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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: N647

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00340

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/25/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

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

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Kathryn Serie, Unit Supervisor 08/30/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 08/30/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
08/23/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245467

August 30, 2016

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

Dear Mr. Gollaher:

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

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

Effective August 23, 2016 the above facility is certified for:

58 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
August 30, 2016

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

RE: Project Number S5467026

Dear Mr. Gollaher:

On July 19, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 14, 2016. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On August 25, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on July 29, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 14, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 23, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 14, 2016, effective August 23, 2016 and therefore remedies outlined in our letter to you dated July 19, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245467 Y1	A. Building B. Wing Y2	8/25/2016 Y3

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

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

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	F0280	Correction	ID Prefix	F0282	Correction	ID Prefix	F0314	Correction
Reg. #	483.20(d)(3), 483.10(k)(2)	Completed	Reg. #	483.20(k)(3)(ii)	Completed	Reg. #	483.25(c)	Completed
LSC		08/23/2016	LSC		08/23/2016	LSC		08/23/2016
ID Prefix	F0329	Correction	ID Prefix	F0431	Correction	ID Prefix		Correction
Reg. #	483.25(l)	Completed	Reg. #	483.60(b), (d), (e)	Completed	Reg. #		Completed
LSC		08/23/2016	LSC		08/23/2016	LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	KS/kfd	8/30/2016	03048	8/25/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
7/14/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245467 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	7/29/2016 Y3

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

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

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed
LSC	K0025	07/20/2016	LSC	K0029	07/29/2016	LSC	K0062	07/20/2016
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #		Completed	Reg. #		Completed
LSC	K0147	07/21/2016	LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	TL/kfd	8/30/2016	36536	7/29/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
7/14/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: N647

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00340

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/14/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **58** (L18)
13.Total Certified Beds **58** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Wendy Willson, HFE NE II 07/26/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 08/19/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 19, 2016

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

RE: Project Number S5467026

Dear Mr. Gollaher:

On July 14, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Health Regulation Division
Minnesota Department of Health
1400 E. Lyon Street
Marshall, Minnesota 56258
Email: Kathryn.serie@state.mn.us
Office: (507) 476-4233 Fax: (507) 537-7194

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by August 23, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

The state agency may, in lieu of a 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:

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by October 14, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 14, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245467	A. BUILDING _____ B. WING _____	07/14/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280		8/23/16

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

Electronically Signed | 07/24/2016

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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	245467	A. BUILDING _____ B. WING _____	07/14/2016

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F 280	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the plans of care were revised to include staff assistance with oral cares for 1 of 3 residents (R28) reviewed for dental status and to include behavioral interventions required for 1 of 1 resident (R5) who experienced verbal and physical behaviors. Findings include: R28's quarterly Minimum Data Set (MDS) assessment dated 4/29/2016, indicated R28 was totally dependent upon staff when eating and received a mechanically altered diet with nectar thickened liquids. An oral/dental assessment with the most recent review date of 4/27/16, indicated R28 had upper dentures, required daily cleaning of teeth/dentures and daily mouth care performed by resident after set up. Review of the electronic record care plan dated 11/20/12, listed a Focus area with diagnoses including dementia and Alzheimer's disease. Interventions included: has a full upper denture and no teeth or denture on lower. R5 may need assist with brushing upper denture-allow her to do own oral cares with cues and/or set up. Review of the Nursing Assistant care sheet dated 7/6/2016, which registered nurse (RN)-B and the director of nursing (DON) verified was updated biweekly indicated: oral cares-upper denture, no lower teeth, set up and supervise. During observation on 7/13/16, at 8:59 a.m. and again on 7/13/16, at 11:44 a.m. R28 was seated	F 280	R28 passed away 7/15/2016. R5 care plan is up to date including interventions for behavior management 8/1/2016 Relevant to all resident care planning inclusive of care plan updating: The facility's process to assure the multi-disciplinary care plan is current and effectively communicated to staff is being reviewed. CNA work sheets are paper documents at this time. We have identified some of the information is "cut off" with our current excel document utilization. We plan to expand the document size from 8x10 to 8 1/2 x 14 to assure all the care plan information is available for staff reference. We also plan to update the work sheets to include behavior interventions. The work sheets are updated weekly. In the mean time, a communication book documents resident care plan changes. Staff are to acknowledge by signing off between shifts of work to assure they are informed of any care plan adjustments. This augments the shift to shift report process. We continue with our 2016 goal to expand the Point Click Care software program to include CNA access to resident information as well as provide means to document care. Nursing and CNA staff education on accountability to follow resident cares as noted on the care plan and CNA worksheets scheduled for 8/11/2016.	

