#### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 087E

Facility ID: 00340

### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

8. ACCREDITATION STATUS:  0 Unaccredited 1 TJC 2 AOA 1 Other  11. LTC PERIOD OF CERTIFICATION From (a):		3. NAME AND AD (L3) HENDRICK (L4) 503 E LINCO (L5) HENDRICK 7. PROVIDER/SUI 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF  10.THE FACILITY X A. In Complian	S COMMUNITY OLN STREET S, MN  PPLIER CATEGOR  05 HHA  06 PRTF  07 X-Ray  08 OPT/SP  IS CERTIFIED AS: nce With	HOSPIT	(L6) 56136  02 (L7)  13 PTIP 22 CLIA  14 CORF  15 ASC  16 HOSPICE  And/Or Approved Waivers Of The			
To (b):  12.Total Facility Beds  13.Total Certified Beds	58 (L18) 58 (L17)	Compliance1. A B. Not in Cor	Requirements ce Based On:  Acceptable POC  mpliance with Progra and/or Applied Waive		2. Technical Personnel3. 24 Hour RN4. 7-Day RN (Rural SNI5. Life Safety Code  * Code: A*			
14. LTC CERTIFIED BED BREAKDOW         18 SNF       18/19 SNF         58         (L37)       (L38)         16. STATE SURVEY AGENCY REMARKATION	19 SNF (L39)	ICF (L42)	IID (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)		
17. SURVEYOR SIGNATURE Date :  Kathryn Serie, Unit Supervisor 10/24/2017  (L19)				(L19)	18. STATE SURVEY AGENCY APPROVAL Date:			
PART II - TO BE COMPLETED BY HCFA REGIONA  19. DETERMINATION OF ELIGIBILITY  20. COMPLIANCE WITH CIVIL RIGHTS ACT:  X 1. Facility is Eligible to Participate  2. Facility is not Eligible					21. 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above :			
2. Facility is not Eligible	-		GHTS ACT:		<ol><li>Ownership/Control</li></ol>	l Interest Disclosure Stmt (HCFA-1513)		
2. Facility is not Eligible  22. ORIGINAL DATE  OF PARTICIPATION  04/01/1987  (L24)  25. LTC EXTENSION DATE:  (L27)	(L21)  23. LTC AGREEM BEGINNING  (L41)  27. ALTERNATI	ENT 2- DATE  /E SANCTIONS of Admissions:	4. LTC AGREEME ENDING DATE (L25) (L44) (L45)		<ol><li>Ownership/Control</li></ol>	I Interest Disclosure Stmt (HCFA-1513)  (L30)  INVOLUNTARY  05-Fail to Meet Health/Safety  ont  06-Fail to Meet Agreement		
22. ORIGINAL DATE  OF PARTICIPATION  04/01/1987  (L24)  25. LTC EXTENSION DATE:	(L21)  23. LTC AGREEM BEGINNING  (L41)  27. ALTERNATI  A. Suspension  B. Rescind Sus	ENT 2- DATE  /E SANCTIONS of Admissions:	4. LTC AGREEME ENDING DATE (L25)  (L44)  (L45)  CARRIER NO.	(L31)	2. Ownership/Control 3. Both of the Above  26. TERMINATION ACTION:  VOLUNTARY  01-Merger, Closure  02-Dissatisfaction W/ Reimbursement  03-Risk of Involuntary Termination	I Interest Disclosure Stmt (HCFA-1513)  (L30)  INVOLUNTARY  05-Fail to Meet Health/Safety  of-Fail to Meet Agreement  OTHER  07-Provider Status Change  00-Active		



CMS Certification Number (CCN): 245467

October 24, 2017

Mr. Jeffrey Gollaher, Administrator Hendricks Community Hospital 503 East 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 October 3, 2017 the above facility is recommended 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,

Joanne Simon, Enforcement Specialist Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us



Electronically delivered

October 24, 2017

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

RE: Project Number S5467027

Dear Mr. Gollaher:

On September 18, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 24, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On October 13, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on October 24, 2017 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 August 24, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 3, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 24, 2017, effective October 3, 2017 and therefore remedies outlined in our letter to you dated September 18, 2017, 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,

Joanne Simon, Enforcement Specialist

Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us



Electronically delivered

October 24, 2017

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

Re: Reinspection Results - Project Number S5467027

Dear Mr. Gollaher:

On October 13, 2017 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 24, 2017, with orders received by you on September 18, 2017. At this time these correction orders were found corrected.

