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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: G369
Facility ID: 00340

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245467**

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **08/10/2018** (L34)

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)
01 Hospital, 02 SNF/NF/Dual, 03 SNF/NF/Distinct, 04 SNF, 05 HHA, 06 PRTF, 07 X-Ray, 08 OPT/SP, 09 ESRD, 10 NF, 11 ICF/IID, 12 RHC, 13 PTIP, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

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

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

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Holly Kranz, Unit Supervisor — Date : 08/15/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Kamala Fiske-Downing, Enforcement Specialist — Date: 08/15/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

CMS Certification Number (CCN): 245467
August 15, 2018

Mr. Jeffrey Gollaher, Administrator
Hendricks Community Hospital
503 E Lincoln Street
Hendricks, MN 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 August 5, 2018 the above facility is certified for:

58 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

An equal opportunity employer.

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 15, 2018

Mr. Jeffrey Gollaher, Administrator
Hendricks Community Hospital
503 East Lincoln Street
Hendricks, MN 56136

RE: Project Number S5467028

Dear Mr. Gollaher:

On July 9, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 21, 2018. 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 August 10, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on July 30, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 21, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 8, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 21, 2018, effective August 5, 2018 and therefore remedies outlined in our letter to you dated July 9, 2018, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us
cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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Facility ID: 00340

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

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(L3) **HENDRICKS COMMUNITY HOSPITAL**
(L4) **503 E LINCOLN STREET**
(L5) **HENDRICKS, MN** (L6) **56136**

4. TYPE OF ACTION: **2** (L8)

1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **06/21/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

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X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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(L37)	(L38)	(L39)	(L42)	(L43)

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1861 (e) (1) or 1861 (j) (1): (L15)

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

17. SURVEYOR SIGNATURE Date :
Lois Boerboom, HFE NE II 07/22/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 08/03/2018 (L20)

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

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
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B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)

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01-Merger, Closure
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04-Other Reason for Withdrawal

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OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Electronically delivered
July 9, 2018

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

RE: Project Number S5467028

Dear Mr. Gollaher:

On June 21, 2018, 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 electronically delivered CMS-2567, whereby corrections are required.

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:

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

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

Remedies - 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;

Potential Consequences - 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 an "F" tag) and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Holly Kranz, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: holly.kranz@state.mn.us
Phone: (507) 344-2742
Fax: (507) 344-2723

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 31, 2018, 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 31, 2018 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is

acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by September 21, 2018 (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 21, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic 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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145

St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245467	A. BUILDING ______ B. WING ______	C 06/21/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on June 25 through June 28, 2018 during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On June 25 through 28th, 2018 a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The plan of correction will serve as your facility's allegation of compliance. Since your facility is enrolled in the electronic Plan of Correction (ePOC), a signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable ePOC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property,	F 609		8/5/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 07/18/2018

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245467	A. BUILDING ______ B. WING ______	C 06/21/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 1 are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to report allegations of physical abuse to the administrator and State agency (SA) within 2 hours for 1 of 1 resident (R14) who reported an allegation of physical abuse while in the facility. Findings include: R14 had diagnoses identified on diagnosis report 6/21/18, that included anxiety, depression, macular degeneration, left eye blindness, and low vision of right eye. R14's quarterly Minimum Data Set (MDS) assessment dated 3/23/18, identified R14 had a Brief Interview for Mental Status (BIMS) score of	F 609	June 28, 2018: ADONs reviewed Vulnerable Adult policy and procedures at Nurse Staff meeting with emphasis on definitions, timeline reporting requirements, investigation initiation and submission to OHFC. Topic is a repeat agenda item for August 2018 meeting. June 22, 2018 and June 26, 2018: Interdisciplinary Team review of Vulnerable Adult policy and procedure with emphasis on definitions, timeline reporting requirements, investigation initiation and submission to OHFC July 9, 2018: ADON met with CNA involved with an incident involving a Vulnerable Adult allegation. Vulnerable Adult policy and procedures reviewed with	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245467	A. BUILDING ______ B. WING ______	C 06/21/2018