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F 280	Continued From page 2 in a high back wheelchair positioned at a table in the dining room. Staff were observed encouraging and providing total feeding assistance to R28. R28 made no attempt to assist with the eating process and required staff prompting to open her mouth for food and/or fluid intake. No dentures were observed in R28's mouth at either the morning nor the noon meal. When interviewed on 7/13/16, at 12:55 p.m. RN-B confirmed the care plan had not been updated but indicated the NA care plan had been revised and kept up to date. However, when the two documents were reviewed it was evident the plan of care (which identified R28 would be allowed to set up) and the NA care sheet (which identified an upper denture, to set up and supervise) had not been revised to reflect the current needs for R28. On 7/13/16, at 1:01 p.m. NA-D stated R28 required total care as does not attempt to participate with oral cares. NA-D further indicated staff provide oral care with swabs in the morning and after meals. In addition, NA-D stated R28 no longer wears upper dentures as they no longer fit as R28 does not allow them to be placed into her mouth. RN-B who was also in attendance indicated she was not aware of these changes and would expect the care plan and the NA sheet to be updated to reflect the appropriate oral cares. RN-B then confirmed that neither the care plan in the electronic record nor the NA care sheet were accurate in listing the oral care required to meet R28's needs. In a subsequent interview on 7/13/16, at 1:40 p.m. NA-D stated R28 had not been wearing her upper denture for an extended period of time,	F 280	Education will include but will not be limited to care plan follow through with oral care and behavior management. Education will include staff role to communicate resident condition changes relevant to need for care plan updates. All care plans are to be reviewed and updated at a minimum of every quarter engaging resident and family input whenever possible with care planning. Dementia training scheduled 7/28/16 for all care giving and ancillary staff who provide services in the Nursing Home to equip them with behavior intervention skills. A random selection of 5 residents/month will be audited as to timeliness and accuracy of resident care plan adjustments and communication to staff. This will include a focus on oral care and behavior management. Audit outcomes to be evaluated through our QAPI program.	

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F 280	Continued From page 3 which she defined as "at least 3 months". R5 was admitted with diagnoses obtained from the electronic record which included: Dementia, anxiety disorder and Major depressive disorder. R5's care plan indicated a focus area: psychosocial well-being problem related to (r/t) diagnosis/history (hx) of depression/anxiety. Interventions included: encourage to verbalize feelings/perceptions and fears. Neither the written care plan nor the nursing assistant care plan had been revised to include how staff were to intervene/respond to verbal/physical behaviors exhibited by R5 nor did it identify that staff should monitor R5 for verbal/physical outbursts directed toward other residents and/or staff. During observation on 7/13/16, at 9:14 a.m. R5 was seated in a wheelchair (w/c) in her room with the door partially closed. When attempting to engage in conversation with R5, she responded loudly and replied, "what are you doing in here?" R5 made negative comments about persons in close proximity to her as they walked past. Licensed practical nurse (LPN)-B entered the room and stated that R5 was not having a good day and was in "one of her moods". LPN-B further explained that when this occurs R5 is removed from the residents located in the common area and allowed to calm down in her room. LPN-B indicated the amount of time varies for R5 to become calm. LPN-B stated that if R5 is not relocated during a behavioral outburst, her vocalizations would increase and escalate, becoming more negative toward residents/staff. LPN-B indicated she could become physically	F 280		

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F 280	Continued From page 4	F 280		

aggressive with staff when they attempt to intervene.