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.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist

Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit

Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 087E

Facility ID: 00340

### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

MEDICARE/MEDICAID PROVIDER     (L1) 245467  2.STATE VENDOR OR MEDICAID NO.     (L2) 204342400  5. EFFECTIVE DATE CHANGE OF OW (L9)		3. NAME AND AI (L3) HENDRICK (L4) 503 E LINC (L5) HENDRICK 7. PROVIDER/SU 01 Hospital	SS COMMUNIT OLN STREET SS, MN	Y HOSPIT	(L6) <b>56136</b> <u>02</u> (L7)  13 PTIP 22 CLIA	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
6. DATE OF SURVEY 08/24// 8. ACCREDITATION STATUS:  0 Unaccredited 1 TIC 2 AOA 3 Other	2017 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30
11. LTC PERIOD OF CERTIFICATION From (a): To (b):  12.Total Facility Beds 13.Total Certified Beds	58 (L18) 58 (L17)	Complian1.  X B. Not in Co		ram	And/Or Approved Waivers Of Th  2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNI 5. Life Safety Code  * Code: <b>B</b> *  15. FACILITY MEETS	6. Scope of Services Limit 7. Medical Director
18 SNF 18/19 SNF 58 (L37) (L38)	19 SNF (L39)  KS (IF APPLICABL	ICF (L42) E SHOW LTC CANC	IID (L43) ELLATION DATE)	:	1861 (e) (1) or 1861 (j) (1):	(L15)
17. SURVEYOR SIGNATURE  Wendy Buckholz, HFE-N	E II	Date :	09/27/2017	(L19)	18. STATE SURVEY AGENCY  Joanne Simon, Certifica	
PA	ART II - TO BI	E COMPLETED	BY HCFA RE	_ ` ′	OFFICE OR SINGLE ST	
DETERMINATION OF ELIGIBILITY      1. Facility is Eligible to Pace     2. Facility is not Eligible	ľ	20. CON	MPLIANCE WITH GHTS ACT:		21. 1. Statement of Final	ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513)
22. ORIGINAL DATE						
OF PARTICIPATION 04/01/1987 (L24) 25. LTC EXTENSION DATE:	23. LTC AGREEM BEGINNING  (L41)  27. ALTERNATI A. Suspension	DATE	24. LTC AGREEM ENDING DAT (L25)		26. TERMINATION ACTION:  VOLUNTARY  01-Merger, Closure  02-Dissatisfaction W/ Reimbursem  03-Risk of Involuntary Termination  04-Other Reason for Withdrawal	05-Fail to Meet Health/Safety nent 06-Fail to Meet Agreement  OTHER 07-Provider Status Change
04/01/1987 (L24)	BEGINNING (L41)  27. ALTERNATI	DATE  VE SANCTIONS  n of Admissions:	ENDING DAT		VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimbursem 03-Risk of Involuntary Termination	0 INVOLUNTARY 05-Fail to Meet Health/Safety ent 06-Fail to Meet Agreement n OTHER
04/01/1987 (L24) 25. LTC EXTENSION DATE:	BEGINNING  (L41)  27. ALTERNATI  A. Suspension  B. Rescind Sus	DATE  VE SANCTIONS  n of Admissions:	(L25) (L44) (L45)		VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimbursem 03-Risk of Involuntary Termination	0 INVOLUNTARY 05-Fail to Meet Health/Safety ent 06-Fail to Meet Agreement 07HER 07-Provider Status Change



