Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 13, 2025

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

RE: CCN: 245467
Cycle Start Date: April 30, 2025

Dear Administrator:

On April 30, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by July 30, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by October 30, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

https://forms.web.health.state.mn.us/form/NHDisputeResolution

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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Compliance Analyst | Federal Enforcement
Health Regulation Division
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May 13, 2025

Administrator
Hendricks Community Hospital
503 E Lincoln Street
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Re: State Nursing Home Licensing Orders
Event ID: GMK211

Dear Administrator:

The above facility was surveyed on April 28, 2025 through April 30, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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Compliance Analyst | Federal Enforcement
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245467	A. BUILDING _____ B. WING _____	C 04/30/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 4/28/25 through 4/30/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 4/28/25 through 4/30/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H54673340C (MN105461). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 640	Encoding/Transmitting Resident Assessments	F 640		6/20/25

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

Electronically Signed | 05/22/2025

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
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F 640 SS=D	Continued From page 1 CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review.	F 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 640	Continued From page 2 (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure timely submission of a Death in facility Minimum Data Set (MDS) for 1 of 14 residents (R9) who was reviewed for an MDS record over 120 days old. Findings include: R9's medical record identified her last scheduled Minimum Data Set (MDS) assessment that had been submitted and validated was 11/26/24. R9's death in facility MDS was signed by the responsible party on 1/7/25 and locked on 1/7/25. The death in facility MDS had not been successfully submitted and/or transmitted; as R9's electronic health record identified it had been completed rather than accepted under the status section, indicating it had not been submitted. Observation, and interview and validation report review on 4/29/25 at 8:49 a.m., with registered nurse (RN)-A identified she had taken over as the MDS coordinator the second or third week of January 2025. Before that, multiple persons had completed MDS assessments. RN-A identified	F 640	The facility failed to accurately complete and transmit the MDS discharge assessment death in facility for (R9) within the appropriate time frame, which resulted in non-compliance with F640. Immediate Action: This has been identified and assessment has been completed and re-submitted to the iQIES system. No negative outcomes were identified due to the delay. Corrective Action: The MDS Coordinator received re-education on F640 requirements and the internal workflow for timely and accurate MDS completion and submissions. The MDS Coordinator implemented a tracking log to monitor all MDS due dates and submission confirmations. All active and complete MDS, along with final MDS, will be reviewed prior to submissions. 1) Weekly IDT discussions will include review of MDS schedule to ensure accuracy of submissions to prevent delays. 2) DON will audit weekly for 3 months to	

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F 640	Continued From page 3 the person who had completed R9's final assessment completed and locked the assessment on 1/7/25, but failed to validate the assessment which would have sent the assessment to the submission file in the Meditech electronic medical record program. She kept a list of MDS due dates, and her process was to submit completed MDS's each week and review the Validation report to ensure all MDS assessments had been submitted successfully. RN-A reported she had not reviewed MDS submissions prior to her taking over the position and had not been aware of the outstanding assessment. RN-A was unsure why R9's death in facility MDS had not been validated and submitted, but she identified she would now validate and submit the assessment. Interview on 4/30/25 at 2:30 p.m. with the director of nursing (DON), identified her expectation for the MDS coordinator to keep track of Assessment Reference Date (ARD), with completion, validation, and submission of MDS assessments within the required time frames. Review of the September 2023, Completion of Assessments policy identified assessments were to be completed according to the MDS ARD with submission according to required time frames. All MDS assessments were to be completed by responsible departments prior to the last identified date of the observation period. The RN MDS coordinator completed and signed the assessment on the Assessment Reference Date.	F 640	ensure 100% accuracy of submissions. These actions being put in place will serve as a benefit for all current and future residents. Corrections: The policy and procedure will undergo review and be revised if needed by completion date. Monitoring results will be brought to QAPI committee for review and follow-up as part of our ongoing quality improvement efforts.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans	F 656		6/20/25

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F 656	Continued From page 4 §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this	F 656		

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F 656	Continued From page 5 section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the care plan was updated for 1 of 1 resident (R34) reviewed for side effect monitoring of anticoagulant (blood thinner) therapy. Findings include: R34's annual Minimum Data Set (MDS) dated 3/13/25, indicated R34 had severe cognitive impairment, received antipsychotic, antianxiety, antidepressant, and anticoagulant medication. R34's diagnoses included history of stroke and deep venous thrombosis (DVT), depression, anxiety, dementia and Alzheimer's disease. R34's medication order form printed 4/30/25, indicated R34's active order dated 4/1/25, for Eliquis (anticoagulant) 2.5 mg orally twice a day for DVT of left lower extremity (LLE). The order did not include any label comments or special instructions. R34's care plan printed 4/30/25, identified R34 was at high risk for falls as evidenced by history of multiple falls and vision loss and was at risk for medication side effects related to the use of antipsychotic, antidepressant, and antianxiety medications. R34's care plan lacked evidence of anticoagulant use, increased risk for bleeding, or need for anticoagulant side effect monitoring.	F 656	The facility failed to accurately update the careplan for R34 for monitoring side effects of anticoagulant therapy. Immediate Action: The careplan for R34 was immediately reviewed and updated to include specific monitoring parameters for side effects of anticoagulant therapy. Corrective Action: Case Managers and MDS Coordinators re-educated on Careplan Policy to ensure careplans reflect current interventions and goals related to anticoagulant therapy. An audit was conducted to identify all residents currently on anticoagulant therapy. All identified resident careplans were reviewed to ensure appropriate monitoring of interventions for side effects are included in the individualized careplans based on the diagnosis for the anticoagulant therapy. 1) An audit will be conducted weekly for 1 month, then monthly for 3 months to ensure anticoagulant therapy interventions with side effects are careplanned. Results will be reviewed and shared during the QAPI meetings as part of our ongoing quality improvement efforts. 2) 100% of residents who are on anticoagulant therapy will have individualized careplans reviewed and will	

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F 656	Continued From page 6 During interview on 4/30/25 at 9:21 a.m., licensed practical nurse (LPN)-A confirmed R34's EMAR listed Eliquis but lacked any special instructions for monitoring for potential side effects. LPN-A further stated such instructions could also be found in the resident's care plan and confirmed R34's care plan lacked any reference to anticoagulant use, side effect monitoring or increased risk for bleeding. During interview on 4/30/25 at 10:20 a.m., director of nursing (DON) stated side effect monitoring for medications should be care planned. DON stated R34's care plan should include anticoagulant use and instruct staff to monitor for potential side effects including increased bleeding risk. DON further stated EMAR could also include special instructions for medications. DON confirmed R34's care plan and EMAR lacked any reference to anticoagulant use, risks or side effect monitoring. DON stated the MDS nurse often updated the resident's care plans and may have additional information. During interview on 4/30/25 at 10:35 a.m., MDS nurse stated side effect monitoring should be on a resident's care plan when they were receiving an anticoagulant. MDS nurse stated staff should be instructed to watch for bleeding. During interview on 4/30/25 at 10:54 a.m., consultant pharmacist (CP) stated staff should be aware of potential side effects of medications and should actively monitor for them. CP further stated this facility's population often received additional medications that put them at risk for falls and therefore, side effect monitoring of anticoagulants was particularly important.	F 656	include monitoring for common side effects. Corrections: The policy and procedure will undergo review and be revised if needed by completion date. Audits will be conducted by DON in correspondence with the MDS Coordinator. Updated #1 to include results will be reviewed at QAPI meetings as part of our ongoing quality improvement efforts. Any concerns brought up at QAPI will be addressed with additional training or process improvement.	