When interviewed on 7/13/16, at 3:19 p.m. trained medication aide (TMA)-A indicated R5 is "moody" in the morning, "most of the time she is good, but if upset requires 1:1 intervention to defuse behaviors" . TMA-A further stated, "at times this works and other times she has to be left alone". TMA-A verified that if R5 was not removed quickly and she was in the area with other residents, the behavior would escalate.

Registered nurse (RN)-B was interviewed on 7/13/16, at 3:56 p.m. and stated the current behavioral intervention implemented involved removal of R5 from the area when located with other residents. Upon returning R5 to her room, staff would spend 1:1 time as she allows. RN-B confirmed R5 can become physically aggressive toward staff and very vocal. In these instances, staff ensure R5 is safe and leave her alone in her room with supervision.

When interviewed on 7/14/16, at 7:39 a.m. the director of nursing (DON) confirmed when R5 experienced the identified behavioral episodes, the intervention was removal from the area in an attempt to de-escalate the behavior and provide 1:1 intervention as R5 allows. The DON further confirmed she would expect this to be included on the NA care sheet as well as in the communication book. The case manager (CM) subsequently updated the NA assignment sheet in addition to the plan of care. The DON confirmed the care plan and nursing assistant assignment sheet had not been revised to include the current implemented interventions for either R5 or R28. She stated she would have expected

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F 280	Continued From page 5 this to be completed and revised in a timely manner.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview the facility failed to provide repositioning as defined in the plan of care for 1 of 1 resident (R25) reviewed with a pressure ulcer (PU). Findings include: The physician progress note dated 5/31/16, identified that R25 had diagnoses including progressive Alzheimer's disease and dementia and also documented that R25 has severe cognitive impairment. The quarterly Minimum Data Set (MDS) assessment dated 4/16/16, identified that R25 received extensive assist of 2 with transfers and bed mobility. The care plan dated 5/19/16, identified R25 at risk for PU development related to immobility. The goal revealed R25 will have intact skin, free of redness, blisters or discoloration. Interventions identified for R25 included: (1) air overlay mattress on bed; (2) apply moisturizer to skin twice dally with cares and as needed; (3) float heels off bed with pillows; (4) foam cushion on	F 282	R25 care plan and CNA worksheet updated as well as a memo to caregiving staff relevant to skin care and repositioning needs was done 7/13/16. Employee counseling relevant to repositioning standards, skin care, accountability to participate with report and review communication book for resident updates done 7/13/16. As of 7/24/16 stage II wound as identified on 7/11/16 has 100% intact healthy pink epithelial tissue. Review current communication processes relevant to resident condition changes. Update Short Term Care Plan document to assure change in a residents repositioning schedule is documented and effectively communicated to care giving staff. 8/1/2016 Clinical nursing staff, CNAs including Activity CNA staff to be included with education reinforcement on responsiveness to following resident care	8/23/16