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

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F 609	Continued From page 2 8, which indicated moderate cognitive impairment. The MDS further identified R14 required extensive assistance of one staff with all activities of daily living (ADL's). During interview on 6/18/18, at 6:59 p.m. R14 stated a male employee had taken him outside and "womped him on the head three times". R14 stated this had happened a few months ago. On 6/18/18, at 7:22 p.m. R14's statement was reported to registered nurse (RN)-A. RN-A was familiar with the accusation and indicated it had already been reported, investigated and found unsubstantiated. RN-A further indicated she would retrieve the documents for review. On 6/19/18, at 2:05 p.m. RN-A stated she became aware of this event on 1/8/18 when R14 reported telling a staff member that nursing assistant (NA)-B had hit him in the head three times. RN-A indicated she had completed an investigation but did not have documentation of this or any corresponding incident report. Review of R14's progress notes dated 1/8/18 to 2/12/18 identified R14 reported a male nursing assistant (NA) hit him on the head three times on 1/8/18, however, there was no evidence of the allegation of abuse having been reported within 2 hours to the administrator or state agency (SA). On 6/21/18, at 7:52 a.m. RN-A verified the incident had not been reported. RN-A further indicated "looking back" this event should have been reported and investigated. On 6/21/18, at 10:08 a.m. director of nursing (DON) verified R14's allegation of being hit on the	F 609	emphasis on timeline reporting requirements, investigation initiation and submission to OHFC. CNA demonstrates competency in Vulnerable Adult reporting and investigation requirements as a mandated reporter. Authorized to return to work. July 10, 2018: ADONs reviewed Vulnerable Adult policy and procedures at CNA/TMA meeting with emphasis on timeline reporting requirements, investigation initiation and submission to OHFC. Topic is a repeat agenda item for August 2018 meeting. ADONs scheduled to review Vulnerable Adult policy and procedures at Activity staff July 31, 2018 meeting with emphasis on timeline reporting requirements, investigation initiation and submission to OHFC. Environmental Service, Maintenance and Volunteer service staff education will be done Vulnerable Adult education for new hires has been updated including but not limited to definitions; reporting and investigation policy and procedure. HCHA Abuse Prevention Program policy and procedure has been reviewed and updated with input from Interdisciplinary Team, Nursing Home QAPI Committee and HCHA QAPI Committee. Document will be routed for final approval at upcoming Medical Staff-QAPI Management Team meeting in August. A Quality Assurance Performance Improvement monitor will be established to assure standard of practice is sustained.	

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	245467	A. BUILDING ______ B. WING ______	C 06/21/2018

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F 609	Continued From page 3	F 609		

head should have been reported right away, investigated, and documented. The DON stated she thought the nurse on duty that day had been on top of the situation and it was believed the allegation was related to R14's behaviors and confusion versus factual. DON stated NA-B had been reassigned and had not cared for R14, and had not worked at the facility since March 2018. The DON further indicated the facility had "mis-stepped" per reporting guidelines. The DON verified she could not find a report to the SA for the incident, however, would report it now.

During interview on 6/21/18, at 10:37 a.m. the administrator indicated he had not been immediately notified of this incident. The administrator further indicated allegations of abuse should be reported right away to both himself and the SA.

During interview on 6/21/18, at 1:00 p.m. family member (FM) stated R14 had reported to her in 1/18 that NA-B had hit R14 on the head three times, however, she had thought the allegation was related to confusion due to a urinary tract infection R14 had been ill with. The FM further stated NA-B had been a favorite of R14 previous to the incident and she had not noted any signs of injury to R14's head at the time of the allegation.

The facility Abuse Prevention Program dated 7/08, directed to complete an Incident Report for each resident incident which includes but is not limited to a fall, complaint of abuse, injuries of unknown origin, missing property. The facility will investigate all incidents after they have been reported. Patients, the alleged perpetrator, and other staff will be protected from harm during an investigation and to report all alleged violations

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F 609	Continued From page 4 and substantiated incidents to the Comment Entry Point (CEP) and Minnesota Department of Health (MDH).	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of potential abuse were thoroughly investigated and protection provided to 1 of 1 resident (R14) who reported allegations of abuse while in the facility. Findings include: R14 had diagnoses identified on diagnosis report 6/21/18, that included anxiety, depression, macular degeneration, left eye blindness, and low vision of right eye.	F 610	June 28, 2018: ADONs reviewed Vulnerable Adult policy and procedures at Nurse Staff meeting with emphasis on definitions, timeline reporting requirements, investigation initiation and submission to OHFC. Topic is a repeat agenda item for July 18, 2018 meeting. June 22, 2019 and June 26, 2018: Interdisciplinary Team review of Vulnerable Adult policy and procedure with emphasis on definitions, timeline reporting requirements, investigation	8/5/18