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F 656	Continued From page 7 Facility policy Anticoagulation-Clinical Protocol dated 2018, instructed staff to, "Assess for any signs or symptoms related to adverse drug reactions due to the medication alone or in combination with other medications." The policy instructed staff to monitor for possible complications such as excessive bruising, hematuria (blood in urine), hemoptysis (coughing up blood), or other bleeding and to contact provider before administering next dose of anticoagulant. Facility policy Care Plans/Care Conferences dated 12/2022, indicated, "An individualized, comprehensive plan of care will be developed, maintained and followed for each resident." The policy further indicated resident care plans should include information regarding how medications were being used and evaluated and should be updated as needed.	F 656		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced	F 727		6/20/25

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F 727	Continued From page 8 by: The facility's request for a waiver was accepted and approved by the State Agency following the survey dated 7/17/23. The tag was re-issued however, NO plan of correction was required. This will remain in effect until such time as the registered nurse (RN) coverage can be filled and the facility achieves compliance. F727: CFR 483.35 (b)(1), RN coverage 8 consecutive hours a day, 7 days a week. Findings include: Review of the facility nursing staff schedules for February 2025, March 2025 and April 2025 identified in: 1) March 2025, No 8-hour consecutive RN coverage for 2 of 31 days: 3/8 and 3/9/2025. 2) April 2025, No 8-hour consecutive RN coverage for 1 of 30 days: for 4/12/2025. Interview on 4/30/25, 2:30 p.m. with the director of nursing (DON) reported the scheduler attempted to fill open shifts and notified management of call-ins or unfilled shifts. The DON reported there was a registered nurse on call, and she could be assigned to cover the open shift also if needed, or the nurse managers could pick up and work the open hours. The facility continues to struggle with hiring to ensure there was a registered nurse (RN) 8 hour/24-hour on duty, but the facility was attempting to find more staff. Interview on 4/30/25 at 3;30 p.m., with the administrator reported the facility has reached out to many resources to fill RN positions, in addition to utilizing online web-sites to obtain licensed	F 727	Waivered tag: No plan of correction required.	

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F 727	Continued From page 9 employees. They struggle with hiring and filling that position all days. Interview and source verification review on 4/30/25 at 3:42 p.m. with human resources officer (HR) identified she had posted staff openings on Indeed, both local and neighboring city newspapers, Facebook, and other county specific web-sites. Review of the July 2023, Scheduling and Absenteeism Policy -HCHA Long Term Care identified the facility policy was to maintain staff staffing levels and provide the necessary care and safety to the residents in the facility, Staffing was identified according to need with the number of residents residing in the facility. The policy identified the goal of RN coverage a minimum of 8 hours/24 hours, 7 days/week.	F 727		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse	F 757		6/20/25

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F 757	Continued From page 10 consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure side effect monitoring for 1 of 1 resident (R34) reviewed for anticoagulant (blood thinner) therapy. Findings include: R34's annual Minimum Data Set (MDS) dated 3/13/25, indicated R34 had severe cognitive impairment, received antipsychotic, antianxiety, antidepressant, and anticoagulant medication. R34's diagnoses included history of stroke and deep venous thrombosis (DVT), depression, anxiety, dementia and Alzheimer's disease. R34's medication order form printed 4/30/25, indicated R34's active order dated 4/1/25, for Eliquis (anticoagulant) 2.5 mg orally twice a day for DVT of left lower extremity (LLE). The order did not include any label comments or special instructions. R34's care plan printed 4/30/25, identified R34 was at high risk for falls as evidenced by history of multiple falls and vision loss and was at risk for medication side effects related to the use of antipsychotic, antidepressant, and antianxiety medications. R34's care plan lacked evidence of anticoagulant use, increased risk for bleeding, or need for anticoagulant side effect monitoring.	F 757	The facility failed to ensure proper monitoring of anticoagulation therapy. Immediate Action: An audit was conducted to identify all residents currently on anticoagulant therapies. All identified resident careplans were reviewed to ensure appropriate monitoring of interventions for side effects are included in the individualized careplans based on the diagnosis for the anticoagulant therapy. Corrective Action: 1) Discuss anticoagulant monitoring at the next nurse / CNA meeting 2) Weigh the risks/benefits/alternatives of continued anticoagulation as appropriate. 3) An audit will be conducted weekly for 1 month, then monthly for 3 months to ensure anticoagulant therapy interventions with side effects are careplanned. Results will be reviewed and shared during the next QAPI meeting. 100% of residents who are on anticoagulant therapy will have individualized careplans reviewed and will include monitoring for common side effects. Corrections: The policy and procedure will undergo	

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F 757	Continued From page 11 During interview on 4/30/25 at 7:46 a.m., licensed practical nurse (LPN)-A stated instructions such as monitoring for side effects of medications should be listed in the electronic medication administration record (EMAR) under special instructions. LPN-A stated increased bleeding was a potential side effect of anticoagulant use. During follow up interview on 4/30/25 at 9:21 a.m., LPN-A confirmed R34's EMAR listed Eliquis but lacked any special instructions for monitoring for potential side effects. LPN-A further stated such instructions could also be found in the resident's care plan and confirmed R34's care plan lacked any reference to anticoagulant use, side effect monitoring or increased risk for bleeding. LPN-A further confirmed R34's Eliquis pill bubble pack contained a yellow label instructing staff to "contact provider if bleeding concerns" and stated does not reference that label since those label instructions were supposed to be included in the EMAR under special instructions. During interview on 4/30/25 at 10:20 a.m., director of nursing (DON) stated side effect monitoring for medications should be care planned. DON stated R34's care plan should include anticoagulant use and instruct staff to monitor for potential side effects including increased bleeding risk. DON further stated EMAR could also include special instructions for medications. DON confirmed R34's care plan and EMAR lacked any reference to anticoagulant use, risks or side effect monitoring. DON stated the MDS nurse often updated the resident's care plans and may have additional information. During interview on 4/30/25 at 10:35 a.m., MDS	F 757	review and be revised if needed by completion date. Audits will be conducted by DON in correspondence with the MDS Coordinator and Case Managers.	