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F 282	Continued From page 6 wheelchair; (5) follow facility policies/protocols for the prevention/treatment of skin breakdown, Braden scale quarterly and tissue tolerance test done annually or with significant change; (6) requires assistance to turn/reposition every 2.5 to 3 hours in bed and chair, more often as needed or requested. The Short term Skin Integrity Care Plan dated 7/11/16, revealed a "open blister to her bottom." Treatment was started with a Mepilex dressing. When observed on 7/13/16, at 9:45 a.m. R25 was seated in the small lobby area at a table. Although R25 was not looking at the magazine she had, eye contact was made and she smiled. R25 spoke but it was difficult to understand what she was saying. At 7/13/16, at 10:57 a.m. nursing staff removed her from the table and transported her into the dining room for the noon meal. R25 was not repositioned nor toileted at this time. At 12:50 p.m. R25 was removed from the dining room via her wheelchair and returned to the lobby table. At 1:07 p.m. the household coordinator (HC)-A was notified of the extended time that R25 had not been repositioned (after 3 hours and 20 minutes). Upon notification, HC-A responded "oh, that's not good" and proceeded to inform nursing staff. At 1:14 p.m. licensed practical nurse (LPN)-A returned with 2 NA's (nursing assistants) to take R25 into the bathroom. With the help of 2 staff and the use of a gait belt, R25 was walked into the bathroom. During interview on 7/13/16, at 1:43 p.m. NA-A confirmed that R25 had not been repositioned since 9:45 a.m. when she had gotten her up for the breakfast meal. Further questioning revealed the NA's did not document and/or communicate repositioning times, "we just kind of know". NA-A	F 282	plans. Engage WOCN with staff education plan to reinforce standards of care relevant to skin care management and repositioning. 8/11/2016 An audit of care plan follow-through will be implemented via a random selection of resident observation of repositioning and documentation of care during selected time in a given shift on a weekly basis. Tracking and trends will be monitored by the Director of Clinical Services or designee. Audit outcomes will be evaluated through our QAPI program.	

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F 282	Continued From page 7 presented a NA worksheet which identified that R25 required repositioning every 2.5 -3 hours. NA-A confirmed she had been unaware that R25 had recently [7/11/16] developed an open blister located on the coccyx. When interviewed on 7/13/16, at 1:43 p.m. HC-A stated the expectation for a resident with a newly developed open area would be a repositioning schedule of every 1.5 to 2 hours. During interview on 7/13/16, at 3:11 p.m. RN-B stated staff were informed of new problems during morning report and confirmed she was aware of the newly identified PU and staff were reminded to reposition R25 every 1.5-2 hours. RN-B confirmed she would expect NA-A to reposition R25 every two hours and not leave her without positioning for over 3 hours as observed. The facility policy titled, Skin Policy and Procedure, with a revision date 8/13 indicated: To provide care and services to prevent pressure ulcer development, to promote the healing of pressure ulcers/wounds that are present, and prevent development of additional pressure ulcers/wounds. .	F 282		

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F 314	Continued From page 8	F 314		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview the facility failed to implement interventions to prevent worsening of a pressure ulcer (PU) for 1 of 1 resident (R25) reviewed who had a PU. Findings include: The physician (MD) progress note dated 5/31/16, identified that R25 had diagnoses including progressive Alzheimer's disease and dementia and also documented that R25 has severe cognitive impairment. The quarterly Minimum Data Set (MDS) assessment dated 4/16/16, identified that R25 received extensive assist of 2 with transfers and bed mobility. R25's Care Area Assessment (CAA) for PU dated 7/22/15, indicated the following: "at low risk for skin breakdown, decreased mobility, needs assistance to change positions, frequent incontinence and skin is often in contact with moisture [from incontinence],	F 314	R25 care plan and CNA worksheet updated as well as a memo to caregiving staff relevant to skin care and repositioning needs was done 7/13/16. Employee counseling relevant to skin care, repositioning standards, accountability to participate with report and review communication book for resident updates done 7/13/16. As of 7/24/16 stage II wound as identified on 7/11/16 has 100% intact healthy pink epithelial tissue. Review current communication processes relevant to resident condition changes. Review Short Term Care Plan document to assure is comprehensive to skin condition changes and intervention directives. 8/1/2016 Clinical nursing staff, CNAs including Activity CNA staff to be included with education reinforcement on	8/23/16