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F 610	Continued From page 5 R14's quarterly Minimum Data Set (MDS) assessment dated 3/23/18, identified R14 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated moderate cognitive impairment. The MDS further identified R14 required extensive assistance of one staff with all activities of daily living (ADL's). During interview on 6/18/18, at 6:59 p.m. R14 stated a male employee had taken him outside and "womped him on the head three times". R14 stated this had happened a few months ago. On 6/18/18, at 7:22 p.m. R14's statement was reported to registered nurse (RN)-A. RN-A was familiar with the accusation and indicated it had already been reported, investigated and found unsubstantiated. RN-A further indicated she would retrieve the documents for review. On 6/19/18, at 2:05 p.m. RN-A stated she became aware of this event on 1/8/18 when R14 reported telling a staff member that nursing assistant (NA)-B had hit him in the head three times. RN-A indicated she had completed an investigation but did not have documentation of this or any corresponding incident report. Review of R14's progress notes dated 1/8/18 to 2/12/18 identified R14 reported a male nursing assistant (NA) hit him on the head three times on 1/8/18, however, there was no evidence of the allegation of abuse having been reported within 2 hours to the administrator or state agency (SA). On 6/21/18, at 7:52 a.m. RN-A verified the incident had not been reported. RN-A further indicated "looking back" this event should have	F 610	initiation and submission to OHFC July 9, 2018: ADON met with CNA involved with an incident involving a Vulnerable Adult allegation. Vulnerable Adult policy and procedures reviewed with emphasis on timeline reporting requirements, investigation initiation and submission to OHFC. CNA demonstrates competency in Vulnerable Adult reporting and investigation requirements as a mandated reporter. Authorized to return to work. July 10, 2018: ADONs reviewed Vulnerable Adult policy and procedures at CNA/TMA meeting with emphasis on timeline reporting requirements, investigation initiation and submission to OHFC. Topic is a repeat agenda item for August 14, 2018 meeting. July 10, 2018: ADONs reviewed Vulnerable Adult policy and procedures at Activity staff meeting with emphasis on timeline reporting requirements, investigation initiation and submission to OHFC. Staff not in attendance is to sign off on the respective meeting minutes at their next scheduled shift. Environmental Service, Maintenance and Volunteer service staff education will be done Vulnerable Adult education for new hires has been updated including but not limited to definitions; reporting and investigation policy and procedure. HCHA Abuse Prevention Program policy and procedure has been reviewed and updated with input from Interdisciplinary Team, Nursing Home QAPI Committee	

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F 610	Continued From page 6 been reported and investigated. On 6/21/18, at 10:08 a.m. director of nursing (DON) verified R14's allegation of being hit on the head should have been reported right away, investigated, and documented. The DON stated she thought the nurse on duty that day had been on top of the situation and it was believed the allegation was related to R14's behaviors and confusion versus factual. DON stated NA-B had been reassigned and had not cared for R14, and had not worked at the facility since March 2018. The DON further indicated the facility had "mis-stepped" per reporting guidelines. The DON verified she could not find a report to the SA for the incident, however, would report it now. During interview on 6/21/18, at 10:37 a.m. the administrator indicated he had not been immediately notified of this incident. The administrator further indicated allegations of abuse should be reported right away to both himself and the SA. During interview on 6/21/18, at 1:00 p.m. family member (FM) stated R14 had reported to her in 1/18 that NA-B had hit R14 on the head three times, however, she had thought the allegation was related to confusion due to a urinary tract infection R14 had been ill with. The FM further stated NA-B had been a favorite of R14 previous to the incident and she had not noted any signs of injury to R14's head at the time of the allegation. The facility Abuse Prevention Program dated 7/08, directed to complete an Incident Report for each resident incident which includes but is not limited to a fall, complaint of abuse, injuries of unknown origin, missing property. The facility will investigate all incidents after they have been	F 610	and HCHA QAPI Committee. Document will be routed for final approval at upcoming Medical Staff-QAPI Management Team meeting August 21, 2018. A Qualtiy Assurance Performance Improvement monitor will be established to assure standard is sustained.	