Electronically delivered September 18, 2017

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

RE: Project Number S5467027

Dear Mr. Gollaher:

On August 24, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

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

#### DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Mankato Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 201
Marshall, Minnesota 56258-2504
Email: kathryn.serie@state.mn.us

Phone: (507) 476-4233 Fax: (507) 344-2723

#### OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by October 3, 2017, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by October 3, 2017 the following remedy will be imposed:

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

#### ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

#### PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

#### VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

#### Original deficiencies not corrected

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

#### Original deficiencies not corrected and new deficiencies found during the revisit

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

#### Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by November 24, 2017 (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 February 24, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

#### **INFORMAL DISPUTE RESOLUTION**

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

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

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

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

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,

Joanne Simon, Enforcement Specialist

Minnesota Department of Health Licensing and Certification Program

Program Assurance Unit Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us

PRINTED: 09/27/2017 FORM APPROVED OMB NO. 0938-0391

1	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		LE CONSTRUCTION		) DATE SURVEY COMPLETED	
		245467	B. WING			08/	24/2017	
	PROVIDER OR SUPPLIER	DSPITAL		5	STREET ADDRESS, CITY, STATE, ZIP CODE 503 E LINCOLN STREET HENDRICKS, MN 56136			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 000	INITIAL COMMEN	тѕ	FO	000				
F 157 SS=D	survey was comple Minnesota Departmyour facility was in of 42 CFR Part 483 Requirements for L.  The facility's plan of as your allegation of Department's access Upon receipt of an revisit of your facility validate that substate regulations has been your verification.  483.10(g)(14) NOT (INJURY/DECLINE)  (g)(14) Notification  (i) A facility must improve the consult with the responsistent with his representative(s) where the consults in injury and physician intervention of the consult with the responsibility of the consults in injury and physician intervention in heat status in either lifeclinical complication.	for correction (POC) will serve of compliance upon the ptance.  acceptable POC, an on-site ty may be conducted to antial compliance with the en attained in accordance with a strict (FROOM, ETC)  of Changes.  Inmediately inform the resident; sident's physician; and notify, or her authority, the resident when there is-  olving the resident which thas the potential for requiring ion;  ange in the resident's physical, ocial status (that is, a alth, mental, or psychosocial threatening conditions or	F 1	157			10/3/17	
LABORATOR)	/ DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE	

Electronically Signed 09/26/2017

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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245467	B. WING		08/	24/2017	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 503 E LINCOLN STREET HENDRICKS, MN 56136		2-1/2011	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ( (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 157	treatment due to a commence a new  (D) A decision to tresident from the fights of the	nue an existing form of dverse consequences, or to form of treatment); or ansfer or discharge the acility as specified in notification under paragraph (g) on, the facility must ensure that ation specified in §483.15(c)(2) ovided upon request to the st also promptly notify the esident representative, if any, om or roommate assignment (3.10(e)(6); or sident rights under Federal or ations as specified in paragraph ion.  Set record and periodically is (mailing and email) and the resident representative(s). NT is not met as evidenced ation, interview, and document failed to ensure that physician and at onset of a pressure ulcer as change during the course of a resident (R48) reviewed who PU's located on the buttock and	F 1	R48 wound status has been medical provider along with A monitoring. Provider is scheen R48 on 9/29/2017 to reassess sites.  Skin Care and Pressure Ulcer policies reviewed. CNA staff 9/12/2017 included staff role in the staff of the staff o	DON WOCN luled to see s pressure r Prevention meeting		