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F 314	Continued From page 9 needs assistance with bed mobility as well which may increase risk of friction and shear; in summary,will be on a repositioning schedule of every 2 1/2-3 hours in bed and chair; has a foam cushion in her wheelchair and her heels are floated in bed with pillows". The Pressure Ulcer Risk (complete with Braden Scale) dated 1/17/16, identified the skin tolerance was normal after 3 hours in bed. Visual inspection of pressure points while in the chair was not conducted during the time of the 1/17/16, PU risk assessment, with the most recent visual inspection dated 10/12/15. The Braden Scale for predicting PU risk dated 7/13/16, revealed R25's score was 15 (low risk). The care plan dated 5/19/16, identified R25 at risk for PU development related to immobility. The goal revealed R25 will have intact skin, free of redness, blisters or discoloration. Interventions identified for R25 include: (1) air overlay mattress on bed; (2.) apply moisturizer to skin twice dally with cares and as needed; (3.) float heels off bed with pillows; (4) foam cushion on wheelchair; (5) follow facility policies/protocols for the prevention/treatment of skin breakdown, Braden scale quarterly and tissue tolerance test done annually or with significant change; (6) requires assistance to turn/reposition every 2.5 to 3 hours in bed and chair, more often as needed or requested and (7.) requires extensive assist of one with use of bed rails to assist with turning. The Short term Skin Integrity Care Plan dated 7/11/16, revealed a "open blister to her bottom." Treatment was started with a Mepilex dressing. The document reveals the physician and family were notified on 7/11/16. The nursing progress note dated 7/11/16, indicated "wound measured and covered with a Mepilex" . No further	F 314	responsiveness to following resident care plans. Engage WOCN with staff education to reinforce standards of care relevant to skin care management to include repositioning standards as a priority in preventative care. 8/11/16 An audit of care plan follow-through will be implemented via a random selection of resident observation of repositioning and documentation of care during selected time in a given shift on a weekly basis. Tracking and trends will be monitored by the Director of Clinical Services or designee. Audit outcomes will be evaluated through our QAPI program.	

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F 314	Continued From page 10	F 314		

documentation of the wound was evident.

R25's Treatment Administration History dated 7/11/16, revealed the right lower coccyx wound dressing (Mepilex) was implemented and was to be monitored daily. Documentation was lacking to indicate that a nursing assessment had been conducted related to the condition of the wound. Wound measurements were documented on 7/13/16, (2 centimeters (cm) x 1.2 cm).

When observed on 7/13/16, at 9:45 a.m. R25 was seated in the small lobby area at a table. Although R25 was not looking at the magazine she had, eye contact was made and she smiled. R25 spoke but it was difficult to understand what she was saying. At 7/13/16, at 10:57 a.m. nursing staff removed her from the table and transported her into the dining room for the noon meal. R25 was not repositioned nor toileted at this time. At 12:50 p.m. R25 was removed from the dining room via her wheelchair and returned to the lobby table. At 1:07 p.m. the household coordinator (HC)-A was notified of the extended time that R25 had not been repositioned (after 3 hours and 20 minutes). Upon notification, HC-A responded "oh, that's not good" and proceeded to inform nursing staff. At 1:14 p.m. licensed practical nurse (LPN)-A returned with 2 NA's (nursing assistants) to take R25 into the bathroom. With the help of 2 staff and the use of a gait belt, R25 was walked into the bathroom.

On 7/13/16, at 1:22 p.m. LPN-A and registered nurse (RN)-A arrived at the bedside to change the dressing located on R25's buttock. A Mepilex dressing was removed and the area was cleansed and measured. The wound measured 2 cm x 1.2 cm. The wound bed was described as

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F 314	Continued From page 11	F 314		

bright pink epithelial tissue, with loose skin sloughing from the outside edges. R25 did not indicate discomfort and/or pain during the dressing change.

During interview on 7/13/16, at 1:43 p.m. NA-A confirmed that R25 had not been repositioned since 9:45 a.m. when she had assisted her up for the breakfast meal. Further questioning revealed the NA's did not document and/or communicate repositioning times, "we just kind of know". NA-A presented a NA worksheet which identified that R25 required repositioning every 2.5 -3 hours. NA-A confirmed she had been unaware that R25 had recently [7/11/16] developed an open blister located on the coccyx.

When interviewed on 7/13/16, at 1:43 p.m. HC-A stated the expectation for a resident with a newly developed open area would be a repositioning schedule of every 1.5 to 2 hours.