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F 757	Continued From page 12 nurse stated side effect monitoring should be on a resident's care plan when they were receiving an anticoagulant. MDA nurse stated staff should be instructed to watch for bleeding. During interview on 4/30/25 at 10:54 a.m., consultant pharmacist (CP) stated staff should be aware of potential side effects of medications and should actively monitor for them. CP further stated this facility's population often received additional medications that put them at risk for falls and therefore, side effect monitoring of anticoagulants was particularly important. Facility policy Anticoagulation-Clinical Protocol dated 2018, instructed staff to, "Assess for any signs or symptoms related to adverse drug reactions due to the medication alone or in combination with other medications." The policy instructed staff to monitor for possible complications such as excessive bruising, hematuria (blood in urine), hemoptysis (coughing up blood), or other bleeding and to contact provider before administering next dose of anticoagulant.	F 757		
F 865 SS=F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and	F 865		6/25/25

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F 865	Continued From page 13 demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice;	F 865		

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F 865	Continued From page 14 §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around	F 865		

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F 865	Continued From page 15 safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure data submitted to 1 of 1 Quality Assurance Performance Improvement (QAPI) committee was analyzed and documented to ensure areas identified had oversight for their perspective outcomes brought forth. This had the potential to affect all 47 residents. Findings include: Review of QAPI meeting minutes provided from 4/16/2024 through March 31, 2025 identified in: 1.) April 16, 2024- agenda items identified problem with falls, but no identified goal, action plan, data collection or analysis of the information identified. 2.) June 25, 2024- agenda items identified some areas of concern, but failed to include goals, action plan, method for data collection or analysis 3.) July 30, 2024- Identified working on family notification for therapy, completion of 72 H forms, resident toileting, or repositioning. No goals, action plan, data or analysis identified. 4.) Oct 2024- no review of any projects in place	F 865	Failed to ensure data submitted to 1 of 1 QAPI committee was analyzed and documented to ensure areas identified had oversight for their perspective outcomes brought forth. Data gathered from both state resources such as quality indicators and manually gathered within our facility will be brought to the QAPI meeting by the managers from the long-term care facility for review. The data will be analyzed and goals will be identified by the QAPI committee. The QAPI committee will determine auditing schedules, education to be provided, etc. needed in order to achieve the set goal. The QAPI committee will continue to re-evaluate the data in order to determine compliance and need for further monitoring. Staff will be education on the facility QAPI plan and progress regularly at staff meetings. Residents and staff will be made aware of areas being worked on in order to get input.	

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F 865	Continued From page 16 Jan 28. 2025-no review of any projects, or associated data. 5.) January 28. 2025-no review of any projects or associated data. 6.) February 25, 2025-no review of any projects or associated data.. 7.) March 31, 2025-no review of any projects, however notation of team review of quality indicators and identified two areas, behaviors/antipsychotic medication use and falls. No goals, action plan, data collection or analysis included. Interview on 4/30/25 at 4:01 p.m., with the Director of Aging Services (QAPI director on the phone), and the facility administrator and the director of nursing (DON) in attendance reported the facility had not completed a thorough analysis of data to include measurable goals, plans, or outcomes. Review of the February 2024 Quality Assurance and Performance Improvement (QAPI) policy identified the facility was to have a QAPI plan to address resident's Quality of Life, and resident choices. The plan was to be developed according to details included in the Facility Assessment. The policy identified the QAPI program was to identify areas of high risk, high volume, and/or problem areas for improvement by identifying and correcting the areas of deficiency. The components to be included: 1.) Tracking and measure of performance 2.) Establish goals with thresholds for performance improvement. 3.) Identify and prioritize areas of quality deficiencies. 4.) Analyze causes of deficiencies.	F 865	The administrator and/or designee is responsible for reporting QAPI activities to the Governing Board for oversite of QAPI.	

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F 865	Continued From page 17 5.) Develop and implement corrective action plans. 6.) Monitor and evaluate the action plan with revisions, as necessary.	F 865		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring,	F 867		6/20/25

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F 867	Continued From page 18 including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.	F 867		

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F 867	Continued From page 19 §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.	F 867		

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F 867	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to have evidence of a Performance Improvement Project (PIP) which focused on high risk or problem-prone areas were identified with appropriate data collection, analysis, and evaluation of the identified concern(s) during Quality Assurance Program Improvement (QAPI). This had the potential to affect all 47 residents residing in the facility. Findings include: Review of QAPI meeting minutes provided from 4/16/2024 through 3/31/25, identified no PIP projects identified with Goals, Action Plans, Data collection, and Analysis for identified areas/issues of concern for improvement within the facility. Interview on 4/30/25 at 4:01 p.m., with the Director of Aging Services (QAPI director on the phone), and the facility administrator and the director of nursing (DON) in attendance reported the facility had some previous PIP projects but had not developed formal PIP plans for the past year. Review of the February 2024 Quality Assurance and Performance Improvement (QAPI) policy identified the facility was to have a QAPI plan to address resident's Quality of Life, and resident choices. The plan was to be developed according to details included in the Facility Assessment. The policy identified the QAPI program was to identify areas of high risk, high volume, and/or problem areas for improvement by identifying and correcting the areas of deficiency.	F 867	Failed to have evidence of a PIP which focused on high risk or problem-prone areas were identified with appropriate data collection, analysis, and evaluation of the identified concerns during QAPI. Immediate Action: Failure to have at least one PIP active throughout the year has been identified. PIP teams have been formed. Project charter to be completed at the May QAPI meeting on 5/27/25. Corrective Action: PIP teams will be formed and overseen by the QAPI committee. These actions put in place will serve as a benefit for all current residents. Corrections: The QAPI committee will monitor facility projects by having the PIP teams present progress reports on their projects on a regular basis. Once solutions to identified deficiencies are put in place, progress monitoring will be presented to the QAPI committee on a regular basis. The QAPI policy will be reviewed and any necessary changes will be made. Corrections: Performance improvement projects have been started for falls and antipsychotic medication use. Project subjects were determined by the QAPI committee. There are frontline staff included as members of	

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F 867	Continued From page 21	F 867	each of these teams. Information regarding the projects, potential solutions put in place, and progress with be shared with staff regularly at staff meetings. Information related to the projects will be shared regularly with residents at resident counsel. Implementation of the PIPs will be ongoing based on the success of the solutions chosen.	
F 868 SS=F	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are	F 868		6/20/25