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		245467	B. WING		08/	24/2017
	PROVIDER OR SUPPLIER	DSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 503 E LINCOLN STREET HENDRICKS, MN 56136		-
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 157	R48 was admitted electronic medical diagnoses at the tir artery disease, chridiabetes.  The Resident Asse indicated that R48 left buttock.  Review of R48's SI Integrity form dated decreased sensation pressure ulcer (PU Interventions include wounds and treatm.  Review of the Shound Integrity form dated to left buttock. Integrity form dated to left buttock, in mention this time.  (2) On 6/15/17, a rebuttock; no mention this time.  (2) On 6/20/17, see and had developed buttock; WN-C's trecavilon barrier creasiff weight when sphysician notification (3) Review of the primary care physician primary care physician primary care physician in the primary care physician primary care physician in the primary care physician in the primary care physician in the primary care physician primary care physician in the primary care phys	on 6/15/17. Review of his record (EMR) indicated his me of admission were coronary onic kidney disease and essment form dated 6/15/17, had a reddened area on the mort Term Care Plan Skin d 7/8/17, indicated R48 had on and mobility. He had a ) to the right heel. ded: notify physician of nents.  Int Term Care Plan Skin d 8/1/17, indicated R48 had PU reventions noted included the enotified at that time.  In sing progress notes and ication identified the following eddened area noted on left on of physician notification at en by wound nurse (WN)-C I one Stage II PU to left eatment included adding the am and encouraging R48 to seated in the w/c or chair. No	F 157	communication to supervising relevant to status of resident status of resident status and requirement for pronotification in the event a new status of a pressure injury is id requiring physician assessmen update in orders if indicated to medical plan of care. This will accomplished by Nursing comencounter form with nursing dowound status and referral for nevaluation.  Medical Staff meeting 9/12/20 standard of care requirement ff assessment of new or status or pressure injury for purposes of or updating medical plan of care WOCN and Medical Director medical plan of care work and Medical Director medical plan of care reviewed at 10/3/2017 Medical Staff meeting. Periodic provides be inclusive of assessment, or and documentation of wound status and Director to overse monitoring on a weekly basis to timely referral by nursing staff pressure injuries requiring provevaluation.	kin issues.  0/2017 staff ovider or update in entified it and resident's be pleting an ocumenting nedical  17 included or provider hanged confirming re. ADON net on date. This Medical er rounds to der review status as it e quality o assure for any	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIEF		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245467	B. WING	i		08/:	24/2017
	PROVIDER OR SUPPLIER  CKS COMMUNITY HO	DSPITAL		50	REET ADDRESS, CITY, STATE, ZIP CODE  3 E LINCOLN STREET  ENDRICKS, MN 56136		
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F 157	nor that staff report However, the PCP activity in his chair therapy (PT) to imp made no mention of (4) On 7/8/17, (18 of and documented a purple bruising around (cm) x 2 cm. WN-C Betadine and left of protector for R48 to off-load pressure. Wappointment was box check marked Documentation was podiatry services has follow-up occurred (5) On 7/14/17, WN buttocks had proground the base. WN-C coof Betadine treatmes foot pain. Documer physician notification worsening condition (6) On 7/21/17, left measured 0.5 cm to WN-C changed tree (skin protectant film (foam dressing). Ricm x 7.5 cm, purple boggy measuring 1 notification was doc (7) On 7/31/17, (10) worsened with two measuring (#1) 0.7 0.3 cm. Drainage was considered to the protectant film (foam dressing). Ricm x 7.5 cm, purple boggy measuring 1 notification was doc (7) On 7/31/17, (10) worsened with two measuring (#1) 0.7 0.3 cm. Drainage was purple to the protectant film (foam dressing) and the protectant film (foam dressing). Ricm x 7.5 cm, purple boggy measuring 1 notification was doc (7) On 7/31/17, (10) worsened with two measuring (#1) 0.7 0.3 cm. Drainage was purple to the protectant film (foam dressing).	led the PU to the physician. Inoted R48 had prolonged and planned to order physical prove muscle function. WN-C of contacting the physician. It days later), WN-C re-assessed Stage II heel PU with slight and edges 3.5 centimeters is painted the heel with pen to air; added a heel of wear when in bed and/or to WN-C also noted a podiatry eing considered. There was a YES for follow-up requested. It is also lacking to indicate ad been offered and/or with the physician.  I-C re-assessed and the left essed to a Stage II, measuring e right heel PU had increased is cm. x 7.5 cm. and boggy at intinued with the same course ent; R48 now complained of intation was lacking to indicate on had occurred related to the	F	157			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION		TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 503 E LINCOLN STREET HENDRICKS, MN 56136	•	