During interview on 7/13/16, at 3:11 p.m. RN-B confirmed the care plan and the NA work sheets had not been updated to reflect the newly identified PU. RN-B stated staff were informed of new problems during morning report and confirmed she was aware of the newly identified PU and staff were reminded to reposition R25 every 1.5-2 hours. RN-B explained that upon discover of a PU, a re-assessment would be conducted related to an appropriate repositioning schedule and occupational therapy (OT) would be implemented. RN-B indicated the wound nurse should be notified, and the resident should be added to weekly rounds for assessment and monitoring of healing. RN-B confirmed she would expect NA-A to reposition R25 every two hours and not leave her without positioning for over 3

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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
F 314	Continued From page 12 hours as observed. The facility policy titled, Skin Policy and Procedure, with a revision date 8/13 indicated: To ensure a resident who enters the facility without pressure ulcers does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable. To provide care and services to prevent pressure ulcer development, to promote the healing of pressure ulcers/wounds that are present, and prevent development of additional pressure ulcers/wounds. Procedure: (3) Tissue Tolerance Test (TTT) may be deferred when a resident is independent with bed mobility and transfers. It will be re-evaluated as needed with a change in one of those areas; (4) Nursing personnel will utilize the results of the physical assessment, Braden Scale, and TTT to determine an individualized pressure ulcer prevention program for each at-risk resident; (5.) When a skin ulcer is identified, a comprehensive wound assessment will be completed. This assessment will include: (a) Site, size, stage, appearance of wound bed, (use%) undermining,depth drainage, (amount, color, type, consistency, and odor) and status of peri-wound tissue; (b) Treatment of the pressure ulcer, (cleansing, debridement, dressings); (c) A critical review of the resident's current POC (plan of care) and medical status - any other possible risk factors, impaired healing due to diagnoses; (d) Type of skin ulcer -Medical Provider is asked to identify type of ulcer, e.g., pressure, stasis (venous), ischemic (arterial), or neuropathic, and provide skin treatment orders.	F 314		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		8/23/16

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F 329	Continued From page 13 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to identify parameters for the use of an as needed (PRN) anti-anxiety medication (lorazepam) for 1 of 5 residents (R48)reviewed for unnecessary medications. Findings include: R48 was admitted on 7/23/15, with diagnoses including: anxiety disorder, Alzheimer's disease,	F 329	Director of Clinical Services met with Medical Director on 7/15/2016 with preliminary findings of survey reported. Director provided report at 7/19/2016 Medical Staff meeting. Discussed indicated need for provider(s) setting parameters for prn utilization of anti-anxiety medications. Medical Director plans to do additional clinical focus discussion on resident medication	

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F 329	Continued From page 14 and recent diagnosis of manic episode (6/28/16) per the Diagnosis Report. R48's signed physician orders dated 6/28/16, included an order for lorazepam 0.5 milligrams by mouth every 2 hours PRN with maximum of 4 tablets daily, for anxiety related to Alzheimer's disease. The quarterly Minimum Data Set (MDS) assessment dated 4/20/16, indicated R48 had severe cognitive impairment, required extensive assistance with all activities of daily living, experienced hallucinations and delusions, exhibited rejection of care and behavior symptoms not directed towards others 1-3 days during the lookback period, and wandering behavior 4-6 days during the lookback period. Review of R48's care plan dated 5/4/16, included a focus area for behavior related to dementia. Though the care plan included non-pharmacological interventions related to the behavior, it did not identify the use of the PRN lorazepam nor parameters to indicate when to administer the PRN medication. Review of R48's medication administration records (MAR) indicated the following related to administration of PRN lorazepam: May 2016 - administered 29 of 31 days for a total of 58 doses. June 2016 - administered 26 of 30 days for a total of 54 doses. July 2016 - administered 2 of 13 days for a total of 2 doses. Documentation on the PRN sheet indicated the reason the medication was administered on	F 329	management at August Medical Staff meeting. R48 prn medication profile to be reviewed with medical provider with parameters for dosing to be clarified. Non-pharmacological interventions related to behavior management are incorporated into the residents care plan. Behavior interventions will be added to CNA worksheets. Dementia training for all staff engaged in providing direct and indirect care to residents will be conducted 7/28/2016. Parameters for medication dosing are included in the care plan as well as noted on the MAR. 7/22/2016 Randomly selected residents who have prn anti-anxiety medication orders will be audited to assure clear parameters for dosing is defined. Audit outcomes will be monitored by the Pharmacy and Therapeutics Committee and QAPI program.	