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F 868	Continued From page 22 necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on interview, and document review the Quality Assurance and Performance Improvement (QAPI) committee failed to document attendance, ensure they received regular reports from the infection preventionist (IP) on the infection control program, and review State Agency (SA) and incident reports for 4 of 4 quarters reviewed. Findings include: Review of provided QAPI meeting minutes of March 31, 2024, April 16, 2024, June 25, 2024, July 30, 2024, October 23, 2024, January 28, 2025, February 25, 2025, and March 31, 2025, identified no data was correlated and presented by the IP on facility process, outcome surveillance, outbreaks, and implementation of any control measures, staff illness,and the Antibiotic Stewardship Program (ASP) related to antibiotic use and resistance data. There was no mention of any review of submitted SA or incident reports provided for review by the QAPI committee. The minutes contained a typed list of members of the QAPI committee, but there was no identification of who was absent and/or who was in attendance to confirm required attendance of the committee members at the quarterly	F 868	Failed to document attendance, ensure they received regular reports from the IP on the infection control program and review State Agency (SA) and incident reports for 4 or 4 quarters. Immediate Action: VA reports have been added to the monthly QAPI meeting agenda. A sign-in sheet for all members of the monthly LTC QAPI committee has been created. Corrective Action: Starting with the May LTC QAPI meeting on 5/27/25 the infection prevention nurse will be required to bring a report including any outbreak information, resident illness, staff illness, antibiotic stewardship information, and any other relevant infection prevention information for that month. The new sign-in sheet will be utilized as well. Vulnerable adult submissions will be reviewed at the monthly LTC QAPI meeting as well as the quarterly facility QAPI meeting with the medical director in attendance. Corrections: The Director of Aging Services will audit completion of sign-in sheet, presence of	

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F 868	Continued From page 23 meetings. Interview on 4/30/25 at 4:01 p.m. with the QAPI/ Director of Aging Services (via phone) and the administrator and director of nursing (DON) in attendance identified the facility did not have sign in sheets to document attendance at meetings. The QAPI director reported she recalled the IP was not present at the March 2025 meeting, but did not recall other meetings. She reported the IP gave a verbal update on what she is working on, any training provided, any concerns but did not document any areas of discussion, goals, or plan for improvement. The administrator and QAPI director reported a short version of SA and incident reports were discussed at the monthly meeting, but she was uncertain if it was discussed with the medical director quarterly. She confirmed there was no documentation of review of incident or SA reports. Review of the February 2024 Quality Assurance and Performance Improvement (QAPI) policy identified the facility was to maintain documentation to confirm the implementation of QAPI program compliance with Centers for Medicare and Medicaid Services (CMS) requirements. The QAPI committee was to consist of at a minimum, the DON, the medical director or designee, the IP, and at least three other staff, one of whom must be the facility administrator, owner, board member, or other individual with knowledge and ability to make changes in facility systems. The facility was to develop, implement and maintain a QAPI program that was effective, data driven, comprehensive and focused on provision of care regarding resident Quality of Life.	F 868	VA reports as needed, and presence of an IP report at the QAPI meetings quarterly for the next year. The QAPI policy will be reviewed and any needed changes will be completed.	

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F 880	Continued From page 24	F 880		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 880		6/20/25

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F 880	Continued From page 25 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based interview and document review the facility failed to have a thorough ongoing infection control surveillance program that included resolution of symptoms and/or if any precautions had been implemented for 3 of 3 residents (R8, R12, R34). The facility also failed to identify when employees would be able to return to work after illness, dependent upon their symptoms of illness for 2 of 3 staff reviewed (nursing assistant	F 880	Resident Surveillance The facility failed to include ongoing infection control surveillance that include resolution of symptoms and if any precautions were implemented. Immediate Action: The charts of the residents identified were reviewed and the residents were assessed. No symptoms of infection were	

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F 880	Continued From page 26 (NA)-A, and trained medication aide (TMA)-A). Additionally, the facility failed to complete a tuberculosis screening for 1 of 5 residents (R32) reviewed. Findings include: Resident Surveillance Review of February 2025, LTC Respiratory Surveillance Line List identified the form included areas to document; Name/age/gender, Resident/staff, Hall/room, Symptoms onset date, Fever, Cough, Myalgia (body ache), Additional symptoms, Chest X-ray, Type of specimen collected/date of collection, Type of test ordered, Pathogen and Symptom resolution date. What the form lacked was if any precaution were implemented, what type of precaution, and/or when precautions were ended. Review of the 3 residents listed on the form identified: 1) R8 was identified with symptoms on 2/6/25, of fever, cough, myalgia and shortness of breath and Influenza A was identified. There was no resolution date or identification if any precautions implemented. 2) R12 was identified with symptoms on 2/6/25, of fever, cough, myalgia, and Influenza B was identified. There was no resolution date or identification if any precautions implemented. 3) R34 was identified with symptoms on 2/6/25, of fever and Influenza B was identified. There was no resolution date or identification if any precautions implemented. R8's 2/6/25, progress notes identified an encounter form had been sent to clinic related to R8 complaining of chest pain with coughing. New medication orders were received for as needed DuoNeb's and cough medication. There was no	F 880	present. No negative outcomes were identified. Corrective Action: 1) Implement a new standardized infection control surveillance that includes date and time of onset of symptoms, when isolation precautions began, type of precautions, and the date and time for discontinuation of precautions. 2) Re-education on documentation and training will be completed at next CNA/nurse meeting. 3) The DON will perform weekly audits for 3 months of all residents placed on transmission-based precautions. Employee Surveillance The facility failed to identify appropriate time off with employee illness. Immediate Action: Infection Preventionist was notified and current employees out due to illness were reviewed to determine proper return-to-work timelines. Identified full compliance at time of survey. Corrective Action: DON and Infection Preventionist reviewed and developed a new return-to-work protocol and system that includes date of last worked day, unit worked, date of scheduled return, and date actually returned. Staff will be educated on how to complete and maintain documentation at the next CNA/Nurse meetings. 1) Audit will be conducted by DON weekly on all return-to-work cases ensuring documentation and compliance. 2) Any deficiencies identified will be addressed with immediate re-education.	

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F 880	Continued From page 27 indication of any precautions being implemented. R8's 2/7/25, progress note identified that R8 had worked with therapy and after breakfast had increased respirations, elevated blood pressure and oxygen saturation was at 89% on room air. An as needed nebulizer and Mucinex was given without much improvement. Resident continued with coughing, wheezing and had crackles auscultated throughout bilateral lungs. A Call was placed to the provider and the resident was sent to ER for evaluation. Resident returned with order for Tamiflu and to continue oxygen. There was no indication of any precautions implemented. Review of progress notes for 2/8/25, 2/10/25, 2/11/25 had no mention of any type of precautions that may have been implemented. On 2/12/25, the progress note identified R8 was on quarantine for influenza and continued with a harsh cough. There was no indication when R8 had been placed in quarantine. R12's 2/3/25, progress note identified R12 had been coughing and the daughter had requested cough medication. There was no indication of any precaution being implemented. On 2/5/25, daughter requested a COVID test which was completed and negative. There was no indication of any precautions being implemented. The 2/6/25, progress note identified the son had requested R12 be tested for influenza. Progress notes on 2/7/25, identified a fever of 100.6, on 2/8/25 a fever of 99.4, 2/9/25 coughing, all with no indication of any precautions implemented. On 2/11/25, the progress note identified she remained in her room per protocol. There was no indication when R12 had started to remain in her room. R34's 2/6/25, progress note identified R34 had a	F 880	Tuberculosis The facility failed to complete a TB risk assessment prior to administration of tuberculosis skin test; the results of the first administered TB was not read/documented. Immediate Action: An assessment was completed on R32 and no signs or symptoms of TB were noted. Corrective Action: The risk assessment for R32 will be conducted. The admission TB protocol was reviewed by admitting RNs and re-education was performed. A review of the admission checklist was completed to confirm necessary components are present. 1) The DON will audit 100% of new admissions for TB risk assessment completion and documentation weekly for 4 weeks, then monthly for 3 months. The audit will include if the TB risk assessment, TB skin test administration was performed, and TB results dates and readings. Corrections: An audit by the DON of all resident records will be conducted to determine if similar deficiencies exist. Identified issues will be addressed with a two-step Mantoux. The policy and procedure will undergo review and be revised if needed by completion date for resident and	