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F 157	color and continued continued as before (8) On 8/9/17, (9 color left buttocks wound cm and (#2)0.1 cm air, a barrier cream application. Right unstageable and result was dry, black-dare Betadine and leavenotification docum (9) On 8/18/17, (9 documented left bocm x 0.5 cm and (PU-3.5 cm x 6 cm on the edge. No period documented.  No other progress staff were made each literview and documented (ADON) and WN-notification at PU composition was to indicated upon idea physician was to indicated	sured 4 cm x 6 cm, purplish in and to be boggy. Treatment re, with Betadine and air drying. lays later), WN-C re-assessed, ds measured (#1) 0.3 cm x 0.1 cm. Treatment-open to applied prior to brief heel PU-described as measured at 3.5 cm x 5 cm, k purple heel. Treatmente open to air. No physician ented. days later), the WN-C uttock PU measured (#1) 0.5 #2)PU resolved. Right heel black scab and starting to peel hysician notification  notes by any other nursing except by WN-C.  ument review on 8/24/17, at the assistance director of nursing C confirmed physician onset and/or at the time the ged had occurred.  9 Skin Policy and Procedure entification of a skin ulcer, the dentify the type of ulcer and if n 2 weeks, staff were to notify eek an order for a wound	F 1	157		
	J	3, indicated if the wound had n 2 weeks, the provider was to				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION  NG		TE SURVEY MPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION OF CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETION DATE
F 279 SS=D	483.20 (d) Use. A facility rassessments comprehensive the resident	must maintain all resident pleted within the previous 15 dent's active record and use the assments to develop, review dent's comprehensive care  E Care Plans  At develop and implement a reson-centered care plan for sistent with the resident rights $O(c)(2)$ and $\S483.10(c)(3)$ , that ple objectives and timeframes as medical, nursing, and mental needs that are identified in the sessment. The comprehensive scribe the following -  At are to be furnished to attain ident's highest practicable and psychosocial well-being as 33.24, $\S483.25$ or $\S483.40$ ; and at would otherwise be required 33.25 or $\S483.40$ but are not a resident's exercise of rights luding the right to refuse 183.10(c)(6).	F 2'	79		10/3/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION  G		E SURVEY PLETED
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PREFIX (EACH DEFICIENCY M	MENT OF DEFICIENCIES  IUST BE PRECEDED BY FULL  IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
rationale in the resider  (iv)In consultation with resident's representation.  (A) The resident's good desired outcomes.  (B) The resident's prefuture discharge. Fact whether the resident's community was assessed local contact agencies entities, for this purpose.  (C) Discharge plans it plan, as appropriate, requirements set forth section.  This REQUIREMENT by:  Based on interview a facility failed to ensure related to anticoagula (R42) reviewed for until Findings include:  R42's quarterly Minimassessment, dated 5/2 receiving an anticoagula R42's current physicia included an order for thinner) 4 milligrams Saturday and 5 mg events and services and	RR, it must indicate its ent's medical record.  the the resident and the tive (s)- als for admission and  eference and potential for silities must document to the seed and any referrals to seed and any referrals to seed and any referrals to seed.  In the comprehensive care in accordance with the hain paragraph (c) of this  T is not met as evidenced and document review, the e a care plan was developed ant therapy for 1 of 1 resident nnecessary medications.  Thum Data Set (MDS)  1/24/17, identified R42 was	F 27	R42 care plan updated as of 8/2 include monitoring for increased bleeding relevant to anticoagula Care Plan policy reviewed and cas up to date.  9/12/2017 CNA staff meeting incimportance to communicate to supervisory nurse any observatificantification of resident conditions changes that could be related to medication side effects.  9/20/2017 Licensed nurse meeting included role of nurses to engagupdating care plans as resident changes. Care plan documentate education has been initiated with	risk for nt therapy. onfirmed cluded on and/or n ng e in condition tion	