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F 329	Continued From page 15 5/19/16 was identified as: "Disturbing other residents-could not distract." All other entries documented the reason for PRN medication administration as noted: "Restless". When interviewed on 7/13/16, at 3:38 p.m. licensed practical nurse (LPN)-D stated she would administer PRN lorazepam when R48 exhibited anxiety/agitation and wouldn't calm down. LPN-D further stated staff would sometimes administer the PRN medication during the night if R48 was unable to sleep and was agitated. LPN-D confirmed parameters related to the administration of R48's lorazepam were not included on the MAR nor the care plan. When interviewed on 7/14/16, at 10:00 a.m. registered nurse (RN)-B confirmed there were no parameters identified related to administration of R48's PRN lorazepam.	F 329		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431		8/23/16

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F 431	Continued From page 16 In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the medication refrigerator temperature was maintained within the proper temperature controls for the storage of medications for 2 of 2 residents (R2, R52) who had insulin stored in the west wing medication refrigerator. Findings include: It was noted on 7/14/16, at 8:28 a.m. that the west wing medication refrigerator temperature measured 31 degrees (F) Fahrenheit. Licensed practical nurse (LPN)-A verified this reading on the thermometer and indicated a temperature of 31 degrees F. was too cold for medication storage. LPN-A further indicated the night shift nurse routinely monitored and documented the	F 431	Both medication refrigerators are labeled with acceptable temperature range 7/14/2016 Temperatures have been monitored and have been maintained within acceptable range since issue was identified during survey 7/14/2016. Temperature monitoring information updated and posted on clipboard for documentation of temperatures. Temperature ranges and directions/procedure in the event temperature is outside of acceptable parameters in place 7/22/2016 New policy for refrigerator temperature management developed 8/1/2015 Nursing Staff education reinforcement on policy and procedure 8/11/2016	

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F 431	Continued From page 17 refrigerator temperatures. The medication storage refrigerator contained the following insulin's used to treat diabetes: (1) Four (4) unopened Novolog FlexPen dispensed 7/11/16, for R2; (2) Three unopened Levemir FlexTouch pen dispensed 6/30/16, for R2; and (3) Three unopened Lantus SoloStar pen dispensed 6/24/16 for R52. It was indicated that R2 and R52 were the only two residents currently in the facility who required insulin for the treatment of diabetes. When interviewed on 7/14/16, at 9:12 a.m. registered nurse (RN)-A confirmed the documentation on the refrigerator temperature check sheet for the months of June and July 2016. RN-A verified the refrigerator temperatures of 30-34 degrees F were below the recommended range for insulin storage and stated both the east and west wings had purchased new medication refrigerators on 6/29/16. RN-A further indicated she was not aware of the out of range temperatures nor did she believe it had been brought to the attention of anyone in the facility. Review of the documentation on the west wing refrigerator temperature check sheet from 6/29/16 to 7/13/16 indicated temperatures ranged between 30 degrees to 34 degrees Fahrenheit. This time frame was after the new refrigerator had been purchased. During interview on 7/14/16, at 9:51 a.m. the facility pharmacist indicated the temperature for refrigerated medications should be around 40 degrees F. and further stated that 31 degrees is "too cold" for medications, including insulin.	F 431	QA monitoring to assure temperature monitoring and procedures for management of medication storage under proper temperature control is in compliance. Weekly auditing implemented. Audit outcomes to be evaluated and managed through Pharmacy and Therapeutics meetings and QAPI program	