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	245467	A. BUILDING _____ B. WING _____	C 04/30/2025

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F 880	Continued From page 28 cough, vitals taken, COVID test completed and negative. There was no indication if any precautions had been implemented or not. The 2/7/25, progress note identified R34's family was updated on the influenza diagnosis and status. R34 had a temperature of 101.3 at 10:30 p.m., and at 1:20 a.m., was down to 99.9. The was no indication if any precautions had been implemented or not. Review of progress notes on 2/8/25, 2/10/25, 2/11/25 had no mention of any type of precautions that may have been implemented. On 2/12/25, the progress note identified R34 was on quarantine for influenza and continued to cough. There is no indication when R34 had been placed in quarantine. EMPLOYEE SURVEILLANCE Review of staff call in log for January 2025 through April 2025 identified the form included area to document; Date/time, shift to be worked, name of employee, reason for call in (describe symptoms), replacement found, illness form filled out and placed in schedule, doctor note, initials of person taking call. Review of 2 staff listed on the form identified: 1) TMA-A called in on 3/3/25, with symptoms of vomiting, diarrhea, and fever. The form identified that an illness form had been filled out. Review of the Employee Illness Report form identified diagnosis/symptoms as gastroenteritis (vomiting/diarrhea) with a temperature of 100.4, date of absence was 3/3/25 and date returned to work was 3/4/25. 2) NA-A called in on 4/14/25, with symptoms of vomiting and diarrhea. The form identified that an illness form had been filled out. The director of nursing (DON) reported she was unable to find an Employee Illness Report form for NA-A. She confirmed that NA-A had returned to work on	F 880	employee surveillance. All monitoring results regarding F880 will be brought to the QAPI committee for review and follow-up as part of our ongoing quality improvement efforts.	

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F 880	Continued From page 29 4/15/25. Interview on 4/30/25 at 2:08 p.m., with DON agreed that the resident surveillance had not been filled out completely with no resolution date. She agreed that there was no place to identified if precaution had been implemented or not. If a resident was placed on precaution that would have been identified in the resident's progress note. She agreed it would be difficult to complete a quick audit or oversight to ensure implementation of precautions timely if not identified on the surveillance form. She confirmed that staff should not be returning to work after 24 hours of having vomiting and diarrhea and the facility should have a better follow up prior to returning to work. Review of September 2024, Infection Prevention and Control Program identified surveillance would be maintained for evaluation of effectiveness in reducing the risk of infections. Infection control program was responsible for prevention of infections through precautions, employee health program, and surveillance. The policy identified employee health surveillance for absence, the staff must complete an Employee Illness Form and staff must be cleared by a licensed nurse before returning to work. Review of undated, Hendricks Community Hospital Association Return to Work Guidelines identified staff with diarrhea would be restricted from patient contact, environment, and food handling until symptoms resolve. Tuberculosis (TB) R32's medical record identified R32 did not have a TB baseline symptom screening completed.	F 880		

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F 880	Continued From page 30 R32 had been administered a tuberculin skin test upon admission however, the results were never read. A second tuberculin skin test was administered on 12/25/23 and read on 12/27/23 with a negative result. Interview on 4/29/25 at 11:05 a.m., with director of nursing (DON) confirmed the TB skin test had been administered but never read. She further agreed that the TB symptom screening should have been completed prior to administering the TB skin test. She reported she already was working on re-training on TB screening and testing. Review of undated, Tuberculosis, Screening Residents for policy identified upon admission all residents would be screened for tuberculosis infection (TB). If a potential resident has been exposed or is at increased risk of TB according to the screening and TB skin test would be completed.	F 880		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/28/25 through 4/30/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed: H54673340C (MN105461). NO citations were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE	2 000		

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2 000	Continued From page 2 FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 255	MN Rule 4658.0070 Quality Assessment and Assurance Committee A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff, representing disciplines directly involved in resident care. The quality assessment and assurance committee must identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee must address, at a minimum, incident and accident reporting, infection control, and medications and pharmacy services. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure data submitted to 1 of 1 Quality Assurance Performance Improvement (QAPI) committee was analyzed and documented to ensure areas identified had oversight for their perspective outcomes brought forth. This had the potential to affect all 47 residents. Findings include:	2 255		6/20/25

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2 255	Continued From page 3 Review of QAPI meeting minutes provided from 4/16/2024 through March 31, 2025 identified in: 1.) April 16, 2024- agenda items identified problem with falls, but no identified goal, action plan, data collection or analysis of the information identified. 2.) June 25, 2024- agenda items identified some areas of concern, but failed to include goals, action plan, method for data collection or analysis 3.) July 30, 2024- Identified working on family notification for therapy, completion of 72 H forms, resident toileting, or repositioning. No goals, action plan, data or analysis identified. 4.) Oct 2024- no review of any projects in place Jan 28. 2025-no review of any projects, or associated data. 5.) January 28. 2025-no review of any projects or associated data. 6.) February 25, 2025-no review of any projects or associated data.. 7.) March 31, 2025-no review of any projects, however notation of team review of quality indicators and identified two areas, behaviors/antipsychotic medication use and falls. No goals, action plan, data collection or analysis included. Interview on 4/30/25 at 4:01 p.m., with the Director of Aging Services (QAPI director on the phone), and the facility administrator and the director of nursing (DON) in attendance reported the facility had not completed a thorough analysis of data to include measurable goals, plans, or outcomes. Review of the February 2024 Quality Assurance and Performance Improvement (QAPI) policy identified the facility was to have a QAPI plan to address resident's Quality of Life, and resident	2 255		

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2 255	Continued From page 4 choices. The plan was to be developed according to details included in the Facility Assessment. The policy identified the QAPI program was to identify areas of high risk, high volume, and/or problem areas for improvement by identifying and correcting the areas of deficiency. The components to be included: 1.) Tracking and measure of performance 2.) Establish goals with thresholds for performance improvement. 3.) Identify and prioritize areas of quality deficiencies. 4.) Analyze causes of deficiencies. 5.) Develop and implement corrective action plans. 6.) Monitor and evaluate the action plan with revisions, as necessary. SUGGESTED METHOD OF CORRECTION: The quality assurance committee could identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee will monitor these area on a regular basis and make recommendations for any changes. The administratior will be reponsible for implementation. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 255		
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development Subpart 1. Development. A nursing home must develop a comprehensive plan of care for	2 555		6/20/25