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F 610	Continued From page 7 reported. Patients, the alleged perpetrator, and other staff will be protected from harm during an investigation and to report all alleged violations and substantiated incidents to the Comment Entry Point (CEP) and Minnesota Department of Health (MDH).	F 610		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.	F 756		8/5/18

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F 756	Continued From page 8 §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility pharmacy consultant (PC) failed to ensure two of two residents (R)22 and R32 prescribed as needed (prn) antipsychotic medications which were utilized beyond 14 days had a duration specified for their use. Findings include: R22's admission diagnosis listing, dated 4/22/18 included late onset Alzheimer's disease, altered mental status, essential hypertension, recurrent Major Depressive Disorder, and unspecified dementia with behavioral disturbance. R22's care area assessment (CAA) dated 4/18/18, identified R22's cognition score as 3, indicating severe cognitive impairment, and a depression score of 5, indicating mild depression. R22 had wandering behaviors 4 of 6 days. R22 had a tendency to wander the halls, frequently stated desire to go home, and frequently looked for a way to go outside. Resident did not like feeing "cooped up." R22 was aware of stop signs located at most exits, and was easily redirected when spoken to. A physician progress dated 5/29/18, and review of R22's current medication administration record	F 756	All resident roster review was completed. Identified 2 residents with prn orders. Attending provider reviewed and discontinued prn medication orders. Hospice resident care management protocol reviewed. Pharmacist education June 21, 2018. Nursing and TMA education on June 27,2018. Provider education accomplished and reinforced at scheduled resident rounds. Standard and process review completed at Medical Staff meeting July 18, 2018. A Quality Assurance Performance Improvement monitor will be established to assure standard of practice is sustained.	

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F 756	Continued From page 9 (MAR) indicated R22's most current order for Zyprexa (an antipsychotic) was 2.5 milligrams (mg) orally (po) prn and had been in place since admission in 4/18. Further review of R22's MAR indicated R22 received Zyprexa prn a total of eight times from 4/12/18, to 4/30/18; 10 times in May 2018, and one time from 6/1/ 2018, to 6/20/2018. Review of R22's physician 60-day progress notes dated 5/29/18, indicated nursing reported resident continued to have exit seeking behavior on a daily basis. R22 wandered into other patient's rooms. R22 tried to elope on two separate occasions during the last month, but was quickly discovered and returned. R22 cried and yelled at staff occasionally. R22 is redirected on a regular basis. Nursing feels medications are adequate. R22's current medications include Zyprexa 2.5 mg prn. R22 was stable since last evaluation. "Medications and recent labs were reviewed...Continue with other present therapy. Continue to redirect [R22's] exiting behavior. If we are unable to keep this under good control, [R22] may need further medication changes. No other new changes for [R22]. Continue with [R22's] current plan of care." Duration for continued use of Zyprexa prn was not indicated by the physician at the face to face visit. R32 R32 was admitted on 2/23/18. On 3/4/18, R32 fell and sustained a hip fracture which was repaired surgically. R32 was evaluated by a psychiatrist related to behaviors during her hospitalization, and was ordered risperidone 0.5 mg po every eight hours prn for anxiety and agitation due to post-operative delirium.	F 756		

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F 756	Continued From page 10	F 756		

On 3/15/18, R32 was readmitted to nursing home with the prn risperidone order. R32's readmission diagnoses included unspecified dislocation of left hip, fracture of left neck of femur, urinary tract infection, history of falling, unspecified dementia with behavioral disturbance, displaced fracture of cuboid bone of unspecified foot, arthritis, and other symptoms and signs involving cognitive functions and awareness.

R32's five day Medicare Minimum Data Set (MDS) assessment, dated 4/9/18, indicated R32's cognition score was 7 indicating moderate impairment. R32 had occurrence of physical and verbal behaviors both directed and not directed towards others, and rejection of cares one to three times per week. R32 was not indicated to be at significant risk for physical injury.

R32's subsequent significant change MDS, dated 5/2/18, indicated a cognition score of 6, moderate impairment. Behaviors of verbal and physical directed and not directed towards others occurred one to three times per week. The MDS did not indicate R32 was at significant risk for harming self or others.