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(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	ILD BE	(X5) COMPLETION DATE
Review of the medidentified R42 had sodium at varying of Review of R42's curcare plan focus nor related to the anticode Review of R42's cure 8/17, lacked monitor warfarin sodium us Interview with the an (ADON) on 8/23/17 plan of care did not sodium or side effectincreased bleeding anticoagulant monificulated in R42's periode probably missed it. During interview on of nursing (DON) in care plan be developed anticoagulant medidenticoagulant mediden	ication administration record been receiving warfarin dosages since 11/11/16.  Irrent care plan lacked any other care plan interventions begulant use.  Irrent treatment record dated bring for side effects of the e.  Issistant director of nursing of at 3:09 p.m. confirmed the trinclude R42's use of warfaring the monitoring due to risk of the at include R42's use of warfaring the trincipal of the state of the tring should have been alan of care stating "honestly I  In 8/23/17, at 3:36 p.m. director addicated her expectation is a supped for residents using cations.  In Care Plans/Care existent using cations are being antion for resident's medical for use, goals for medication affectiveness of the medication affectiveness of the medication. It further directed care plans needed and reviewed at least		enhance care plan update comm for multi-disciplinary team. Week Multi-disciplinary team meetings relevant care plan updates. Phar reviews medication profiles and pinput for medical and nursing consideration as to side effect ar medication contraindication. Factoriving to enhance electronic mercord documentation with plan to increase utilization of Point Click software system to support alerts monitoring resident of potential reconditions relevant to medication effects.  ADON Care Coordinator and Dirbe responsible to oversee bi-mon quality assurance monitoring of caccuracy.	to include macist provides ad/or fility is edical to a care as for a side ector will anthly	10/3/17
		. 202	-		10,0,11
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE  Continued From pa  Review of the meditidentified R42 had sodium at varying of the sodium of the sodium of the sodium use.  Interview with the at (ADON) on 8/23/17 plan of care did not sodium or side effectinceased bleeding anticoagulant monitincluded in R42's probably missed it.  During interview on of nursing (DON) in care plan be developed anticoagulant medital the sodium of th	REVIEW of R42's current treatment record dated 8/17, lacked monitoring for side effects of the warfarin sodium use.  Interview with the assistant director of nursing (ADON) on 8/23/17, at 3:36 p.m. director of nursing (DON) indicated anticoagulant monitoring should have been included in R42's plan of care stating "honestly I probably missed it".  During interview on 8/23/17, at 3:36 p.m. director of nursing (DON) indicated her expectation is a care plan be developed for residents using anticoagulant medications.  A facility policy titled Care Plans/Care Conferences last revised and reviewed at least quarterly.  483.21(b)(3)(ii) SERVICES BY QUALIFIED	Review of R42's current care plan lacked any care plan focus nor other care plan interview with the assistant director of nursing (ADON) on 8/23/17, at 3:09 p.m. confirmed the plan of care did not include R42's use of warfarin sodium or side effect monitoring due to risk of increased bleeding. The ADON indicated anticoagulant medications divided in R42's plan of care stating "honestly I probably missed it".  During interview on 8/23/17, at 3:36 p.m. director of nursing (DON) indicated her expectation is a care plan be developed for resident's medical needs, indications for use, goals for medication used and how the effectiveness of the medication is being evaluated. It further directed care plans will be updated as needed and reviewed at least quarterly.  483.21(b)(3)(ii) SERVICES BY QUALIFIED  F 282	FORRECTION  245467  245467  245467  245467  245467  245467  245467  245467  25TREET ADDRESS, CITY, STATE, ZIP CODE 503 E LINCOLN STREET HENDRICKS, MN 56136  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 7  Review of the medication administration record identified R42 had been receiving warfarin sodium at varying dosages since 11/11/16.  Review of R42's current care plan lacked any care plan focus nor other care plan interventions related to the anticoagulant use.  Review of R42's current treatment record dated 8/17, lacked monitoring for side effects of the warfarin sodium use.  Interview with the assistant director of nursing (ADON) on 8/23/17, at 3:30 p.m. confirmed the plan of care did not include R42's use of warfarin sodium or side effect monitoring due to risk of increased bleeding. The ADON indicated anticoagulant monitoring should have been included in R42's plan of care stating "honestly I probably missed it".  During interview on 8/23/17, at 3:36 p.m. director of nursing (DON) indicated her expectation is a care plan be developed for residents using anticoagulant medications.  A facility policy titled Care Plans/Care Conferences last revised 11/09, stated resident care plans will include how medications are being used as an intervention for resident's medical needs, indications for use, goals for medication is being evaluated. It further directed care plans will be updated as needed and reviewed at least quarterly.  483.21(b)(3)(ii) SERVICES BY QUALIFIED  F 282	TOORNECTION AUTHOR PROVIDER OR SUPPLIER  245467  245467  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 503 E LINCOLN STREET HENDRICKS, MN 56138  SUMMARY STATEMENT OF DEFICIENCIES (IEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 7  Review of the medication administration record identified R42 had been receiving warfarin sodium at varying dosages since 11/11/16.  Review of R42's current care plan lacked any care plan focus nor other care plan interventions related to the anticoagulant use.  Review of R42's current treatment record dated 8/17, lacked monitoring for side effects of the warfarin sodium use.  Review of R42's current treatment record dated 8/17, lacked monitoring for side effects of the warfarin sodium use.  Review of R42's current treatment record dated 8/17, lacked monitoring due to risk of increased bleeding. The ADON indicated anticoagulant monitoring should have been included in R42's plan of care stating "honestly! probably missed it".  During interview on 8/23/17, at 3:36 p.m. director of nursing (DON) indicated her expectation is a care plan be developed for residents using anticoagulant medications.  A facility policy titled Care Plans/Care Conferences last revised 11/09, stated resident care plans will include how medications are being used as an intervention for resident's medical needs, indications for use, goals for medication used and how the effectiveness of the medication is being evaluated. It further directed care plans will be updated as needed and reviewed at least quarterly.  48.21(b)(3)(ii) SERVICES BY QUALIFIED  F 282