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F 431	Continued From page 18 The manufacturer's recommendation documented on the medication box for the unopened Novolog Flex Pen instructed: "avoid freezing". Manufacturer's recommendation documented on the medication box for the unopened Levemir FlexTouch pens included: "store unopened pens between 36-46 degrees F". The manufacturers recommendation for Lantus SoloStar documented on the box packaging stated: "store between 36-46 degrees F" and "do not freeze". A facility policy related to the monitoring of refrigerator temperatures was requested but not provided.	F 431		

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K 000	INITIAL COMMENTS FIRE SAFETY 01 Main Building THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Hendricks Community Hospital Nursing Home was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/22/2016

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

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K 000	Continued From page 1	K 000		

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

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

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

2. The actual, or proposed, completion date.

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

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

The nursing home is separated from a critical access hospital by a two-hour fire wall, and the opening protective consisted of a labeled, self-closing, positive latching, 90-minute fire rated

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K 000	Continued From page 2 door assembly. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. Resident Rooms are protected with automatic smoke detectors which are interconnected to the building fire alarm control panel [FACP]. The facility has a capacity of 58 beds and had a census of 56 at the time of the survey. The requirement at 42 CR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was determined that the facility failed to maintain smoke barrier walls in accordance with NFPA 101-2000 edition, Sections 19.3.7.1, 19.3.7.3, 8.3.2, and 8.3.6. This deficient practice could allow the products of combustion spread throughout the facility in the event of a fire which could affect 24 of the 56 residents as well as an undetermined number of staff and visitors. Findings include: On the facility tour between 8:30 am to 11:30 am	K 025	The 1 inch diameter penetration above the corridor doors in the west wing smoke barrier wall has been sealed with a fire barrier sealant. Maintenance will do quarterly inspections of smoke barrier walls to assure wall integrity is maintained.	7/20/16

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K 025	Continued From page 3 on 07/14/2016 observations and staff interview revealed a 1 inch diameter penetration above the corridor doors in the smoke barrier wall in the west wing. This deficient condition was verified by the Maintenance Supervisor	K 025		
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility has failed to provide proper protection from 1 of several hazardous areas located throughout the facility in accordance with NFPA Life Safety Code 101 (2000 edition) section 19.3.2.1. This deficient conditions could, in the event of a fire, allow smoke and flames to spread throughout the corridor and adjacent areas making them untenable, which could negatively affect the exiting capabilities for 24 of the 56 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:30 am to 11:30 am on 07/14/2016 observations and staff interview revealed a small room in the west wing being	K 029	The small soiled utility room in the west wing has had a door closer installed. Carts of lower height have replaced the higher carts so the door can close.	7/29/16

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K 029	Continued From page 4 used for soiled utility. The door did not have a closer and the carts would not allow the door to close. This deficient condition was verified by the Maintenance Supervisor.	K 029		
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00), Section 19.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, (98). This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect all 34 of the 56 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:30 am to 11:30 am on 07/14/2016 observations and staff interview revealed a sprinkler escutcheon missing from the ceiling of resident room 313. This deficient condition was verified by the Maintenance Supervisor.	K 062	The sprinkler escutcheon missing from the ceiling in room 313 has been replaced. Maintenance will do quarterly environment inspections to make sure all sprinklers are in compliance.	7/20/16
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 147		7/21/16

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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
K 147	Continued From page 5 Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Based on observation and interview with the staff, the facility was using an unapproved electrical device that is not in accordance with NFPA 70 (99), National Electrical Code. This deficient practice could negatively affect the safety of 1 of the 56 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:30 am to 11:30 am on 07/14/2016 observations and staff interview revealed a resident using a non-approved electrical adapter in room 207. This deficient condition was verified by the Maintenance Supervisor.	K 147	The resident using a non-approved electrical adapter in room 207 has been removed. It has been replaced with an approved UL rated power strip. Social Services has updated the facility admission packet to include informing residents and families that no electrical adapter other than approved UL rated power strips are allowed. Current residents and families are also being notified. Maintenance and Nursing staff will monitor resident rooms to assure appropriate adapter utilization.	