R32's most recent long term care physician's note dated 6/20/18, stated according to nursing home staff, R32's pain is controlled. R32 is not ambulatory due to left hip dislocation and is not a candidate for surgical treatment. R32 has history of abnormal behavior and nursing home staff report behaviors of pocketing food and undressing public, and being awake most of the night. Resident used prn risperidone 7 times. Physician indicated to continue present cares. Chronic and mental problems are stable. Left hip

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F 756	Continued From page 11 pain is well controlled with current medications. Resident is at high risk for falls due to chronic hip dislocation and being nonambulatory. Continue to treat abnormal behavior with mirtazapine and risperidone as recommended by her psychiatrist. Patient will be evaluated during next routine nursing home visit or sooner if needed. R32's physician did not indicate the duration for use of the prn risperidone. Most recent physician order dated 5/23/18, indicated R32 was ordered risperidone 0.5 mg po every eight hours as needed for anxiety and agitation three times daily as needed. The order did not indicate a duration for continued use of the prn risperidone. Review of pharmacy monthly medication reviews dated 3/21/18, 4/30/18, and 5/31/18, indicated all medications were reviewed. No recommendations indicated. During an interview on 06/20/18, 12:46 p.m. the PC stated it was not common practice to prescribe prn antipsychotics, and prn antipsychotic use is not recommended. The PC was not aware R22 and R32 were ordered prn antipsychotics. Medications for R22 and R32 were reviewed, and the PC stated "I am surprised that it is prescribed," R22 is newer to the facility, and behaviors were more extreme and included severe exit seeing behavior. R32 was in and out of the hospital due to a hip fracture, and was "severely demented", and displaced the hip several times since the initial fracture, and "essentially the only time she is safe is when she is sleeping." The prn risperidone is a new prescription that is being trialed to try to reduce restlessness due to the fracture and cognition.	F 756		

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F 756	Continued From page 12 "They are trying to keep R32 from moving as much to allow the hip to heal, but R32 keeps re-injuring the hip. "It is a very difficult situation." PC stated the prn risperidone and Zyprexa were not reviewed within 14 days, and did not have documentation to indicate the duration of prn use.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a	F 758		8/5/18

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F 758	Continued From page 13 diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure two of two residents (R)22 and R32 prescribed as needed (prn) antipsychotic medications which were utilized beyond 14 days had a duration specified for their use. Findings include: R22's admission diagnosis listing, dated 4/22/18 included late onset Alzheimer's disease, altered mental status, essential hypertension, recurrent Major Depressive Disorder, and unspecified dementia with behavioral disturbance. R22's care area assessment (CAA) dated 4/18/18, identified R22's cognition score as 3, indicating severe cognitive impairment, and a depression score of 5, indicating mild depression. R22 had wandering behaviors 4 of 6 days. R22	F 758	All resident roster review was completed. Identified 2 residents with prn orders. Attending provider reviewed and discontinued medication order. Hospice resident care management protocol reviewed. Pharmacist education June 21, 2018. Nursing and TMA education on June 27,2018. Provider education accomplished and reinforced at scheduled resident rounds. Standard and process review completed at Medical Staff meeting July 18, 2018. A Quality Assurance Performance Improvement monitor will be established to assure standard of practice is sustained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245467	A. BUILDING ______ B. WING ______	C **06/21/2018**

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

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F 758	Continued From page 14 had a tendency to wander the halls, frequently stated desire to go home, and frequently looked for a way to go outside. Resident did not like feeing "cooped up." R22 was aware of stop signs located at most exits, and was easily redirected when spoken to. A physician progress dated 5/29/18, and review of R22's current medication administration record (MAR) indicated R22's most current order for Zyprexa (an antipsychotic) was 2.5 milligrams (mg) orally (po) prn and had been in place since admission in 4/18. Further review of R22's MAR indicated R22 received Zyprexa prn a total of eight times from 4/12/18, to 4/30/18; 10 times in May 2018, and one time from 6/1/ 2018, to 6/20/2018. Review of physician 60-day progress notes dated 5/29/18, indicated nursing reported resident continued to have exit seeking behavior on a daily basis. R22 wandered into other patient's rooms. R22 tried to elope on 2 separate occasions during the last month, but was quickly discovered and returned. R22 cried and yelled at staff occasionally. R22 is redirected on a regular basis. Nursing feels medications are adequate. R22's current medications include Zyprexa 2.5 mg prn. R22 was stable since last evaluation. "Medications and recent labs were reviewed...Continue with other present therapy. Continue to redirect [R22's] exiting behavior. If we are unable to keep this under good control, [R22] may need further medication changes. No other new changes for [R22]. Continue with [R22's] current plan of care." Duration for continued use of Zyprexa prn was not indicated by the physician at the face to face visit.	F 758		

