DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 10, 2020

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

RE: CCN: 245467
Survey Start Date: July 8, 2020

Dear Administrator:

On July 8, 2020 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of June 4, 2020. Per the CMS Memo QSO-20-20-All, enforcement remedies were suspended from March 23, 2020 to May 31, 2020 and will be evaluated at a later date.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

Electronically delivered
May 29, 2020

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

SUBJECT: SURVEY RESULTS
CCN: 245467
Cycle Start Date: May 12, 2020

Dear Administrator:

SUSPENSION OF SURVEY AND ENFORCEMENT ACTIVITIES

The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with Memorandum QSO-20-20-All, CMS is suspending certain Federal and State Survey Agency surveys, and delaying revisit surveys, for all certified provider and supplier types.

During this time, CMS is prioritizing and conducting only the following surveys: focused infection control surveys, investigations of complaints and facility-reported incidents that are triaged at the Immediate Jeopardy (IJ) level, and revisit surveys for unremoved IJ level deficiencies. With the exception of unremoved IJs, CMS will also be exercising enforcement discretion during the suspension period. For additional information on the prioritization of survey activities please visit https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0.

SURVEY RESULTS

On May 12, 2020, the Minnesota Department of Health completed a COVID-19 Focused Survey at Hendricks Community Hospital to determine if your facility was in compliance with Federal requirements related to implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the electronically delivered CMS 2567.

PLAN OF CORRECTION

You must submit an acceptable electronic plan of correction (ePOC) for the enclosed deficiencies that were cited during the May 12, 2020 survey. Hendricks Community Hospital may choose to delay submission of an ePOC until after the survey and enforcement suspensions have been lifted. The

provider will have ten days from the date the suspensions are lifted to submit an ePOC. 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. Please note that if an onsite revisit is required, the revisit will be delayed until after survey and enforcement suspensions are lifted. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation.

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; and
- The date that each deficiency will be corrected.

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

Nicole Osterloh, Unit Supervisor
Health Regulation Division
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230 Cell: 218-340-308
Fax: 507-537-7194

INFORMAL DISPUTE RESOLUTION

You have one opportunity to dispute the deficiencies cited on the May 12, 2020 survey through Informal Dispute Resolution (IDR) in accordance with 42 CFR § 488.331. To receive an IDR, send (1) your written request, (2) the specific deficiencies being disputed, (3) an explanation of why you are disputing those deficiencies, and (4) supporting documentation by fax or email to:

Nicole Osterloh, Unit Supervisor
Health Regulation Division
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230 Cell: 218-340-308
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An IDR may not be used to challenge any aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;

- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by counsel for your IDR, then you must indicate that in your written request for informal dispute resolution.

Hendricks Community Hospital may choose to delay a request for an IDR until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit a request for an IDR in accordance with the instructions above.

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at https://qioprogram.org/. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at https://qioprogram.org/locate-your-qio.

Sincerely,

Kamala Fiske-Downing

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Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
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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 _____	05/12/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A COVID-19 Focused Infection Control survey was conducted 5/12/20, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility was IN full compliance. Because you are enrolled in ePOC, your 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 facilty acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control survey was conducted 5/12/20, at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was NOT in compliance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Upon receipt of an acceptable electronic POC, an revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program	F 880		6/4/20

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

Electronically Signed | 06/04/2020

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

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F 880	Continued From page 2 least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure staff discarded personal protective equipment (PPE) prior to exiting a resident's room, and disinfect lift slings between multiple resident (R1, R2, R3, R4, and R5, R6, and R7), or perfom ongoing surveillance in accordance with Centers for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS) guidelines for COVID-19. This had the potential to affect all 41 residents in the facility. Findings include: PPE	F 880	PPE, DONNING & DOFFING: On May 12th, 2020, after the exit interview. The Director of Nursing , Environmental Services Supervisor, and Infection Control Coordinator immediately corrected the donning and doffing locations and procedures in R1-7. At 6pm on May 12th, 2020, corrected donning & doffing instructions were posted outside resident rooms and in employee communication book. On June 4th, 2020, an "Isolation Room Requirement" list was initiated to be completed nightly by the night shift LPN or RN. When the resident is initially placed on isolation, the	