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2 555	Continued From page 5 each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the care plan was updated for 1 of 1 resident (R34) reviewed for side effect monitoring of anticoagulant (blood thinner) therapy. Findings include: R34's annual Minimum Data Set (MDS) dated 3/13/25, indicated R34 had severe cognitive impairment, received antipsychotic, antianxiety, antidepressant, and anticoagulant medication. R34's diagnoses included history of stroke and deep venous thrombosis (DVT), depression, anxiety, dementia and Alzheimer's disease. R34's medication order form printed 4/30/25, indicated R34's active order dated 4/1/25, for Eliquis (anticoagulant) 2.5 mg orally twice a day for DVT of left lower extremity (LLE). The order did not include any label comments or special instructions. R34's care plan printed 4/30/25, identified R34 was at high risk for falls as evidenced by history	2 555		

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2 555	Continued From page 6 of multiple falls and vision loss and was at risk for medication side effects related to the use of antipsychotic, antidepressant, and antianxiety medications. R34's care plan lacked evidence of anticoagulant use, increased risk for bleeding, or need for anticoagulant side effect monitoring. During interview on 4/30/25 at 9:21 a.m., licensed practical nurse (LPN)-A confirmed R34's EMAR listed Eliquis but lacked any special instructions for monitoring for potential side effects. LPN-A further stated such instructions could also be found in the resident's care plan and confirmed R34's care plan lacked any reference to anticoagulant use, side effect monitoring or increased risk for bleeding. During interview on 4/30/25 at 10:20 a.m., director of nursing (DON) stated side effect monitoring for medications should be care planned. DON stated R34's care plan should include anticoagulant use and instruct staff to monitor for potential side effects including increased bleeding risk. DON further stated EMAR could also include special instructions for medications. DON confirmed R34's care plan and EMAR lacked any reference to anticoagulant use, risks or side effect monitoring. DON stated the MDS nurse often updated the resident's care plans and may have additional information. During interview on 4/30/25 at 10:35 a.m., MDS nurse stated side effect monitoring should be on a resident's care plan when they were receiving an anticoagulant. MDS nurse stated staff should be instructed to watch for bleeding. During interview on 4/30/25 at 10:54 a.m., consultant pharmacist (CP) stated staff should be aware of potential side effects of medications and	2 555		

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2 555	Continued From page 7 should actively monitor for them. CP further stated this facility's population often received additional medications that put them at risk for falls and therefore, side effect monitoring of anticoagulants was particularly important. Facility policy Anticoagulation-Clinical Protocol dated 2018, instructed staff to, "Assess for any signs or symptoms related to adverse drug reactions due to the medication alone or in combination with other medications." The policy instructed staff to monitor for possible complications such as excessive bruising, hematuria (blood in urine), hemoptysis (coughing up blood), or other bleeding and to contact provider before administering next dose of anticoagulant. Facility policy Care Plans/Care Conferences dated 12/2022, indicated, "An individualized, comprehensive plan of care will be developed, maintained and followed for each resident." The policy further indicated resident care plans should include information regarding how medications were being used and evaluated and should be updated as needed. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to revision of the care plan as needed to meet the needs of each individual resident. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure individual care plans are revised as necessary. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 555		

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2 810	Continued From page 8	2 810		
2 810	MN Rule 4658.0510 Subp. 3 Nursing Personnel; On-site coverage Subp. 3. On-site coverage. A nurse must be employed so that on-site nursing coverage is provided eight hours per day, seven days per week. This MN Requirement is not met as evidenced by: The facility's request for a continuation of the waiver of the following licensing order has been approved by the State Agency and has been forwarded to the CMS Region V Office for its determination. 0810: RN coverage 8 consecutive hours a day, 7 days a week. Approval of the continued waiver request has been recommended.	2 810		6/20/25
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based interview and document review the facility failed to have a thorough ongoing infection control surveillance program that included resolution of symptoms and/or if any precautions had been implemented for 3 of 3 residents (R8,	21375		6/20/25

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21375	Continued From page 9 R12, R34). Review of February 2025, LTC Respiratory Surveillance Line List identified the form included areas to document; Name/age/gender, Resident/staff, Hall/room, Symptoms onset date, Fever, Cough, Myalgia (body ache), Additional symptoms, Chest X-ray, Type of specimen collected/date of collection, Type of test ordered, Pathogen and Symptom resolution date. What the form lacked was if any precaution were implemented, what type of precaution, and/or when precautions were ended. Review of the 3 residents listed on the form identified: 1) R8 was identified with symptoms on 2/6/25, of fever, cough, myalgia and shortness of breath and Influenza A was identified. There was no resolution date or identification if any precautions implemented. 2) R12 was identified with symptoms on 2/6/25, of fever, cough, myalgia, and Influenza B was identified. There was no resolution date or identification if any precautions implemented. 3) R34 was identified with symptoms on 2/6/25, of fever and Influenza B was identified. There was no resolution date or identification if any precautions implemented. R8's 2/6/25, progress notes identified an encounter form had been sent to clinic related to R8 complaining of chest pain with coughing. New medication orders were received for as needed DuoNeb's and cough medication. There was no indication of any precautions being implemented. R8's 2/7/25, progress note identified that R8 had worked with therapy and after breakfast had increased respirations, elevated blood pressure and oxygen saturation was at 89% on room air. An as needed nebulizer and Mucinex was given without much improvement. Resident continued	21375		

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	00340	A. BUILDING: _____ B. WING _____	C 04/30/2025

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21375	Continued From page 10 with coughing, wheezing and had crackles auscultated throughout bilateral lungs. A Call was placed to the provider and the resident was sent to ER for evaluation. Resident returned with order for Tamiflu and to continue oxygen. There was no indication of any precautions implemented. Review of progress notes for 2/8/25, 2/10/25, 2/11/25 had no mention of any type of precautions that may have been implemented. On 2/12/25, the progress note identified R8 was on quarantine for influenza and continued with a harsh cough. There was no indication when R8 had been placed in quarantine. R12's 2/3/25, progress note identified R12 had been coughing and the daughter had requested cough medication. There was no indication of any precaution being implemented. On 2/5/25, daughter requested a COVID test which was completed and negative. There was no indication of any precautions being implemented. The 2/6/25, progress note identified the son had requested R12 be tested for influenza. Progress notes on 2/7/25, identified a fever of 100.6, on 2/8/25 a fever of 99.4, 2/9/25 coughing, all with no indication of any precautions implemented. On 2/11/25, the progress note identified she remained in her room per protocol. There was no indication when R12 had started to remain in her room. R34's 2/6/25, progress note identified R34 had a cough, vitals taken, COVID test completed and negative. There was no indication if any precautions had been implemented or not. The 2/7/25, progress note identified R34's family was updated on the influenza diagnosis and status. R34 had a temperature of 101.3 at 10:30 p.m., and at 1:20 a.m., was down to 99.9. The was no indication if any precautions had been	21375		

