.m. when providing cares for R4,	•		the late evening hours will be pla scheduled for the resident's frequ		
		the "down" position as she			history of use of the medication.		10
		She stated that when the rail			resident will not have an "as need		
	is "up", she places	a pillow between R4 and the			of anxiety medication. R61's eff		
1		er face since R4 is unable to			of his anti-anxiety medication is l		-
Í		idependently if her face is			tracked by reviewing the hours of		Į.
	against the rail.				resident is getting. His care plan	is updated	1
1	During interview on	6/5/14 at 9:37 a.m. the			to reflect this use of the medication	<b>л.</b> і	
	director of nursing a	on 6/5/14 at 9:37 a.m. verified					
	the appropriate use	of R4's siderall would need to			2. Corrective Action as it applies		
	be care planned.				a. All resident with anti-		
	R26's care plan dat	ed 5/20/14, directed staff to			medications were reviewed for di "as needed" status with appropria		
1		nd palm protector; however,			pharmacologic interventions care		
		ot address the usage of a palm			Resident with medications given		
	protector with finger	r separators as recommended			were reviewed for monitoring the		
		therapy assessment dated			effectiveness of the medication.		
	5/25/12.					[	

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Manestoa Department of Health Marshall

	T OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	OMB NO. 09 (X3) DATE SI	JRVEY
AND PLAN C		IDENTIFICATION NUMBER:	A. BUILDIN	G	COMPLE	TED
		245467	B. WING		06/05/	2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
HENDRI	CKS COMMUNITY HO			503 E LINCOLN STREET HENDRICKS, MN 56136		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE CO	(X5) DMPLETION DATE
F 280	Continued From page	ge 3	F 28	0		
	wheel chair with a le have a palm protect left hand fingers we formation. At that tir when asked upon c	o.m. R26 was observed in her eft palm protector that did not tor with finger separators. The re observed in a fist ne resident did open left hand ommand however, R26 was ely open and fingers were not ned completely.				
	recall R26 having a separators on sever	.m. NAR-A stated she can hand splint with finger al months ago but currently kin palm protector on the left				
	have a left hand, fin vs. a sheep skin pal	.m., RN-B verified R26 should ger separator hand splint on m protector. RN-B stated the be revised regarding the				
	attempted prior to th anti-anxiety medicat Drug Use- care area 3/18/2014, indicate and antidepressant. an as needed (PRN time due to anxiety a consistently every ni medication added to	al interventions to be		· .		
	Alprazolam (anti-an)	ers dated 3/17/14, indicated kiety) 0.5 milligrams (mg) S) as needed for anxiety.				

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TATE STRUME OF DEPICIENCES     [X1] PHOLVERSUPPLENCIAL IDENTIFICATION NUMBER     (X2) NUTFICE CONSTRUCTION A BUILING     (X3) DATE SURVEY COMPLETED       NUME OF PROVIDER OR SUPPLER HENDRICKS COMMUNITY HOSPITAL     245467     (X4) WINT     (X5) DATE SURVEY COMPLETED       NUME OF PROVIDER OR SUPPLER HENDRICKS COMMUNITY HOSPITAL     STREET ADDRESS, DIT, STATE, 2P ODDE S03 E LINCOLN STREET HENDRICKS, MM 5136     (X5) DATE SURVEY COMPLETED       PART HENDRICKS COMMUNITY HOSPITAL     STREET ADDRESS, DIT, STATE, 2P ODDE S03 E LINCOLN STREET HENDRICKS, MM 5136     (X5) DATE SURVEY COMPLETED       F2 20     Continued From page 4 RS0's Medication Administration Records (MAR) Cated 37/174-32/11, (Lin, Inclared the PRIN Apprazolam had been administered every day, The MAR hated 47/11-4-43/02/01, (Linclared the PRN Apprazolam had been administered 22 out of 31 days for ankey). The MAR dated 61/11-4- 30 days. The 5/11-4-43/02/01, (Linclared the PRN Apprazolam had been administered 23 out of 31 days for ankey. The MAR dated 61/11-4- 30 (24); for ankey. The MAR date 61/11-4- 30 (24); for ankeked anty and pharmacological Interventions and would be absorted			AND HUMAN SERVICES				FORM	APPROVED 0938-0391	)
VAME OF PROVIDER OR BUPPLER     STREET ADDRESS, OTY, STATE, ZP CODE 303 E LINCOLA STREET       PAYING HENDRICKS COMMUNITY HOSPITAL     STREET ADDRESS, OTY, STATE, ZP CODE 303 E LINCOLA STREET HENDRICKS, MM S6136       PRETX TAG     ISUMMAY STREMENT OF DEFICIENCIES INCOLATIONY OF LSC IDENTIFYING INFORMATION     D       PRETX TAG     ISUMARY STREMENT OF DEFICIENCIES INCOLATIONY OF LSC IDENTIFYING INFORMATION     D       F 280     Continued From page 4 R60'S Medication Administration Reports (MAR); dated 3/17/14/301/14, indicated the PRN Alprazolam had been administrered 2 out of 30 days. The 6/1/14-4/302014, indicated the PRN Alprazolam had been administrered 2 out of 31 days for anxiety. The MAR dated 6/1/14- 6/1/14, idicated 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 disordor, however, it lacked any non-pharmazological interventions for R60's numbers.       During review of B60's plan of care (POC) dated 3/11/14, indicated the following: R59 had a long history of meral linex end any non-pharmazological interventions for R60's numbers.       R69's diagnoses were documented as: dementia with behavioral disturbances and depressive disorder. R59's psychotropic drug use assessment care are assessment (CAA) dated 3/11/14, indicated the following: R59 had a long history of meral lines, including depressive disorder. R59's late on any R10 (dated a long history of meral lines has been on depression phatery of depression, PHQ9 (a tool used to identify the severity of depressive of meral ataus), score of 14. Documentation indicated the formedican used for depression row of meral atatus), score of 14	STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1. 1					
HENDRICKS COMMUNITY HOSPITAL     582 E LINCOLN STREET HENDRICKS, MN 56136       (M) D PRETEX TAC     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDE BY PULL) (EACH DEFICIENCY DEFICIENCY BAD SHOULD BE CROSS MEDILATION OLSCIENTIFING NFORMATION (All Calified 3/17/14-3/31/14, Indicated the PRN Alprazolam had been administered 20 out of 30 days. The 5/1/1-4/3/321/14, Indicated the PRN Alprazolam had been administered 20 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 RB0'S request.     F 280       During review of RB0'S plan ot care (POC) dated 31/12/14, Itidentified the use of anti-maxiety medication related to an antively disorder; however, It lacked any non-pharmacological interventions for RB0'S plan ot care (POC) dated 31/12/14, Indicated the PIN Alprazolam had been administered 3 out of 25 m, R59'S diagnoses were documented as: dementia with behavioral disturbances and depressive disorder. R59's paychoropic drug use assessment care area assessment (OAA) dated 31/11/14, Indicated the following: R59 had a long history of mental lineses, including depression. R59 is courrently on alprazolam 0.25 mg. R59'S diagnoses were following: R59 had a long history of mental indicated and mental status y score of 14. Documentation indicated the family stated that R59 has ben on orelated to an expression symptons) with BINK (brief interview of mental status) score of 14. Documentation indicated the family stated that R59 has bear on or dispession			245467	B. WING	i		06/0	)5/2014	
HENDRICKS COMMUNTY HOSPITAL       HENDRICKS, MN 56136         (MI)D PRETX 7.42       SUMMARY STATEMENT OF DEFICIENCIES PREDX ACAD EPRICIENCY Wast SE PRECEDENCIES PREDX RedULTORY OR JSC DENTIFYING ANOMATION       PRETX 7.42       PROVIDERS PLAN OF CORRECTION EACH COMPETTIES AND OF COMPETTIES AND OF COMPETTIES AND OF COMPETTIES AND OF COMPETTI	NAME OF	PROVIDER OR SUPPLIER	∮,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	• <u>•••••</u> •	STREET ADDRESS, CITY, ST	TATE, ZIP CODE			1
PREFIX       EACH DEFICIENCY MUST BE PRECEDED BY FULL       PREFX       (EACH CORRECTOR STOTME ACTION SHOULD BE CROSS-REFERENCED TO THE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE       COMMENTION DEFICIENCY         F 280       Continued From page 4       F 280         R60'S Medication Administration Records (MAR) Cated 37/174-37/114, Inclicated the PRN Alprazolam had been administered 227 out of 30 days. The 5/1/14-67/31/4, MR Indicated the PRN Alprazolam had been administered 23 out of 31 days for anxiety. The MAR dated 6/1/14- 6/4/14, inclicated 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, inclicated 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, inclicated the on 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 aceassessment (CAA) dated 311/14, indicated the following: R59 had a long history of mental illness, including depressive disorder. R59's basico novenlataxine (a medication used for depressive PSN (as needed) for anxiety/sleep. R59 has along not pressive symptons) with BMNS (their interview of mental status) score of 14. Documentation indicated the family istaed that R59 has been on depressive	HENDRI	CKS COMMUNITY HC	SPITAL			6			
R60's Medication Administration Records (MAR)         dated 3/17/14-3/31/14, indicated the PRN         Alprazolam had been administered 2very day.         The MAR dated 4/1/14-4/30/2014, indicated the         PRN Alprazolam had been administered 22 out of         30 days. The 5/1/14-5/31/14, MAR Indicated the         PRN Alprazolam had been administered 22 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         3/1/214, It identified the use of anti-anxiety         medication related to an anxiety disorder;         however, it lacked any non-pharmacological         interventions for R60's and to an anxiety disorder;         however, it lacked any non-pharmacological         interventions for R60's and expressive         verified the care pla lacked any         non-pharmacological interventions and would be         adding.         R59's idagnoses were documented as: dementia         with behavioral disturbances and depressive         disorder. R59's psychotropic drug use         assessment care area assessment (CAA) dated         3/1/14, indicated the following: R59 had a long         history of mentai ling d	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF	IX (EACH CORRECT) CROSS-REFERENCE	VE ACTION SHOULD	BE	COMPLETION	
family stated that R59 has been on depression	F 280	Continued From pa R60's Medication A dated 3/17/14-3/31/ Alprazolam had bee The MAR dated 4/1 PRN Alprazolam ha 30 days. The 5/1/12 PRN Alprazolam ha 31 days for anxiety. 6/4/14, indicated the administered 3 out was given per R60's During review of R6 3/12/14, it identified medication related t however, it lacked a interventions for R6 Interview on 6/4/14 verified the care pla non-pharmacologica adding. R59's diagnoses we with behavioral distu disorder. R59's psy assessment care ar 3/11/14, indicated th history of mental illn R59 is currently on a (milligrams) every 8 anxiety/sleep. R59 medication used for times a day) for dep to identify the severi score was a 2 (whic symptoms) with BIN	ge 4 dministration Records (MAR) '14, indicated the PRN en administered every day. /14- 4/30/2014, indicated the id been administered 27 out of 1-5/31/14, MAR indicated the id been administered 23 out of The MAR dated 6/1/14- e PRN Alprazolam had been of 4 day for anxiety. The PRN is request. 0's plan of care (POC) dated the use of anti-anxiety to an anxiety disorder; iny non-pharmacological 0's anxiety. at 3:00 p.m. with RN-A, it was n lacked any al interventions and would be ere documented as: dementia urbances and depressive chotropic drug use ea assessment (CAA) dated he following: R59 had a long less, including depression. alprazolam 0.25 mg. hours PRN (as needed) for is also on venlafaxine (a depression) 75 mg BID (two ression. PHQ9 (a tool used ty of depressive symptoms) h indicated a low depressive IS (brief interview of mental		DEF				
		family stated that R	59 has been on depression						