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F 880	Continued From page 3 Observation and interview on 5/12/20 at 8:54 a.m, outside of R1 and R5's isolation rooms identified an overbed table with SaniCloth, hand sanitizer wipes, gowns clipboard, thermometer and hand sanitizer. Three garbage cans contain were lined with red bags. Each bin was labeled "isolation gowns", "paper garbage", and "linens and bagged personal items". NA-A stood in doorway of R5's room, and doffed gown and reaching out of room to place in the gown bin and place her gloves in the garbage. She identified that they were to stand within the threshold of the room and reach out to "throw stuff in the appropriate bins". Observation on 5/12/20 at 9:41 a.m., identified NA-A exited isolation room R5 with a clear garbage bag with linens in her hand. She reached past the clean isolation supplies to the bin and threw the bag into the bin marked for linens. She remained standing outside of the room and doffed her gloves and gown, and sanitized her face shield. Observation on 5/12/20 at 10:45 a.m., of the PPE station outside R5's room identified a PPE door caddy was hung the outside of the entrance door. Two bedside tables were placed on the wall of R5's room entrance. The right table had a stack of black gowns stacked near the wall. Two white bins labeled "trash" and "gowns were placed in front of the right table. The left table on the wall of the room entrance had alcohol-based hand sanitizer, a spray bottle, and a tub of Super Sani Wipes, and a roll of paper towels placed on it. A large grey bin labeled "soiled linen" sat front of the the left table. NA-D opened R5's room door and without removing her gown and gloves,	F 880	educated professional staff will sign off that donning and doffing locations are correct. The Infection Control Coordinator or designee will perform surveillance three times weekly for two months. Frequency determined by results thereafter. PPE: will be placed with clean outside door and soiled PPE bins items inside the room door. Current procedure is currently being followed. Will continue to monitor 3x weekly for 2 months by DON,ICP or designee for staff compliance. This practice will also be presented to facility QAPI for any ongoing concerns. SURVEILLANCE: On May 18th, 2020, the Director of Nursing met with the infection control coordinator to discuss the weak area in the infection control monitoring that were identified in the exit interview with State. The current practices had potential to impact all 41 residents negatively. Director of Nursing met with case manager to form plan for infection reporting on May 19th, 2020. The focus areas of the discussion included 72 hour antibiotic timeout, analysis of infections, preventative actions taken to prevent ongoing infections, identifying when infections resolved, and including staff illnesses. The following forms were retrieved from the MN department of Health Website: 72 Hour Antibiotic Time-Out Sample Template; MN Antimicrobial Stewardship Program Toolkit for Long-Term Care Facilities; Infection	