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F 758	Continued From page 15 R32 R32 was admitted on 2/23/18. On 3/4/18, R32 fell and sustained a hip fracture which was repaired surgically. R32 was evaluated by a psychiatrist related to behaviors during her hospitalization, and was ordered risperidone 0.5 mg po every eight hours prn for anxiety and agitation due to post-operative delirium. On 3/15/18, R32 was readmitted to nursing home with the prn risperidone order. R32's readmission diagnoses included unspecified dislocation of left hip, fracture of left neck of femur, urinary tract infection, history of falling, unspecified dementia with behavioral disturbance, displaced fracture of cuboid bone of unspecified foot, arthritis, and other symptoms and signs involving cognitive functions and awareness. R32's five day Medicare Minimum Data Set (MDS) assessment, dated 4/9/18, indicated R32's cognition score was 7 indicating moderate impairment. R32 had occurrence of physical and verbal behaviors both directed and not directed towards others, and rejection of cares one to three times per week. R32 was not indicated to be at significant risk for physical injury. R32's subsequent significant change MDS, dated 5/2/18, indicated a cognition score of 6, moderate impairment. Behaviors of verbal and physical directed and not directed towards others occurred one to three times per week. The MDS did not indicate R32 was at significant risk for harming self or others. R32's most recent long term care physician's note dated 6/20/18, stated according to nursing	F 758		

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F 758	Continued From page 16 home staff, R32's pain is controlled. R32 is not ambulatory due to left hip dislocation and is not a candidate for surgical treatment. R32 has history of abnormal behavior and nursing home staff report behaviors of pocketing food and undressing public, and being awake most of the night. Resident used prn risperidone 7 times. Physician indicated to continue present cares. Chronic and mental problems are stable. Left hip pain is well controlled with current medications. Resident is at high risk for falls due to chronic hip dislocation and being nonambulatory. Continue to treat abnormal behavior with mirtazapine and risperidone as recommended by her psychiatrist. Patient will be evaluated during next routine nursing home visit or sooner if needed. R32's physician did not indicate the duration for use of the prn risperidone. Most recent physician order dated 5/23/18, indicated R32 was ordered risperidone 0.5 mg po every eight hours as needed for anxiety and agitation three times daily as needed. The order did not indicate a duration for continued use of the prn risperidone. Review of pharmacy monthly medication reviews dated 3/21/18, 4/30/18, and 5/31/18, indicated all medications were reviewed. No recommendations indicated. During an interview on 06/20/18, 12:46 p.m. pharmacist consultant (PC) stated it is not common practice to prescribe prn antipsychotics, and prn antipsychotic use is not recommended. PC was not aware R22 and R32 were ordered prn antipsychotics. Medications for R22 and R32 were reviewed, and the PC stated "I am surprised that it is prescribed," R22 is newer to the facility,	F 758		

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F 758	Continued From page 17 and behaviors were more extreme and included severe exit seeing behavior. R32 was in and out of the hospital due to a hip fracture, and was "severely demented", and displaced the hip several times since the initial fracture, and "essentially the only time she is safe is when she is sleeping." The prn risperidone is a new prescription that is being trialed to try to reduce restlessness due to the fracture and cognition. "They are trying to keep R32 from moving as much to allow the hip to heal, but R32 keeps re-injuring the hip. "It is a very difficult situation." PC stated the prn risperidone and Zyprexa were not reviewed within 14 days, and did not have documentation to indicate the duration of prn use. During an interview on 06/20/18, 1:37 p.m. The prn antipsychotic medications had been ordered for difficult behaviors for R22 and R32. R22 was prescribed Zyprexa for her wandering and anxiety and exit seeking due to her dementia. R22 had not been evaluated by a psychiatrist since her return to the hospital. R32 was ordered risperidone prn after a psychiatric review in the hospital. Recovery was difficult for R32 after her hip fracture. R32 had dislocated the left hip a few times after the fracture due to cognition. The ADON stated she was not aware prn antipsychotic medicates were limited to use of fourteen days without a physician review indicating the duration for continued use.	F 758		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call	F 919		8/5/18