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JUL 07 2014

Mannestoa Department of Health Marshall

STREEMENT OF CORRECTION         (M) Providensuper-Lendua DEMTIFICATION NUMBER:         (M) AUTURE CONSTRUCTION A BULLING         (M) DITE BUFWEY A BULLING           NAME OF PROVIDER OF BUFPLIER         245467         INVINCE BUF BUFWEY A BULLING         INVINCE BUF BUFWEY BUF BUFWEY A BUFUER ADDRESS, OTV, STATE, 2P CODE SUB LINCOL STREET         DB/05/2014           MAME OF PROVIDER OF BUFPLIER         STREET ADDRESS, OTV, STATE, 2P CODE SUB LINCOL STREET         DB/05/2014           MENDACKS COMMUNITY HOSPITAL         STREET ADDRESS, OTV, STATE, 2P CODE SUB LINCOL STREET         DB/05/2014           PROVIDER OF PROVIDER OF BUFPLIER         EUROPACING NOR STREET PENDRECKS, MN S6136         DP/07 PUFWERT EALTOP COMPETER ALL OF COMPETING INCOL STREET ADDRESS, OTTV, STATE, 2P CODE SUB LINCOL STREET PENDRECKS, MN S6136         DP/07 PUFWERT EALTOP COMPETER ALL OF COMPETING INCOL STREET ADDRESS, OTTV, STATE, 2P CODE SUB LINCOL STREET PENDRECKS, MN S6136         DP/07 PUFWERT EALTOP COMPETER ALL OF COMPETING INCOL STREET PENDRECKS, MN S6136         DP/07 PUFWERT EALTOP COMPETING INCOL STREET PENDRECKS, MN S6136         DP/07 PUFWERT EALTOP COMPETING PUFWERT EALTOP COMPETING INCOL STREET PENDRECKS, MN S6136         DP/07 PUFWERT EALTOP COMPETING PUFWERT EALTOP COMPETIN			AND HUMAN SERVICES			•		FORM	: 06/20/2014 APPROVED . 0938-0391
NAME OF PROVIDER OR SUPPLIEN     STREET ADDRESS, OTHY, STATE, 2P CODE S05 & LINCOLN STREET       HENDRICKS, COMMUNITY HOSPITAL     STREET ADDRESS, OTHY, STATE, 2P CODE S05 & LINCOLN STREET       Main T     SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST EE PRECEDE by FULL REQULATORY OR USD EERTIFYING UNEOPMATION)     PAETX PRETX TAG     PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST EE PRECEDE by FULL REQULATORY OR USD EERTIFYING UNEOPMATION)     PAETX PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST EE PRECEDE by FULL REQULATORY OR USD EERTIFYING UNEOPMATION)     PAETX TAG       F 280     Continued From page 5 response If the veniafaxine (antidepressant) was discontinued.     F 280       The initial MDS dated 3/11/14 Identified that P59 was cognitive with a BIMS (Brief Interview of Mental Status) score of 14/15. Also documented was 1 cplosed of feeling down, cloropresed or hopeless and no identified behaviors and R59 received an anti-anxiety medication of der menth and/er note (undateo) and hand writter, was attached to the Apriz 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 (200 p.m.) per family request. R59 received the PRN (as needed) and-anxiety medication at approximately 2000 p.m. daily from 43/14 ut 165/14. The PRN medication 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 various times during the day, noted R59 as not displaying any symptoms of anxiety. On 6/4/14 at various times during the day, noted R59 as not displaying any symptoms of anxiety. On 6/4/14 at various times during the day. Noted R59 as not displaying any symptoms of anxiety. On 6/4/14 at various times during the day. Noted R59 as no	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1					
HENDRICKS COMMUNITY HOSPITAL     503 E LINCOLN STREET HENDRICKS, MN 56136       PHETR TAG     SUMAAY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY METS BE PRECIEDED by FULL TAG     D PHETK TAG     D			245467	B. WING	∋			06/	05/2014
HENDRICKS COMUNITY HOSPITAL         HENDRICKS, MN 56136           PM:DIX TWG         SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MIST BE HARDEDED by FULL) (EACH DEFICIENCY MIST BE HARDEDED by FULL) (EACH DEFICIENCY AND THE ACTION SHOULD BE CHOSSEREFERENCY br>ACTION SHOULD BE CHOSSEREFERENCY ACTION SHOULD BE CHOSSEREFERENCY ACTION SHOULD BE ACTION SHOULD BE CHOSSEREFERENCY ACTION SHOULD BE ACTION SHOULD ACTION SH	NAME OF	PROVIDER OR SUPPLIER		4			ZIP CODE		
Prefix Txg       READEDRENCY MUST BE PRECEDED BY FULL Txg       PPERIX Txg       READEDRENCY MUST BE PRECEDED BY FULL Txg       PPERIX Txg       READEDRENCY MUST BE PRECEDED BY FULL Txg       PPERIX Txg       READEDRENCY MUST BE PRECEDED BY FULL Txg       PPERIX Txg       READEDRENCY MUST BE PRECEDED BY FULL Txg       PPERIX Txg       READEDRENCY MUST BE PRECEDED BY FULL Txg       PPERIX Txg       READEDRENCY MUST BE PRECEDED BY FULL Txg       PPERIX Txg       READEDRENCY MUST BE PRECEDED BY FULL Txg       PPERIX Txg       READEDRENCY MUST BE PRECEDED BY FULL Txg       PPERIX Txg       READEDRENCY MUST BE PRECEDED BY FULL Txg       PPERIX Txg       READEDRENCY MUST BE PRECEDED BY FULL Txg       PPERIX Txg       READEDRENCY MUST BE PRECEDED BY FULL Txg       PPERIX Txg       READEDRENCY MUST BE PRECEDED BY FULL Txg       PPERIX Txg       READEDRENCY MUST BE PRECEDED BY FULL TXG       PPERIX Txg       PRECEDED BY Tyg       PRECEDED BYG       PRECEDED BYG       PRECEDED B	HENDRI	CKS COMMUNITY HO	SPITAL		1				
response if the veniafaxine (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 scheet lacked documentation by the licensed staff which indicated the rationale for the administration of the PRN 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 axiety. 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.	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD	BE	COMPLETION
noted to be smiling and wheeling towards her room in her wheelchair.	F 280	response if the ven discontinued. The initial MDS dat was cognitive with a Mental Status) scor was 1 episode of fe hopeless and no ide received an anti-an days. The admitting physi included alprazolam 0.25 mg. (milligram PRN (as needed) fo disturbances. A po written, was attache (medication adminis of the month next to order. The hand wr resident alprazolam family request. R59 needed) anti-anxiet 2:00 p.m. daily from medication sheet la licensed staff which administration of the symptoms R59 exh non-pharmacologic prior to the administ the response. Observation of R59 during the day, note symptoms of anxiet	lafaxine (antidepressant) was ed 3/11/14 identified that R59 a BIMS (Brief Interview of re of 14/15. Also documented reling down, depressed or entified behaviors and R59 xiety medication 6 out of 7 ician's orders, dated 3/5/14, n (anti-anxiety medication) s) by mouth every 8 hours or dementia with behavioral st-it note (undated) and hand ed to the April 2014 MAR stration record) over the days of the alprazolam medication ritten note read: Need to offer daily at 1400 (2:00 p.m.) per received the PRN (as y medication at approximately 4/3/14 until 6/5/14. The PRN cked documentation by the indicated the rationale for the e PRN medication, the ibited and/or any al interventions attempted tration of the medication, nor on 6/4/14 at various times of R59 as not displaying any y. On 6/4/14 at 9:01 a.m. R59	F	280				
		noted to be smiling	and wheeling towards her nair.						