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F 880	Continued From page 4 exited the room. NA stood outside R5's door between the tables and bins untied the neck tie of the gown and waist, removed the gown, inverted the sleeves and removed the gloves, and discarded them in the appropriate bins. Without performing hand hygiene, NA-D sanitized the face shield with the Super-Sani Wipes. Without waiting the 2 minute dry-time, NA-D wiped the face shield with the paper towel and performed hand hygiene. NA-A exited R5's room and doffed PPE in the hallway. Interview on 5/12/20 at 10:50 a.m., NA-D identified she was instructed to remove the gown and gloves within the exit of R5's room. Face shields were to be wiped down with sanitizer wipes after exiting quarantined rooms. The shield was supposed to remain wet for 2 minutes before wiping the film off the face shield. Observation on 5/12/20 at 11:08 a.m., NA-A exited R1's room and doffed PPE in the hallway. Review of the Sani-wipes wipes manufacture's directions identified staff were to to remove all visible debris from surfaces to be disinfected The user was to use a clean germacidal wipe to wet the surfaces, ensure the surfaces remain wet for two minutes, then allow to air dry. SURVEILLANCE Review of the facility's January 2020, February 2020, March, 2020, and April 2020, Infection Control Monitoring report identified the reports include the following information: residents with infections, onset date of infections, the type of infection, the organism treated, and antibiotics prescribed. Infections were mapped out to	F 880	Surveillance Definition Worksheet. These forms were used as a guide for putting measures into place to ensure that the deficient practice would not recur. Facility monitoring for any and all possible infections will be done weekly x1 months then monthly, by DON or designee and reported to QAPI. On June 1st, 2020, a new infection reporting procedure was initiated for daily monitoring of trends, antibiotic stewardship, and appropriate assessment and treatment. Nursing staff informed that they are responsible for completing the documentation in the resident chart and were to utilize the designated McGeer's antibiotic surveillance tool. Infection control logs were placed at each nurses' cubby. The following elements are included on the infection control report: 1) Date of onset of symptoms 2) Name and room number 3) ordering physician name 4) Indicated Interventions (i.e. if someone is put on precautions) 5) Completing a follow up 6) Xray or culture, prescribed antibiotic, and any further additional comments that pertain to the identified infection. The reports will be ongoing and started at initial onset. The forms are kept in the infection log book until the 72-hour Antibiotic Time Out can be completed after 72 hours of antibiotic. Key elements of the 72-hour Antibiotic Time Out include: 1)Start date, dose, route, duration, and scheduled stop date of the antibiotic 2)Prescriber's name and credentials 3)Reason antibiotic was prescribed 4)Antibiotic protocol 5) Red Flags (i.e. antibiotic ordered more than 7 days,	

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F 880	Continued From page 5 identify where infections were located. The reports lacked information of when infections resolved, analysis of infections and actions taken to prevent further infection. Additionally, staff infections were not included in the infection reports. Interview on 5/12/20 at 12:200 p.m., with the infection preventionist (IP), registered nurse (RN)-A identified COVID-19 resident data was reviewed on a daily basis. All other infection data was reviewed on a monthly basis to identify trends and potential outbreaks in the facilty. Staff illnesses were tracked by the IP and and the human resources department, but were not compared with resident data to identify whether infections were transmitted between staff and residents. RN-A agreed staff illness should be reviewed and compared with resident illness data to identify potential transmission. Infections could be analyzed to identify potential causes of infection, to implement actions to prevent continued transmission, and reduce further instances of some infections and to identify breaks in infection control practices. Interview on 5/12/20, at 12:37 p.m., with the director of nursing (DON) identified facility infections were not actively logged on a daily basis, but symptoms of infection, but were reviewed within 72 hours by the IP, and herself. The facilty had few infections, but the DON agreed infection surveillance was to be ongoing, and should include review of staff illnesses and analysis of potential causes of infections to identify if additional infection control measures were needed. Interview on 5/12/20, at 1:18 p.m., with the	F 880	inconsistency with organism identified on culture and sensitivity) 6) Provider review tool to describe any changes after 72 hours & Provider signature. The data will reflect the number of infections in the nursing home, the type of infection, resolved infections, and the prescribed antibiotic and/or antiviral. Trends in location, employee infections, and group resident infections will be included as data in the infection control log. The log to be reviewed daily in nurses report. Employee illnesses will be reported immediately to Infection Control Coordinator or DON. The DON and/or Infection Control Coordinator will review employee and resident illnesses and ensure procedures are followed prior to their return to work and any potential further resident exposures. The infection control team will meet once every 2 week for 1 month beginning June 15th, 2020, to identify needed areas of education for the nurses and needed corrections for 2 months to identify needed areas of education for the nurses and needed corrections so that the deficient practice will not recur. The meeting will be ongoing monthly thereafter unless a need would arise to increase meeting frequency. The team will review the antibiotic review tools, nursing documentation, employee illnesses, and infection control reports. The interdisciplinary team will meet once daily in the morning on weekdays to discuss current and recently resolved infections in the facility. All areas of monitoring related to infection control policy and procedures will be reviewed at	