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F 919	Continued From page 18 directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assure call lights were maintained in functional working order for 2 of 48 residents (R45, R8) reviewed during the survey. Findings include: During interview on 6/18/18, at 7:03 p.m. R45 stated the call light by his chair was "dead", further stating staff had been told about it, yet it hadn't worked for about "three to four months". When tested, the call light (which was located next to the recliner chair), did not turn on at the wall or light up outside the room. Maintenance manager(MM)-A verified R45's call light did not light up or make an audible sound and further stated he was unaware it was not working. MM-A described the process for reporting needed repairs as: If urgent, staff page maintenance staff; and if not urgent, the request is written in the maintenance repair log binder located at the main nursing station which maintenance staff check every morning. MM -A confirmed that a non working call light would be considered an urgent request and should have been paged. On 6/18/18, at 7:25 p.m., the call light was replaced. During observation on 6/20/18, at 8:34 a.m. R8 was observed laying in bed awake. R8's bathroom call light was tested. The call light next to the toilet did not turn on either at the wall connection nor on the display outside the room. R8 was observed to utilize the bedside call light at	F 919	CNA and Nurse training on call light alert system completed in July 2018. Have increased monitoring to daily. Will establish a Quality Assurance Performance Improvement monitor to confirm logging of battery checks.	

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F 919	Continued From page 19 8:59 a.m. requesting supplies. NA-A entered R8's room and verified R8's bathroom call light was not working. NA-A stated R8 is independent with ambulating to the bathroom and is at high risk for falls and further stated that she would report it immediately. R8's bathroom call light activity report for June 2018 was reviewed and the most recent activation of the call light was logged as 6/8/18. The Maintenance repair log was reviewed from the dates of 12/1/17 to 6/19/18, no repair request was logged for room 215 or 400. On 3/12/18, at 11:01 a.m. RN-A stated that nursing doesn't routinely check the call lights and further stated maintenance does that. On 6/21/18, at 10:52 a.m. during interview with the maintenance manager(MM) it was stated, "they (surveyors) asked this question last year and they (facility) was supposed to come up with a plan where the night shift checked the call lights. The MM stated, "We don't check them, we just fix them when we are told they don't work." An interview with the facility services manager on 6/21/18, at 11:04 a.m. revealed call lights are all checked quarterly and were last done on 5/11/18 and would be completed again in July.	F 919		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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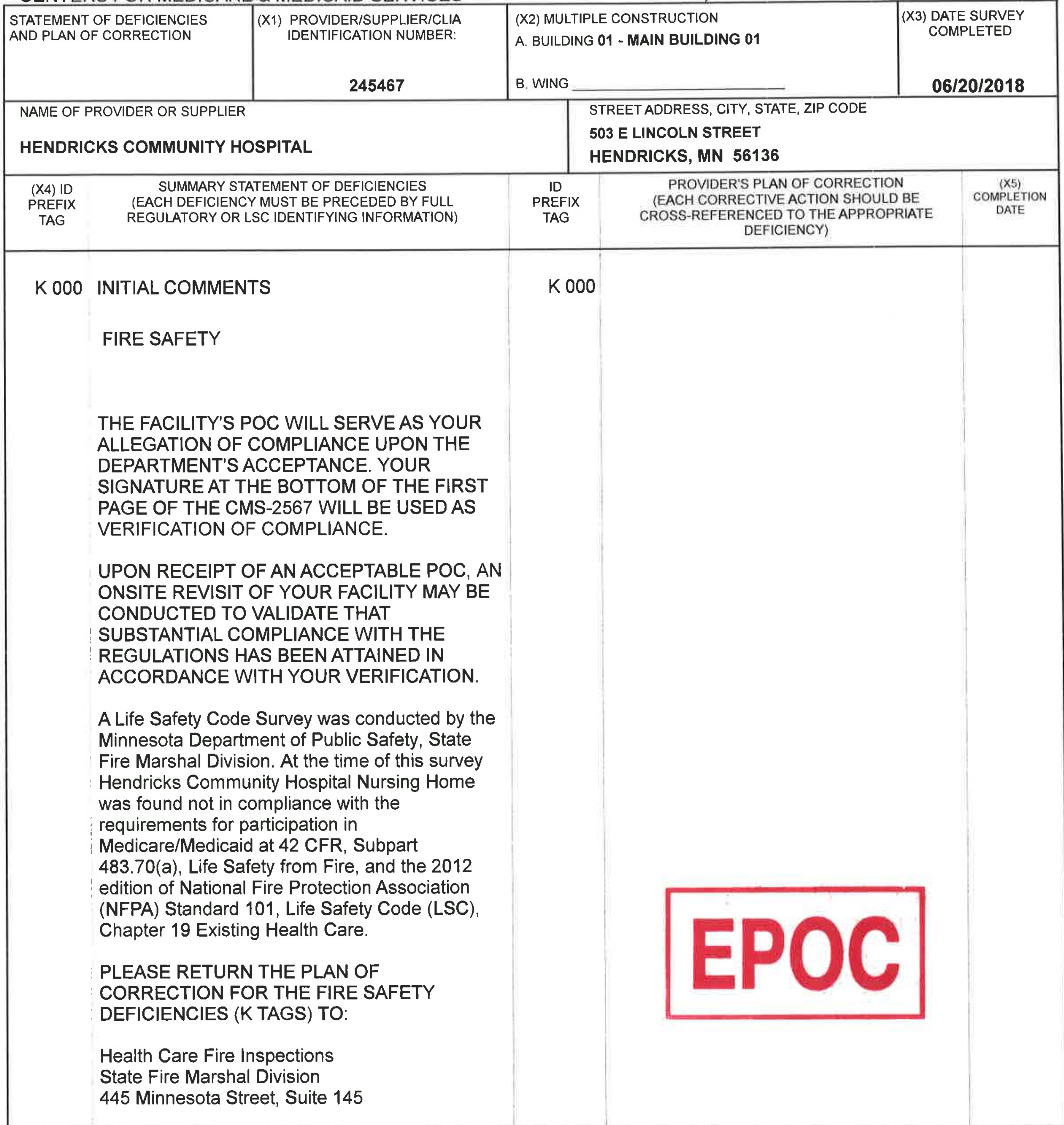
OMB NO. 0938-0391