JUL 07 2014

Event ID: FEFF11

Facility ID: 00340

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STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A, BUILD	ING _		001	
	-	245467	B, WING		·	06/	/05/2014
	NAME OF PROVIDER OR SUPPLIER HENDRICKS COMMUNITY HOSPITAL			50	TREET ADDRESS, CITY, STATE, ZIP CODE D3 E LINCOLN STREET ENDRICKS, MN 56136	· .	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 280	(nurses notes) from documentation that interventions were administration of the alprazolam daily ar Review of the plan that R59 was on ar HCL), antipsychotic (alprazolam) medic Beyond education to related to risks, ber toxic symptoms of medications, nothing the plan of care relation anti-anxiety medications, nothing the plan of care relation anti-anxiety medications, nothing the plan of care relations, nothing and the care plan here the plan of all and the care plan here the plan of all a BIMS (brief intervolution). R61 was admitted the diagnoses that inclutions a BIMS (brief intervolution) of the physician or following: alprazolations, of the physician or following: alprazolations, alpha anti-anxiety "Wants anti-anxiety"	erdisciplinary progress notes a 3/5/14 - 6/4/14, lacked non-pharmacological attempted prior to the e anti-anxiety medication, ound 2 p.m. of care dated 4/7/14 identified nantidepressant (venlafaxine c (abilify) and anti-anxiety ation related to depression. to R59 and family/caregivers hefits and side effects and/or the above identified in further was documented in ated to the use of the tion, alprazolam and/or al interventions to reduce 8 on 6/5/14 at 8:51 a.m., armacological interventions blanned, prior to the brazolam daily at 2:00 p.m. ad not been revised to include 0 the facility on 3/12/14 with uded depression and anxiety. mission assessment revealed iew for mental status) score of to be cognitively intact. Review ers dated 3/17/14 included the	F 2	80			

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Event ID: FEFF11

Facility ID: 00340

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TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     (X1) PROVIDER/SUPPLIER/CLIA		TIPLE CONSTRUCTION		E SURVEY		
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	VG				
		245467	B, WING _		06/	05/2014		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E			
HENDRI	CKS COMMUNITY HO	DSPITAL		503 E LINCOLN STREET HENDRICKS, MN 56136				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE		
E 280	Continued From pr	2007	F 28	<b>F318</b>				
F 280	that sleep monitorin care plan dated 4/1 an anti-anxiety med The facility policy, 0 revised 8/2009, ind would be revised w	nd in R61's record to indicate ng was being tracked. R61's /14 did not address the use of dication for issues with sleep. Care Planning Process, icated a resident's care plan hen any change or update	F 28	<ol> <li>Corrective Action:         <ul> <li>a. Resident R26's a splint with finger separators is currently care planned and</li> </ul> </li> <li>Corrective Action as is ap         <ul> <li>a. All residents with reviewed, observed, and care</li> </ul> </li> </ol>	was located a l in use oplies to othe h splints wer e plans updat	rs: e		
F 318 SS=D	The policy indicated responsible to cond the care was delive designed in the car 483.25(e)(2) INCRE IN RANGE OF MO Based on the comp resident, the facility with a limited range	s noted in a resident's plan of care. e policy indicated each discipline was ponsible to conduct periodic audits to assure care was delivered to the resident as signed in the care plan 3.25(e)(2) INCREASE/PREVENT DECREASE RANGE OF MOTION sed on the comprehensive assessment of a ident, the facility must ensure that a resident n a limited range of motion receives		ted in a resident's plan of care. icy indicated each discipline was sible to conduct periodic audits to assure a was delivered to the resident as ed in the care plan e)(2) INCREASE/PREVENT DECREASE GE OF MOTION on the comprehensive assessment of a t, the facility must ensure that a resident	F 31	completed July 8 <sup>th</sup> and 10 <sup>th</sup> . included the appropriate use planning for splints, and the procedure.	ocedure for the l and rsing staff w The education of splints, ca new policy a	as m re nd
	appropriate treatme	ent and services to increase d/or to prevent further		3. All Corrective Actions wi by: July 14 <sup>th</sup> , 2014	-	ted		
	by: Based on observat review, the facility fa splint device was a contractures (a con to passive stretch o	NT is not met as evidenced ion, interview and document alled to ensure the correct oplied to minimize dition of fixed high resistance f a muscle) for 1 of 1 resident n usage of a splint device.		<ul> <li>4. Reoccurrence will be prev <ol> <li>An RN will be reader</li> <li>An RN will be reader</li> <li>audits of residents who have be conducted on 2 residents preview for proper equipment and care planning.</li> <li>Audits will contine</li> <li>Audits will contine</li> <li>Assurance (QA) Team for reader</li> </ol></li></ul>	esponsible for splints and w per week to , placement, inue for 90 d e Quality view and to	vill		
	Findings include:			5. The Correction will be me a. The Director of N				
	It was noted on the (MDS) dated 5/14/1	annual minimum data set		designee.	Ũ			