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F 880	Continued From page 6 administrator identified the facilty's infection data was incomplete and lacked evidence surveillance was ongoing. He agreed the IP records should include analysis of infections to identify potential causes or sources of infections and implement actions to improve infection control practices to prevent further infections in the facility. Review of the January 2020, Infection Prevention and Control Program policy identified it's purpose was to (1) maintain surveillance of the healthcare infection potentials, (2) identify and analyze incidents and caution of healthcare-associated infections, (3) develop and implement a preventative and/or corrective program to minimize infection hazards, (4) and supervise the program, and (5) act upon recommendations of the chief of staff, medical staff, facility departments and other hospital committees. The The infection control program established a committee. The committee was responsible to ensure a permanent record for all activities related to infection control were submitted to the medical staff and hospital governing board for review. The infection preventionist was responsible for supervising and implementing the infection control program, collecting and analyzing data, reporting infection control actions, and teaching and reinforcing infection control policies an procedures. The IP was to coordinate the employee heath program and the infection control program to assure adequate surveillance of infections in personal and maintenance of an effective infection control and prevention program. MULTI-USE EQUIPMENT Observation on 5/12/20 at 9:18 a.m., identified	F 880	QAPI to determine compliance. MULTI-USE EQUIPMENT: Multi-use slings will be laundered if soiled, and once weekly on resident bath day. Slings will not be shared with other residents unless laundered. Administrator informed of need for individual resident EZ stand slings. Goal for EZ stand slings purchase by August 1st, 2020. The facility will identify other residents on an ongoing basis having the potential to be affected by the deficient practice. Staff educated by posting of information in staff meeting areas, staff will also be instructed on this policy and procedure with the next months NAR meeting. Monitoring to be done 3 x week for 2 months by DON, ICP or designee. This data will be brought to the Quality Assurance Committee and QAPI for further review and discussion on an ongoing basis. This deficiency will be corrected by August 1st, 2020. Completion Date:06/04/2020	

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F 880	Continued From page 7	F 880		

mechanical lift slings were draped over the lift. NA-B and NA-C entered R3's room with a lift and NA-C exited room at 9:20 a.m. with the lift and the lift sheet again draped over the lift. She used Sani-Cloth wipes to wipe down the surfaces of the lift. However, she did not clean the lift sheet in any way and it remained draped over the machine.

Observation on 5/12/20 at 9:30 a.m., identified NA-A exited R2's room with the lift. The lift sheet was draped over the lift. NA-A used a Sani-Cloth to wipe down the lift but failed discard the lift sheet to be laundered.

Interview on 5/12/20 at 9:43 a.m., with NA-A identified R2 and R3 had used the same transfer sling. Slings for the lifts were shared among the residents. The slings were not sanitized between resident uses and were cleaned once per week or when visibly soiled.

Interview on 5/12/20 at 10:14 a.m., with LPN-A identified lift slings were shared between residents. They slings were to be cleaned once a week and if visibly soiled. No cleaning or disinfecting of the sheets was performed between residents.

Interview on 5/12/20 at 10:34 a.m., with NA-C identified lift sheets were shared between residents. She had used the lift to transfer R3. The lift sheets were not cleaned between residents and were sent to laundry only if visibly soiled. She was unaware of any scheduled cleaning.

Interview on 5/12/20 at 12:15 p.m., with RN-A, the infection preventionist identified lift sheets should

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HENDRICKS COMMUNITY HOSPITAL	503 E LINCOLN STREET HENDRICKS, MN 56136

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 8 not be shared between residents, however, the facility did not have enough slings for each resident to use. Interview on 5/12/20 at 12:40 p.m., with DON identified lift slings were shared between residents. The facility had no formal policy for cleaning slings. Mesh lift slings were laundered weekly as they were a cloth mesh. Slings were to be cleaned between resident use. The DON agreed to appropriately clean and disinfect cloth slings, they must be laundered. No policy or procedure was in place regarding use of shared lift slings. Interview on 5/12/20 at 1:15 p.m., with the administrator identified he was unaware lift slings were not being cleaned between residents. His expectation was that staff would follow CDC recommendations.	F 880		