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21375	Continued From page 11 implemented or not. Review of progress notes on 2/8/25, 2/10/25, 2/11/25 had no mention of any type of precautions that may have been implemented. On 2/12/25, the progress note identified R34 was on quarantine for influenza and continued to cough. There is no indication when R34 had been placed in quarantine. SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee should review/revise facility policies to ensure they contain all components of an infection control program to mitigate transmission of potential infections. The DON or designee could educate all staff on existing or revised policies and perform audits to ensure the policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Time Period for Correction: Twenty-one (21) days.	21375		
21395	MN Rule 4658.0805 Persons Providing Services All persons providing services, including volunteers, with a communicable disease as listed in part 4605.7040 or with infected skin lesions must not be permitted to work in the nursing home unless it is determined that the person's condition will permit the person to work without endangering the health and safety of residents and other staff. The employee health policies required in part 4658.0800, subpart 4, item F, must address grounds for excluding persons from work and for reinstating persons to work due to a communicable disease or infected skin lesions.	21395		6/20/25

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21395	Continued From page 12 This MN Requirement is not met as evidenced by: Based interview and document review the facility failed to have a thorough ongoing infection control surveillance program to identify when employees would be able to return to work after illness, dependent upon their symptoms for 2 of 3 staff reviewed (nursing assistant (NA)-A, trained medication aide (TMA)-A). Findings include: Review of staff call in log for January 2025 through April 2025 identified the form included area to document; Date/time, shift to be worked, name of employee, reason for call in (describe symptoms), replacement found, illness form filled out and placed in schedule, doctor note, initials of person taking call. Review of 2 staff listed on the form identified: 1) TMA-A called in on 3/3/25, with symptoms of vomiting, diarrhea, and fever. The form identified that an illness form had been filled out. Review of the Employee Illness Report form identified diagnosis/symptoms as gastroenteritis (vomiting/diarrhea) with a temperature of 100.4, date of absence was 3/3/25 and date returned to work was 3/4/25. 2) NA-A called in on 4/14/25, with symptoms of vomiting and diarrhea. The form identified that an illness form had been filled out. The director of nursing (DON) reported she was unable to find an Employee Illness Report form for NA-A. She confirmed that NA-A had returned to work on 4/15/25. Interview on 4/30/25 at 2:08 p.m., with DON agreed that the resident surveillance had not	21395		

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21395	Continued From page 13 been filled out completely with no resolution date. She agreed that there was no place to identified if precaution had been implemented or not. If a resident was placed on precaution that would have been identified in the resident's progress note. She agreed it would be difficult to complete a quick audit or oversight to ensure implementation of precautions timely if not identified on the surveillance form. She confirmed that staff should not be returning to work after 24 hours of having vomiting and diarrhea and the facility should have a better follow up prior to returning to work. Review of September 2024, Infection Prevention and Control Program identified surveillance would be maintained for evaluation of effectiveness in reducing the risk of infections. Infection control program was responsible for prevention of infections through precautions, employee health program, and surveillance. The policy identified employee health surveillance for absence, the staff must complete an Employee Illness Form and staff must be cleared by a licensed nurse before returning to work. Review of undated, Hendricks Community Hospital Association Return to Work Guidelines identified staff with diarrhea would be restricted from patient contact, environment, and food handling until symptoms resolve. SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee should review/revise facility policies to ensure they contain all components of an infection control program to mitigate transmission of potential infections with respect to employee illness and return to work. The DON or designee could educate all staff on existing or revised policies	21395		

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21395	Continued From page 14 and perform audits to ensure the policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Time Period for Correction: Twenty-one (21) days.	21395		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based interview and document review the facility	21426		6/20/25

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21426	Continued From page 15 failed to complete a tuberculosis (TB) screening for 1 of 5 residents (R32) reviewed. Findings include: R32's medical record identified R32 did not have a TB baseline symptom screening completed. R32 had been administered a tuberculin skin test upon admission however, the results were never read. A second tuberculin skin test was administered on 12/25/23 and read on 12/27/23 with a negative result. Interview on 4/29/25 at 11:05 a.m., with director of nursing (DON) confirmed the TB skin test had been administered but never read. She further agreed that the TB symptom screening should have been completed prior to administering the TB skin test. She reported she already was working on re-training on TB screening and testing. Review of undated, Tuberculosis, Screening Residents for policy identified upon admission all residents would be screened for tuberculosis infection (TB). If a potential resident has been exposed or is at increased risk of TB according to the screening and TB skin test would be completed. SUGGESTED METHOD OF CORRECTION: The infection control nurse (ICN), director of nursing (DON) and/or designee should review policies and procedures related to the screening and testing for tuberculosis for residents and/or employees (staff). Facility staff could be educated on the TB regulations, symptom screening, and the two-step Mantoux process. The ICN, DON and/or designee could audit resident admissions and/or staff new hires as well as current residents	21426		

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21426	Continued From page 16 and/or staff records to ensure compliance. The ICN, DON and/or designee should take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time until the QAPI committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty one-(21) days	21426		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced	21540		6/20/25

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21540	Continued From page 17 by: Based on interview and document review, the facility failed to ensure side effect monitoring for 1 of 1 resident (R34) reviewed for anticoagulant (blood thinner) therapy. Findings include: R34's annual Minimum Data Set (MDS) dated 3/13/25, indicated R34 had severe cognitive impairment, received antipsychotic, antianxiety, antidepressant, and anticoagulant medication. R34's diagnoses included history of stroke and deep venous thrombosis (DVT), depression, anxiety, dementia and Alzheimer's disease. R34's medication order form printed 4/30/25, indicated R34's active order dated 4/1/25, for Eliquis (anticoagulant) 2.5 mg orally twice a day for DVT of left lower extremity (LLE). The order did not include any label comments or special instructions. R34's care plan printed 4/30/25, identified R34 was at high risk for falls as evidenced by history of multiple falls and vision loss and was at risk for medication side effects related to the use of antipsychotic, antidepressant, and antianxiety medications. R34's care plan lacked evidence of anticoagulant use, increased risk for bleeding, or need for anticoagulant side effect monitoring. During interview on 4/30/25 at 7:46 a.m., licensed practical nurse (LPN)-A stated instructions such as monitoring for side effects of medications should be listed in the electronic medication administration record (EMAR) under special instructions. LPN-A stated increased bleeding was a potential side effect of anticoagulant use.	21540		