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Event ID: FEFF11

Facility ID: 00340

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
	245467	B, WING			06/05/2014
NAME OF PROVIDER OR SUPPLIER	)SPITAL		STREET ADDRESS, CITY, STATE 503 E LINCOLN STREET HENDRICKS, MN 56136	E, ZIP CODE	
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		ACTION SHOULD I	BE COMPLETION
<ul> <li>osteoporosis and w MDS indicated R26 bed mobility, ambul used a walker and w</li> <li>The 5/14/14, activiti area assessment (0 palm protector on the move hand, wrist, a normally.</li> <li>The 4/13/14, occup treatment indicated discontinued from se recommendations of protector with finger contractures. At the educated on R26 's 6/2014, nursing ass R26 was to have pa "off" for cleaning.</li> <li>R26's care plan dat apply R26's left han plan of care did not protector with finger 1:45 p.m. R26 was of with a left palm prot separators. Left har fist formation. At tha hand when requested to completely extend her hand.</li> </ul>	hellitus, Bells Palsy, ras cognitively impaired. The required extensive assist with lation, personal cares and wheel chair. The of daily living (ADL) care CAA) indicated R26 wore a ne left hand, and was able to and fingers slowly, but ational therapy plan of on 5/25/12, R26 was rervices with of wearing a left hand palm r separators to minimize at time nursing staff was a splint wearing schedule. The istant care sheet indicated and protector to left hand and ed 5/20/14, directed staff to d palm protector however the address the usage of a palm separators. On 6/4/14, at observed in her wheel chair ector that did not have finger at time R26 did open the left ed; however, R26 was unable d the fingers when opened	F3	318		
stated she could rec with finger separato	6/5/14, at 7:15 a.m. NAR-A call R26 having a hand splint rs on several months ago but lain lamb skin palm protector		Facility ID: 00340	If on the set	n sheet Page 9 of 27

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STATEMENT OF DEFICIENCIES ( AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	[···	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245467	B. WING		06/05/2014	
	PROVIDER OR SUPPLIEF	• •		STREET ADDRESS, CITY, STATE, ZIP COD 503 E LINCOLN STREET HENDRICKS, MN 56136		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE COMPLETIC	
F 318 F 329 SS=D	on the left hand. During interview o verified R26 shoul separator hand sp protector. RN state separator hand sp was probably the r protector got appli RN stated the care reflect accurately thand splint. A policy on the use none was provided 483.25(I) DRUG R UNNECESSARY I Each resident's dr unnecessary drugs drug when used in duplicate therapy); without adequate r indications for its u adverse conseque should be reduced combinations of th Based on a compr resident, the facility who have not used given these drugs therapy is necessa as diagnosed and record; and resider	n 6/5/14, at 8:10 a.m., RN-B d have a left hand, finger lint on vs. a lamb skin palm ed they had one finger lint but it gets soiled and that reason the plain fussy palm ed to R26's left hand. e plan needed to be revised to he use of the finger separator e of splints was requested but d. EGIMEN IS FREE FROM DRUGS ug regimen must be free from s. An unnecessary drug is any excessive dose (including or for excessive duration; or nonitoring; or without adequate ise; or in the presence of nces which indicate the dose or discontinued; or any	F 318	F329 1. Corrective Action: a. Resident's R61 a sleep monitoring initiated to the effectiveness of the medi had used the anti-anxiety me home and found it helped his was trying a new Over the C Medication (OTC) to see if th improve her sleep pattern. B are cognitively intact and abl their feelings about the effect for the medication. b. Resident R 59 ha conditions of anxiety and psy use of the anti-anxiety medic appropriate as deemed by the	help determine cation. R61 dication at seleeping. R59 ounter hat helped oth residents e to verbalize tiveness/need s chronic vchosis and the ation is e care team. xiety e given now at dose as well, n- is that will be R60's use of or help during e planned to be requent use and ion. The needed'' dose time. plies to others: medications for viewed and gnosis and care medication was cologic for the	

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		245467	B. WING		06/05/2014
	PROVIDER OR SUPPLIEF		50	REET ADDRESS, CITY, STATE, ZIP CODE D3 E LINCOLN STREET ENDRICKS, MN 56136	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETIC
F 329	contraindicated, in drugs. This REQUIREME by: Based on interview facility failed to mo medication for 2 of reviewed for unnec to adequately idem indications for the for 2 of 2 residents needed (PRN) anti Findings include: R61 was admitted diagnoses that incl Review of R61's ac a BIMS (brief intervi- 14 indicating R61 t of the physician or following: alprazol medication) 0.5 mg QHS (every bedtim A fax to the physici "Wants anti-anxiety Slept poorly this we documentation fou- that sleep monitorin care plan dated 4/1 an anti-anxiety med During interview or	age 10 an effort to discontinue these NT is not met as evidenced w and document review, the nitor the effectiveness of sleep 5 residents (R61 & R59) cessary medications; and failed tify, assess and monitor clinical continued use of anti-anxiety (R59 & R60) who received as -anxiety medication routinely. to the facility on 3/12/14 with uded depression and anxiety. dmission assessment revealed view for mental status) score of o be cognitively intact. Review ders dated 3/17/14 included the am (an anti-anxiety g (milligrams) po (by mouth) he) for a diagnosis of insomnia. an dated 3/17/14 indicated: v ordered. Used to take Ativan. eekend." There was no nd in R61's record to indicate ng was being tracked. R61's /14 did not address the use of dication for issues with sleep. h 6/4/14 at 3:20 p.m., tN)-A confirmed that sleep	F 329	<ul> <li>hours of sleep monitoring was in those who did not have it.</li> <li>b. The policy for Unnea Medication was reviewed and is</li> <li>c. Education for nursing completed July 8<sup>th</sup> and 10<sup>th</sup> on the the need for appropriate non-medinterventions prior to PRN doses psychotropic medications. And the monitoring and tracking of sleep behaviors.</li> <li>3. All Corrective Actions will be by: July 14<sup>th</sup>, 2014</li> <li>4. Reoccurrence will be prevente 1. An RN will conduct residents per week on anti-anxiet medications to determine if they requirements for those medication under the unnecessary medication regulations.</li> <li>2. Audits will continue and the results brought to the Qu Assurance (QA) Team for review determine the need for further au</li> <li>5. The Correction will be monito a. The Director of Nursi Consultant Pharmacist or designed</li> </ul>	cessary current. g staff was e policy and lication of for the and target e completed ed by: audits of 2 y or sleep meet the n classes n for 90 days ality v and to dits. pred by: ng and

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	ARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
	245467	B, WING	06/05/2014
NAME OF PROVIDER OR SUPP	LIER	STREET ADDRESS, CITY, S 503 E LINCOLN STREET HENDRICKS, MN 561	STATE, ZIP CODE
PREFIX (EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECT TAG CROSS-REFERENC	LAN OF CORRECTION (X5) FIVE ACTION SHOULD BE COMPLETION DED TO THE APPROPRIATE DATE FICIENCY)
initiation of the should have be During interview director of nurs have expected with the initiation R59 received a adequate moni medication. R5 for insomnia bu sleep study or of that the sleep n On 4/10/14 and physician for m	not been tracked for R61 since alprazolam and stated that it	F 329	
Review of the M record) from 4/ R59 received th 4/10/14 to prese Observation of identified R59 a Interview with F verified a sleep conducted for F medication bee	IAR's (medication administration 0/14 to present, identified that is medication every evening from		
daily basis with symptoms and use. R59's diag	n anti-anxiety medication on a but being assessed for anxiety without identified indications for phoses were documented as: ehavioral disturbances and sions Obsolete Event ID: FEFF1	Facility ID: 00340	If continuation sheet Page 12 of 2