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K 000	INITIAL COMMENTS FIRE SAFETY 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 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Hendricks Community Hospital Nursing Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/18/2018

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

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K 000	Continued From page 1	K 000		

St. Paul, MN 55101

Or by e-mail to:
Marian.Whitney@state.mn.us
and
Angela.Kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency

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

The nursing home is separated from a critical access hospital by a two-hour fire wall, and the

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K 000	Continued From page 2 opening protective consisted of a labeled, self-closing, positive latching, 90-minute fire rated door assembly. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. Resident Rooms are protected with automatic smoke detectors which are interconnected to the building fire alarm control panel [FACP]. The facility has a capacity of 58 beds and had a census of 48 at the time of the survey. The requirement at 42 CR, Subpart 483.70(a) is **NOT MET** as evidenced by:	K 000		
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the	K 914		7/12/18

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K 914	Continued From page 3 electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) FINDINGS INCLUDE: Based on observation and interview, the Facility failed to comply with (NFPA 99). On facility tour between 10:00 AM and 1:00 PM on 06/20/2018, it was revealed that not all of the testing procedures were being conducted during the electric receptacle testing. The electrical receptacles must receive the following inspections:	K 914	Electric receptacle testing will be done annually by the Maintenance Department. This will include: 1) Visual Inspection 2) Verification of the continuity of the grounding circuit in each electrical receptable 3) Confirm correct polarity of the hot and neutral connections in each receptacle 4) Confirm the retention force of the grounding blade of each electrical receptacle is within accepatable paramenter-not exceeding 115g (4oz).	

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K 914	Continued From page 4 1.The physical integrity of each receptacle shall be confirmed by visual inspection. 2. The continuity of the grounding circuit in each electrical receptacle shall be verified. 3. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed. 4. The retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 g (4 oz). This deficient practice was verified by the Facility Maintenance Director.	K 914		