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21540	Continued From page 18 During follow up interview on 4/30/25 at 9:21 a.m., LPN-A confirmed R34's EMAR listed Eliquis but lacked any special instructions for monitoring for potential side effects. LPN-A further stated such instructions could also be found in the resident's care plan and confirmed R34's care plan lacked any reference to anticoagulant use, side effect monitoring or increased risk for bleeding. LPN-A further confirmed R34's Eliquis pill bubble pack contained a yellow label instructing staff to "contact provider if bleeding concerns" and stated does not reference that label since those label instructions were supposed to be included in the EMAR under special instructions. During interview on 4/30/25 at 10:20 a.m., director of nursing (DON) stated side effect monitoring for medications should be care planned. DON stated R34's care plan should include anticoagulant use and instruct staff to monitor for potential side effects including increased bleeding risk. DON further stated EMAR could also include special instructions for medications. DON confirmed R34's care plan and EMAR lacked any reference to anticoagulant use, risks or side effect monitoring. DON stated the MDS nurse often updated the resident's care plans and may have additional information. During interview on 4/30/25 at 10:35 a.m., MDS nurse stated side effect monitoring should be on a resident's care plan when they were receiving an anticoagulant. MDA nurse stated staff should be instructed to watch for bleeding. During interview on 4/30/25 at 10:54 a.m., consultant pharmacist (CP) stated staff should be aware of potential side effects of medications and should actively monitor for them. CP further	21540		

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21540	Continued From page 19 stated this facility's population often received additional medications that put them at risk for falls and therefore, side effect monitoring of anticoagulants was particularly important. Facility policy Anticoagulation-Clinical Protocol dated 2018, instructed staff to, "Assess for any signs or symptoms related to adverse drug reactions due to the medication alone or in combination with other medications." The policy instructed staff to monitor for possible complications such as excessive bruising, hematuria (blood in urine), hemoptysis (coughing up blood), or other bleeding and to contact provider before administering next dose of anticoagulant. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee and the consulting pharmacist should develop and/or revise policies to monitor medications for side effects as diagnosed and documented in the clinical record to ensure each resident's entire drug medication regimen is managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being and be consistent with manufacturer's recommendations and/or clinical practice guidelines, clinical standards of practice, medication references, clinical studies or evidence-based review articles that are published in medical and/or pharmacy journals. The director of nursing (DON) or designee and the consulting pharmacist should educate physicians and staff on the importance of ensuring medication ordered is monitired appropriately. Audits should be developed to ensure monitoring of medications side effects occurs for a specific and measurable amount of time. The DON and/or designee should take those findings/education to	21540		

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21540	Continued From page 20 the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: 21 DAYS	21540		

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

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	245467	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/29/2025**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 04/29/2025. At the time of this survey, Hendricks Community Hospital Nursing Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/22/2025

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Hendricks Community Hospital Nursing Home The facility has a capacity of 48 beds and had a census of 46 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 131	Continued From page 2	K 131		
K 131 SS=F	Multiple Occupancies CFR(s): NFPA 101 Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: o They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. o They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. o The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide a two-hour rated fire wall and fire rated doors in accordance with the requirements of NFPA 101 - 2012 edition, Sections 19.1.1.4, 19.1.1.4.1, 8.3, 8.3.1, 8.3.1.2, 8.3.2, 8.3.2.1 and 8.3.5. This deficient finding could have a widespread impact on the residents within the facility. Findings include:	K 131	All accessible penetrations identified above the ceiling were caulked on finding. The Maintenance Supervisor will perform inspections after contractor work is completed to ensure compliance. Responsibility: Maintenance Supervisor	5/20/25

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	245467	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/29/2025**

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K 131	Continued From page 3 On 04/29/25 between 9:30 AM and 12:30 PM, it was revealed by observation that above the ceiling at the 2-hour rated fire wall in between the hospital and the nursing home multiple holes penetrated the fire wall and were not properly fire stopped. This deficient finding was confirmed by the Maintenance Supervisor at the times of discovery.	K 131		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain their sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.1.1 and 9.7.5, NFPA 25 (2011 edition),	K 353	Sprinkler systems were completed within the time of inspection and will continue to be conducted quarterly. The Maintenance Supervisor will notify the sprinkler	5/21/25

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K 353	Continued From page 4 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 4.3, 4.4, 4.7 and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, section 26.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/29/2025 between 9:30 AM and 12:30 PM, it was revealed by a review of available documentation that the facility could not provide documentation for quarterly sprinkler inspections for the 1st quarter of 2025. This deficient finding were confirmed by the Maintenance Supervisor at the time of discovery.	K 353	inspection company to ensure quarterly compliance is done within regulation. Supervisor will report compliance at quarterly QAPI meetings. Responsibility: Maintenance Supervisor	
K 511 SS=F	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to secure electrical panels per NFPA 99 (2012 edition), Health Care Facilities Code,	K 511	All electrical panels were secured at time of discovery. Quarterly audit inspections of Nursing Home electrical panels will be	5/30/25

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K 511	Continued From page 5 section 6.3.2.2.1.3 and failed to maintain the Gas and Utility System per NFPA 101 (2012 edition), Life Safety Code section 9.1.2 and NFPA 70 (2011 edition), National Electric Code, section 408.20. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 04/29/2025, between 9:30 AM and 12:30 PM, it was revealed by observation that the electrical panel located in the Activity Office was not secured. 2. On 04/29/2025, between 9:30 AM and 12:30 PM, it was revealed by observation that the electrical panel located in the Soiled Utility rooms were not secured. These deficient findings were confirmed by the Maintenance Supervisor at the time of discovery.	K 511	conducted to ensure all doors are secured, panels are labeled, and clearance is maintained. The Maintenance Supervisor will perform the quarterly inspections of electrical panels, document findings and report in QAPI meetings. Responsibility: Maintenance Supervisor	
K 711 SS=F	Evacuation and Relocation Plan CFR(s): NFPA 101 Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2,	K 711		5/27/25

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K 711	Continued From page 6 19.7.2.2, 19.7.2.3 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement a fire safety plan per NFPA 101 (2012 edition), Life Safety Code, section 19.7.2.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/29/2025 between 09:30 AM and 12:30 PM, it was revealed by a review of available documentation that the fire safety plan that was provided at the time of the survey did not include transmission of alarms to fire department. This deficient finding was confirmed by the Maintenance Supervisor at the time of discovery.	K 711	The policy was reviewed and updated to notify 911 to ensure fire department is dispatched. Staff will be notified of updated policy and procedures at the next bi-monthly Safety Meeting. Responsibility: Maintenance Supervisor.	
K 926 SS=F	Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement medical gas training for staff per NFPA 99 (2012	K 926	Maintenance is currently seeking a video resource that provides best practices for safe handling, storage, and usage of	5/30/25

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K 926	Continued From page 7 edition), Health Care Facilities Code, section 11.5.2.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/29/2025, between 9:30 and 12:30 PM, it was revealed by review of available documentation and staff interview that the facility could not provide evidence of training provided to personnel on the application and maintenance of medical gases, and the potential risks associated with their handling and use. This deficient finding was confirmed by the Maintenance Supervisor at the time of discovery.	K 926	oxygen tanks. This video will be presented to all staff, present and future, in department meetings. Maintenance Supervisor, in correlation with DON, will audit trainings to ensure all staff meet compliance. Responsibility: Maintenance Supervisor. DON.	