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	TMENT OF HEALTH							FORM	06/20/201 APPROVEI 0938-039
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/		1 ' '		É CONSTRUCTION			E SURVEY PLETED
		24	15467	B. WING	ì			06/	05/2014
NAME OF	PROVIDER OR SUPPLIER			<u> </u>	S	TREET ADDRESS, CITY, STATE, ZI	P CODE		
HENDRI	CKS COMMUNITY HO	SPITAL				03 E LINCOLN STREET			
				<u>, 1997)</u>	E	ENDRICKS, MN 56136			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		DED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD	BE	(X5) COMPLETION DATE
F 329	Continued From pa depressive disorder use assessment ca dated 3/11/14, indic long history of men depression. R59 is mg. (milligrams) ev for anxiety/sleep. F medication used for times a day) for dep to identify the sever score was a 2 (whic symptoms) with BIN status) score of 14. family stated that F medications for yea response if the venil discontinued. The initial MDS date was cognitive with a Mental Status) scor also identified that F down, depressed or identified behaviors received an anti-any days. The admitting physi included alprazolam 0.25 mg. (milligrams PRN (as needed) for disturbances. A pos written, was attache (medication adminis of the month next to order. The hand wr resident alprazolam family request. R59 needed) anti-anxiety	r. R59's psych re area asses pated the follow tal illness, inclu- currently on a ery 8 hours PF 359 is also on r depression. PHC ty of depression oression. PHC ty of depression of depression. PHC the alpression of the alpression of the alpression of the alpression of the alpression of the alpression of the alpression of the alpression of the alpression of the alpression	sment (CAA) ving: R59 had a uding liprazolam 0.25 RN (as needed) venlafaxine (a 75 mg BID (two Q9 (a tool used ve symptoms) low depressive view of mental on indicated the on depression fraid of her epressant) was htified that R59 nterview of ocumentation ode of feeling had no nented that R59 on 6 out of 7 dated 3/5/14, medication) very 8 hours th behavioral ated) and hand 2014 MAR over the days m medication : Need to offer (2:00 p.m.) per PRN (as	F	329				
FORM CMS-25	67(02-99) Previous Versions (	Obsolete	Event ID: FEFF11		Faci	ity ID: 00340	f continuatio	n sheet P	age 13 of 27

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Manestoa Department of Health Marshall

		AND HUMAN SERVICES			FORM	); 06/20/2014 / APPROVED ), 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
	and the second	245467	B. WING		06	/05/2014
NAME OF I	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP COL	DE	
HENDRI	CKS COMMUNITY HC	SPITAL	_	03 E LINCOLN STREET IENDRICKS, MN 56136		1 N
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 329	Continued From pa	ge 13	F 329			
	medication sheet la	A 4/3/14 until 6/5/14. The PRN cked documentation by the				
	administration of th symptoms R59 exh	indicated the rationale for the e PRN medication, the ibited and/or any	• •			
	non-pharmacologic	al interventions attempted tration of the medication, nor	- -			
	(nurses notes) from documentation that interventions were a	erdisciplinary progress notes 3/5/14 - 6/4/14, lacked non-pharmacological attempted prior to the e anti-anxiety medication, bund 2 p.m.				1
	verified that R59 wa	3 on 6/5/14 at 8:51 a.m., as not assessed for anxiety being medicated with				
	(MDS) indicated R6 coronary heart dise anxiety disorder, an The MDS indicated that R60 reported n	mission minimum data set 0's diagnoses included ase, Parkinson's disease, d arthritis. R60 had intact cognition and o hallucinations, delusions or as during the assessment				
	Assessment (CAA) was triggered due to antidepressant. The as needed (PRN) or (antianxiety) at bed consistently every n anxiety. The CAA in	Drug Use Care Area dated 3/18/2014, indicated it o daily use of anti-anxiety and cCAA indicated R60 had an rder for Alprazolam time and had taken ight and had diagnosis of dicated the Alprazolam added ne 3/12/14, Fall Risk				

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		AND HUMAN SERVICES & MEDICAID SERVICES	- p			FORM /	06/20/2014 APPROVED 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	a and a second secon	245467	B. WINC	<u>}</u>	· · · · · · · · · · · · · · · · · · ·	06/0	5/2014	
NAME OF	PROVIDER OR SUPPLIER		<b>L</b> :		STREET ADDRESS, CITY, STATE, ZIP CODE	· • · · · · · · · · · · · · · · · · · ·	-	
HENDRI	CKS COMMUNITY HO	SPITAL			503 E LINCOLN STREET HENDRICKS, MN 56136	<u>.</u>	and the second	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE	
F 329	Assessment indicat R60's Physician ord Alprazolam 0.5 milli (HS) as needed for throughout the day f R60 was observed. directions given to h cooperative while re- sit quietly in her root was not observed to behavior. R60's MAR dated 3/ PRN Alprazolam has days. The 5/1/14-5/3 PRN Alprazolam has days for anxiety. The indicated the PRN A administered 3 of 4 was given per R60's Review of R60's inte dated 3/17/14 throug documentation of no interventions prior to antianxiety medication During interview on pharmacist consulta should be providing interventions prior to PRN Alprazolam for R60's medical recom- pharmacist, docume- non-pharmacologica	ed R60 was at risk for falls. ers dated 3/17/14, indicated grams (mg) orally at bed time anxiety. On 6/3/14, rom 8:00 a.m. to 4:00 p.m. R60 was observed to follow er by the staff, she was ceiving cares and was able to m and attend activities. R60 o display any type of disruptive (17/14-3/31/14, indicated the d been administered daily. (14- 4/30/2014, indicated the d been administered 27 of 30 B1/14, MAR indicated the d been administered 23 of 31 e MAR dated 6/1/14- 6/4/14, lprazolam had been days for anxiety. The PRN request. erdisciplinary progress notes gh 6/4/14, revealed no on-pharmacological the administration of the on. 6/4/13, at 12:05 p.m. with the nt, it was stated the nurses non-pharmacological the administration of the anxiety. However, when ds were reviewed by the	F	329				
BM CMS-25	record prior to admir 67(02-99) Previous Versions C	histration of the PRN		Fac	ility ID: 00340 If continuat	ion sheet Pa	ige 15 of 27	

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Manestoa Department of Health Marchall

		AND HUMAN SERVICES			FORM APPROVED OMB NO. 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2010-1910-1910- 1910-1910-1910-1910-1910-	245467	B. WING		06/05/2014
NAME OF	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
HENDRI	CKS COMMUNITY HO	DSPITAL		03 E LINCOLN STREET ENDRICKS, MN 56136	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 329 F 356 SS=C	Alprazolam for anx On 6/5/2014, at 10 policy dated 11/09, It indicated the cor each resident's me review included all assured that all dia available in the resident's documented all cor The policy indicated regimen must be fr 483.30(e) POSTED INFORMATION The facility must por a daily basis: o Facility nume. o The courrent date. o The total number by the following cat unlicensed nursing resident care per sl - Registered nu - Licensed prac vocational nurses (a - Certified nurse o Resident census. The facility must po specified above on of each shift. Data o Clear and readab o In a prominent pla residents and visito The facility must, up make nurse staffing	iety. 55 a.m. the DON provided the Medication Regimen Reviews. Isultant pharmacist reviews dication regimen monthly. The drugs currently ordered, gnostic and monitoring was ident's medical record, and mments. d each resident's medication ee from unnecessary drugs. NURSE STAFFING ast the following information on and the actual hours worked egories of licensed and staff directly responsible for hift: rses. tical nurses or licensed as defined under State law). a aides. st the nurse staffing data a daily basis at the beginning must be posted as follows: le format. ace readily accessible to	F 329	<ul> <li>F356 <ol> <li>Corrective Action: <ol> <li>The Nurse Staffing was updated to include any of the short/middle shifts that are regulated to include any of the short/middle shifts that are regulated nursing home. The form was include all the required component of the nursing home. The form was include all the required component of the short of the required component of the short of the public to share hours and census for each day. <ol> <li>Corrective Action as is applianed and the public to share hours and census for each day.</li> <li>The policy for Daily Staff Hours was reviewed and recent of the need for shift updates and he completed July 8<sup>th</sup> and 10<sup>th</sup> on the need for shift updates and he complete the form.</li> </ol> </li> <li>All Corrective Actions will be by: July 14<sup>th</sup>, 2014</li> <li>Reoccurrence will be preven 1. Audits will be cond House hold coordinator or DON forms twice per week to determ compliance and will be checked daily staff assignment sheet.</li> <li>Audits will continuand the results brought to the Q Assurance (QA) Team for revier determine the need for further and for further and the need for further and for further and the need for further and t</li></ol></li></ol></li></ul>	he larly used in as devised to ents. es to others: l residents, our staffing y Posting of evised. ng staff was he policy and ow to be completed ted by: ucted by the V of the ine l against the e for 90 days uality w and to udits. tored by: sing or

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Minnestoa Department of Health Marshall

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

Event ID: FEFF11

Facility ID: 00340

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PRINTED: 06/20/2014

		AND HUMAN SERVICES				FORM	APPROVED 0.0938-0391	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A, BUILI		E CONSTRUCTION	(X3) DA1	TE SURVEY MPLETED	1
		245467	B, WINC	à	· · · · · · · · · · · · · · · · · · ·	06	/05/2014	
NAME OF I	PROVIDER OR SUPPLIER			1 1 1	TREET ADDRESS, CITY, STATE, ZIP CODE D3 E LINCOLN STREET			]
HENDRI	CKS COMMUNITY HO	DSPITAL			ENDRICKS, MN 56136		والمترجع وأراجع	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 356		ige 16 aintain the posted daily nurse ninimum of 18 months, or as	F	356				
	required by State la	NT is not met as evidenced						
	review the facility fa daily nurse staffing facility name and ac category of nursing to affect all 56 curre well as family mem	tion, interview and document illed to ensure the required information included the ctual hours worked by each staff. This had the potential ent residents in the facility, as bers, and the general public view this information.						
	Findings include:							
	2:45 p.m., an obser nursing staff hours included the curren total hours worked shifts for registered practical nurses (LF (NA). The posting i each shift but did no worked within each	ar of the facility on 6/2/14 at vation was made of posted for the facility. The posting t date, current census, and the on the day, evening, and night nurses (RN), licensed PN), and nursing assistants ncluded the the total hours for of include shorter shifts 8 hour shift for each ting also did not include the						
	registered nurse (R evening shift (2:00 p	6/2/14 at 2:45 p.m., N)-A confirmed that on the p.m. – 10:30 p.m.) there was iddle shift from 4:00 p.m. – s.						
ORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: FEFF11		Facil	ity ID: 00340 If continuati	on sheet	Page 17 of 27	

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Event ID: FEFF11

	· · · · · · · · · · · · · · · · · · ·	& MEDICAID SERVICES			the second s	0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		245467	B. WING	· · · · · · · · · · · · · · · · · · ·		05/2014
	PROVIDER OR SUPPLIER	DSPITAL	50	REET ADDRESS, CITY, STATE, ZIP CC 3 E LINCOLN STREET ENDRICKS, MN 56136	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 356 F 371 SS=F	director of nursing middle shift within t and further confirm 10:00 a.m. middle s to assist residents of 483.35(i) FOOD PF	6/5/14, at 11:49 a.m. the (DON) confirmed there was a he scheduled evening shift ed there was a 7:00 a.m shift within the day shift hours during dining.	F 356 F 371	<ul> <li>F371</li> <li>1. Corrective Action: <ul> <li>a. The cooking uto</li> <li>properly cleaned and dried.</li> <li>immediately removed and c</li> <li>placed back in the kitchen.</li> </ul> </li> <li>2. Corrective Action as is a <ul> <li>a. The dietary staf</li> </ul> </li> </ul>	The fan was cleaned and no upplies to other	s:
	considered satisfac authorities; and	om sources approved or tory by Federal, State or local distribute and serve food litions		<ul> <li>and provided written inform proper procedure for dishwardrying. Written information for staff.</li> <li>b. A policy for Dideveloped to include the prodishes.</li> <li>3. All Corrective Actions we by: July 14<sup>th</sup>, 2014</li> </ul>	nation on the ashing and n was also pos shwashing wa oper drying of	ted 5
	by: Based on observat review the facility fa utensils were dried properly clean the fa	IT is not met as evidenced ion, interview and document iled to assure that cooking prior to storage and failed to an . This had the potential to ts who were served from the		<ul> <li>4. Reoccurrence will be properly 1. Audits by the D or designee will be conduct week to determine compliant dishwashing and drying of 2. Audits will con and the results brought to the Assurance (QA) Team for r determine the need for further the second /li></ul>	Dietary Manage ed 3 times per nce with prope- utensils. tinue for 90 da ne Quality eview and to ner audits.	r
	2:40 p.m., with cook practices were idem pans, 6 inch square ready for use, revea them. When cook-/	r of the kitchen on 6/2/14 at k-A the following deficient tified: 3 of 3 steam table , that were on the shelf and led to have standing water in A picked up the pans and r observation, water ran down		5. The Correction will be n a. The Dietary Mar designee.		

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		AND HUMAN SERVICES & MEDICAID SERVICES		<u>.</u>		FOR	D: 06/20/2014 MAPPROVED D. 0938-0391	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) ML A. BUIL				(X3) DATE SURVEY COMPLETED	
		245467	B. WING	<u>}</u>	and an ann ann an an an an an an an an an a	01	6/05/2014	
	PROVIDER OR SUPPLIER CKS COMMUNITY HO	SPITAL		50	REET ADDRESS, CITY, STATE, ZIP COI 3 E LINCOLN STREET ENDRICKS, MN 56136	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 371	pans used in the ste use, was noted to h pan; 1 of 3 scoops 1 use was wet; 1 of 8 and ready for use w 4 of 10 preparation being clean and rea inside them; and th 1-2 inches of standi the clean mixer agit The above was veri 2:59 p.m. On 6/2/14 at 3:03 p tour with the assista clean dish room, a f running on high, blo and utensils. During was identified that 3 approximately 3 incl and the outer casing blowing out about 1/ Review of the docur with assistant dietar 3:07 p.m., noted tha on the cleaning sche assistant dietary ma time. When asked about p relating to putting kill preparation, away cl dietary manager-A s available that she was been trained to put of	ad on the floor; 1 of 3 oblong earn table, that was ready for ave standing water inside the hat was clean and ready for cutting boards that was clean as noted to have water on it; bowls that were identified as dy for use had standing water e large mixer bowl had about ng water inside the bowl with ator arm touching the water. fied by cook-A on 6/2/14 at .m. during the initial kitchen nt dietary manager-A in the an was identified to be wing air over clean dishes g an inspection of this fan, it blades inside the fan had hes of greasy grim on them g had a grimy debris that was 2 inch from the casing. nented cleaning schedule y manager-A on 6/2/14 at t cleaning of the fan was not edule. This was verified by nager-A at the same date and policies and procedures chen items, used for food ean and dry, the assistant tated that there was no policy as aware of, but staff had blean items away dry. She	F	371				
EORM CMS 25		onstration of Knowledge ger's Food Safety Handbook: Desolete Event ID:FEFF11		Facilit	y ID: 00340 If cont	inuation sheet	Page 19 of 27	

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	TMENT OF HEALTH AND HUMAN SERVICES RS FOR MEDICARE & MEDICAID SERVICES		PRINTED: 06/20/2014 FORM APPROVED OMB NO: 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1 1 1 1 1 1	LE CONSTRUCTION (X3) DATE SURVEY COMPLETED
	245467	B. WING	
	PROVIDER OR SUPPLIER CKS COMMUNITY HOSPITAL	5	STREET ADDRESS, CITY, STATE, ZIP CODE 303 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 (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
F 371	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". 483.55(b) ROUTINE/EMERGENCY DENTAL	F 371	<ul> <li>F412 <ol> <li>Corrective Action: <ol> <li>Resident R41's son decided he</li> <li>did not want the resident to have a dental appointment. Resident R41 also did not desire a dental appointment.</li> </ol> </li> <li>Corrective Action as is applies to others: <ol> <li>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.</li> <li>The policy on Dental Services was reviewed and is current.</li> <li>Education for nursing staff was completed July 8<sup>th</sup> and 10<sup>th</sup> on the policy and they were educated on the procedure for scheduling a dental exam.</li> </ol> </li> <li>All Corrective Actions will be completed by: July 14<sup>th</sup>, 2014</li> <li>Reoccurrence will be prevented by: <ol> <li>Audits by an RN will be conducted on 3 residents are up to date and if this has been evaluated with the quarterly assessments/care conference.</li> <li>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.</li> </ol> </li> <li>The Correction will be monitored by: <ul> <li>The Director of Nursing or designee.</li> </ul> </li> </ol></li></ul>

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLI. IDENTIFICATION NUMBER	A (X2)	MULTIPL JILDING	E CONSTRUCTION	······		E SURVEY APLETED
n n transie Na Roja S		245467	B, W	ING			06/	/05/2014
NAME OF	PROVIDER OR SUPPLIER		<del>منبع الخصص</del>	S	TREET ADDRESS, CITY,	STATE, ZIP CODE		
HENDRI	CKS COMMUNITY HC	<b>ISPITAL</b>			03 E LINCOLN STREE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID REFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORREC TIVE ACTION SHO ICED TO THE APPI EFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 412	annual comprehens 2/12/14 indicated th status (BIMS) asse conducted as the re understood. Review assessment with ar last reviewed 2/12/- resident has 3 teeth no teeth on the bott teeth. Are teeth bro- indicated "yes". Th- indicated, "unknowr indicated, "unknowr indi	eviewed. Review of the sive assessment dated re brief interview for ment ssment was unable to be sident was rarely or neve w of the Oral/Dental Statu h original date of 2/14/13 a 14 included the following: top right, 2 teeth top left, om. The statement, "If ov ken, loose or have decay e date of the last dental e r". The assessment furth been a year or more sinc appointment to the reside family. Document the date ate whether or not an theduled: Resident states al exam et (and) he has n of) pain or discomfort. as at care conference with would like him to have a due to his cognitive w of the care conference 13, 8/28/13, 11/27/13, 4 did not indicate that R41 isulted related to the desintist. 6/5/14, at 10:40 a.m., the DON) and registered nurs ere was no evidence in th been asked if a dental isired for R41.	al rr s and and wn ?" xam er e the nt of te s he o n ''s re	F 412				
	member (FM)-B cor	6/5/14 at 10:48 a.m., fam firmed he had never beer his father (R41) would lik	ר					
ORM CMS-256	57(02-99) Previous Versions (	Obsolete Event ID:	FEFF11	Facil	ity ID: 00340	If continu	uation sheet F	Page 21 of 27

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		AND HUMAN SERVICES			FORM APPROVED MB NO. 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
1 1 1 1 1 1 1 1		245467	B. WING		06/05/2014
NAME OF				STREET ADDRESS, CITY, STATE, ZIP CODE	
HENDRI	CKS COMMUNITY HO	SPITAL		503 E LINCOLN STREET HENDRICKS, MN 56136	n 1. juur - Santa Santa Maria II. juur
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE COMPLÉTION
F 412	During Interview on stated she had just who shared that his years ago and was not want to pull R41 Coumadin (an antio RN-A stated that wh wanted R41 to see ok with him but wan	6/5/14 at 10:54 a.m., RN-A talked with R41's son (FM-B) father had seen a dentist told by the dentist that he did l's remaining teeth due to coagulant medication) use. hen she questioned FM-B if he a dentist, he indicated it was need R41 to have the final say.	F 412	a. The pharmacist review residents medication regimens on basis. The resident cited, R59, 60 were missing some information in reviews related to monitoring for use of non-pharmacologic interve prior to use of a PRN medication anxiety. The Pharmacist did revi residents for June and assured the	a monthly , and 61 those sleep and ntions for ew these required
F 428 SS=D	IRREGULAR, ACT The drug regimen of reviewed at least or pharmacist. The pharmacist mu the attending physic nursing, and these r	of each resident must be the a month by a licensed st report any irregularities to bian, and the director of reports must be acted upon.	F 428	<ul> <li>R59's sleep medication is being n for effectiveness and her anxiety n is being scheduled, R60's anxiety medication was scheduled, R61's medication for sleep and anxiety i monitored.</li> <li>2. Corrective Action as is applies <ul> <li>a. All residents' on med anxiety and for sleep had their phareviewed evaluated for appropriat recommendations related to unneed medications policy and procedure b. The policy for Medication</li> </ul></li></ul>	nonitored nedication s being to others: ications for armacy e cessary
	by: Based on interview facility failed to ensu- medication irregular needed (PRN) anti-a non pharmacologica monitor the effective medication prescrib- residents (R59, R60 unnecessary medica Findings include:	IT is not met as evidenced and document review, the ire the pharmacist reported ities related to the use of as anxiety medication without al interventions in place and/or eness of an anti-anxiety ed for sleep for 3 of 5 0 & R61) reviewed for ations. anti-anxiety medication and		Regimen Reviews and Unnecessa Medication was reviewed and are c. Education for nursing completed July 8 <sup>th</sup> and 10 <sup>th</sup> on the and the need for appropriate non interventions prior to PRN doses of psychotropic medications. And for monitoring and tracking of sleep a behaviors. The Pharmacist and D review the policies and determine a need for further education for th pharmacist.	ry current. was policies medication of or the and target ON will if there is

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		AND HUMAN SERVICES & MEDICAID SERVICES			PRINTED: 06/20/2014 FORM APPROVED OMB NO. 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	۵ <u>۵ می کو</u> در معروف می می از مراجع می می از می افغان مراجع می می می می می می می می	245467	B, WING		06/05/2014
	PROVIDER OR SUPPLIER CKS COMMUNITY HO		50	FREET ADDRESS, CITY, STATE, ZIP CC 33 E LINCOLN STREET ENDRICKS, MN 56136	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
F 428	the consultant phart report that non-phar not been attempted the medication. The 3/24/14, the ad (MDS) indicated R6 coronary heart dise anxiety disorder, an The MDS indicated that R60 reported n behavioral symptom period. R60's Psychotropic Assessment (CAA) was triggered due to antidepressant. The as needed (PRN) or (antianxiety) at bed consistently every n anxiety. The CAA in to R60's fall risk. Th Assessment indicate R60's Physician ord Alprazolam 0.5 millig (HS) as needed for throughout the day f R60 was observed. directions given to h cooperative while re sit quietly in her roor was not observed to behavior. R60's MAR dated 3/ PRN Alprazolam had The MAR dated 4/1/ PRN Alprazolam had	macist did not identify nor macological interventions had prior to the administration of mission minimum data set 0's diagnoses included ase, Parkinson's disease, d arthritis. R60 had intact cognition and o hallucinations, delusions or ns during the assessment Drug Use Care Area dated 3/18/2014, indicated it o daily use of anti-anxiety and CAA indicated R60 had an ider for Alprazolam time and had taken ight and had diagnosis of dicated the Alprazolam added he 3/12/14, Fall Risk ed R60 was at risk for falls. ers dated 3/17/14, indicated grams (mg) orally at bed time anxiety. On 6/3/14, rom 8:00 a.m. to 4:00 p.m. R60 was observed to follow er by the staff, she was ceiving cares and was able to n and attend activities. R60 display any type of disruptive 17/14-3/31/14, indicated the d been administered daily. 14- 4/30/2014, indicated the d been administered 27 of 30	F 428	<ol> <li>All Corrective Actions v by: July 14<sup>th</sup>, 2014</li> <li>Reoccurrence will be pra <ol> <li>The DON or de conduct audits of 6 resident review their pharmacy revie criteria is being met for the Medication Policy and the I Regimen Reviews.                 <ol></ol></li></ol></li></ol>	evented by: ssignee will s per month and ews to see if all Unnecessary Medication tinue for 90 days ne Quality eview and to ner audits. nonitored by: Nursing and
ORM CMS-25	67(02-99) Previous Versions (	Dbsolete Event ID: FEFF11	Facil	ity ID: 00340 If cor	ntinuation sheet Page 23 of 27

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ENTER TEMENT		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			FORM DMB NO (X3) DAT	: 06/20/2014 APPROVED . 0938-0391 E SURVEY IPLETED	
			A. BUILI				1997 - 1997 -	
		245467	B, WINC			06/	05/2014	
	PROVIDER OR SUPPLIER	SPITA		5	TREET ADDRESS, CITY, STATE, ZIP CODE			
				H	IENDRICKS, MN 56136	81.1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	an na
	PRN Alprazolam ha days for anxiety. Th indicated the PRN / administered 3 of 4 was given per R60' Review of R60's int dated 3/17/14 throu documentation of n interventions prior t antianxiety medicat Review of R60's Ph Review forms dated documentation rela and implementation interventions to be n administration of an On 6/4/13, at 12:05 consultant verified h non-pharmacologic drug regimen review of the PRN medicat On 6/4/14, at 3:00 p confirmed the pharn concerns related to interventions prior to medication. On 6/5/2014, at 10:: policy Medication R indicated the consu resident's medicatio review included all c	31/14, MAR indicated the ad been administered 23 of 31 ie MAR dated 6/1/14- 6/4/14, Alprazolam had been days for anxiety. The PRN s request: erdisciplinary progress notes rgh 6/4/14, revealed no on-pharmacological o the administration of the ion. armacist Drug Regimen d 3/31/14, revealed a lack of ted to the lack of identification of non-pharmacological used by staff prior to the til-anxiety medications. p.m. the pharmacist he had not addressed al interventions on the monthly vs prior to the administration ion, Alprazolam. b.m. registered nurse (RN)-A nacist had not identified any non-pharmacological o the administration of the 55 a.m. the DON provided a egimen Reviews dated 11/09, Itant pharmacist reviews each on regimen monthly. The drugs currently ordered, gnostic and monitoring was	F	128				
	available in the resid documented all com The policy indicated	dent's medical record, and						

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interest (a) in a subscription		E & MEDICAID SERVICES		LE CONSTRUCTION	and a second of the second	D. 0938-03 TE SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER;	A. BUILDING			MPLETED
		245467	B. WING		0	6/05/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
HENDRIC	CKS COMMUNITY HO	DSPITAL		503 E LINCOLN STREET HENDRICKS, MN 56136	n Neferska sta	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO		(X5) COMPLETI
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	DATE
F 428	Continued From pa	age 24	F 428			
			1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			
		ere documented as: dementia turbances and depressive		· · · · · · · · · · · · · · · · · · ·		
	disorder. The admi	tting physician's orders, dated				
	3/5/14, included alp	prazolam (anti-anxiety ng. (milligrams) by mouth every				-
		eeded) for dementia with				
	behavioral disturba	nces. A post it note (undated)				
		ached to the April 2014 MAR stration record) over the days	÷			
	of the month next t	o the alprazolam medication				
		hand written note that read: ssed off) Need to offer				
	resident alprazolan	1 daily at 1400 (2:00 p.m.) per				
	family requestJen	nie. R59 received the PRN				
		nxiety medication daily at p.m., daily since 4/3/14 to				
	present. The PRN	Medication Sheet was never				
		the administering staff as to 9 was displaying to require the				
	administration of th	e medication, what				
	non-pharmacologic	al interventions were administering the medication				
	and what results R	59 received from the				
	medication.	-				
		erdisciplinary Progress Notes				
	(nurses notes) from	n 3/5/14 - 6/4/14, lacked any /mptoms prior to administering				
	the alprazolam.	impions pror to administering				
	Interview with RN (I	registered nurse) -B on 6/5/14				
		d that R59 was not assessed ns prior to being medicated				
	with alprazolam.	ns phor to being medicated				
	During a telephone	interview on 6/6/14 at 12:36				
1	p.m., with the consu		1			1

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and the second sec		AND HUMAN SERVICES			FORM	06/20/2014 APPROVED 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A, BUILDING	CONSTRUCTION		E SURVEY IPLETED
	Agentica de la companya de la compan A companya de la comp	245467	B. WING		06/	05/2014
NAME OF PF	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, 2		2
HENDRICI	KS COMMUNITY HO	SPITAL		3 E LINCOLN STREET ENDRICKS, MN 56136		an a
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
and a star of the	Continued From pa for a documented re of medication order	eason that related to the class	F 428			
···· ·		r was received for R59, by the onin 6 mg. (milligrams) orally b) for insomnia.				
r	ecord) from 4/10/1	's (medication administration 4 thru 6/4/14, revealed R59 ation every evening from				
۱ r	verified that R59's r	on 6/5/14 at 8:51 a.m., esponse to the use of een documented to monitor				
r c r	o.m. the consulting considered conduct locumenting hours	interview on 6/6/14 at 12:36 pharmacist verified he never ing a sleep study or of sleep, as this is was a be purchased over the				
F   L   F	5.m. the consulting insure of the reason nedication , adding hair"; "I'm just not s	, "it might be for her skin or ure". The consulting		• •		
id r F	dentified for a poter nonthly drug regime not alerted the DON R61 was admitted to	the facility on 3/12/14 with				
F	Review of R61's adr BIMS (brief intervi	ded depression and anxiety. nission assessment revealed ew for mental status) score of be cognitively intact. Review				

Manesion Department of Health Marchail

		HAND HUMAN SERVICES E & MEDICAID SERVICES			PRINTED: FORM / OMB NO.	<b>PPROVE</b>	
TATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED		
		245467	B. WING		06/05/2014		
	PROVIDER OR SUPPLIEF	1911월 1912년 1912년 - 1912년 1913년 1917년 1917년 1917년 - 1917년 1917년 1917년 1917년 1917년 1917년 1917년 1917년 1917년 1917년 1917년 - 1917년	50	REET ADDRESS, CITY, STATE, ZIP CODE 3 E LINCOLN STREET ENDRICKS, MN 56136			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETIC DATE	
	following: alprazol medication) 0,5 mg QHS (every bedtin A fax to the physic "Wants anti-anxiet Slept poorly this w documentation fout that sleep monitoric care plan dated 4/ an anti-anxiety me During interview or confirmed that R61 monitored the initia "it should have bee During interview or confirmed it would staff to monitor sle- initiation of alprazo During interview or consulting pharmation of sleep should have	ders dated 3/17/14 included the am (an anti-anxiety g (milligrams) po (by mouth) ne) for a diagnosis of insomnia, ian dated 3/17/14 indicated: y ordered. Used to take Ativan, eekend." There was no nd in R61's record to indicate ng was being tracked. R61's 1/14 did not address the use of dication for issues with sleep. h 6/4/14 at 3:20 p.m., RN-A 's sleep had not been ation of the alprazolam, stating m". h 6/4/14 at 9:15 a.m. the DON have been an expectation for ep behavior prior to the lam for insomnia. h 6/6/14, at 4:06 p.m. the cist confirmed that R61's hours ve been monitored after the lam to assess effectiveness	F 428				
		, ,	-				

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Minnestoa Department of Health Marshall

	MENT OF HEALTH			Ŧ	5467022	FORM	06/09/2014 1 APPROVED . 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		1. 1	PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245467		B. WING		06/0	4/2014
	PROVIDER OR SUPPLIER	HOSPITAL	503 E L	RESS, CITY, S INCOLN S ICKS, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCI BE PRECEDED BY FULL NTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	S		K 000			
	FIRE SAFETY A Life Safety Code	Survey was conduct	ed by the				
	Minnesota Departm Fire Marshal Divisio time of this survey,	ient of Public Safety, on, on June 04, 2014 Hendricks Commun	, State . At the ity				
	compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National F	ome was found be in e requirements for pa id at 42 CFR, Subpa ety from Fire, and the Fire Protection Assoc	articipation art 2000 ciation				
		01, Life Safety Code Health Care Occup					
	was constructed as The original building one-story, has no b	g was constructed in asement, is fully fire determined to be of <sup>-</sup>	1969, is sprinkler				
	The first addition wa one-story, has no b protected and was II(111) construction;	as constructed in 198 asement, is fully fire determined to be of <sup>-</sup>	sprinkler Type				
	one-story, has no b protected and was o II(111) construction.	asement, is fully fire determined to be of <sup>-</sup>	sprinkler Type				
	access hospital by a opening protective of	s separated from a c a two-hour fire wall, a consisted of a labele e latching, 90-minute	and the d,				
	detection in the corr	e alarm system with idors and spaces op	en to the		TITLE		(X6) DATE
LADUKAIO	RY DIRECTOR'S OR PROV	DERVOUPPLIER REPRESE	INTATIVE 5 SIG	NATURE	TITLE		(AU) DATE

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 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391								
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE			(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
2454		245467		B. WING		06/0	06/04/2014	
				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 (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE			
K 000	corridors which is n department notifica protected with auto are interconnected control panel [FACF of 58 beds and had survey.	age 1 nonitored for automation. Resident Room matic smoke detecto to the building fire al ?]. The facility has a a census of 57 at tir 42 CFR, Subpart 48	s are ors which arm capacity me of the	K 000	DEFICIENCY	()		
							×.	

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

If continuation sheet Page 2 of 2