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245467	B. WING		08/2	4/2017
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F 282	(b)(3) Comprehens The services provid as outlined by the c		F 282			
	accordance with eacare. This REQUIREMED by: Based on observareview, the facility for care for 1 of 1 residence of the facility	to the facility on 6/15/17. ronic medical record (EMR) bases at the time of admission ry disease, chronic kidney tes.  dent Assessment form attock had a reddened area.  ent EMR care plan, accessed rses, revealed on 6/22/17, the base were to have been		R48 buttock injury resolved 9/21/2 Had pressure reduction air overlay bed. Rook boot ordered 9/20/2017 assessment as resident has tender push with toes to reposition self in Concern for pressure injury occurre this area. Has pressure reduction hypotector on until Rook boot arrives continues to work with resident for therapeutic intervention. Braden assessment repeated 9/19/2017 ar again on 9/25/2017. R48 reposition in bed to his side, but does require x 1-2 to boost up in bed and to lay or sit up in bed. CNA care plan upd reflect use of w/c for long distances use walker for ambulation to bathroand in room, EZ stand if feeling we repositioning schedule of every 2 he besides toileting times.  Education completed with CNA state 9/12/2017 regarding notification to supervisor nurse regarding any identification of new or problematic issues. Education on contributing faleading to pressure injuries provide ADON WOCN Staff Coordinator and	on per OT ncy to ped. ence to leel leel leel leel leel leel leel le	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		` '	O DATE SURVEY COMPLETED	
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NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
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F 282	form dated 7/8/17, sensation and mob to the right heel. Intinspect the skin dai and at each dressir reposition on a schwas left blank; (3) a bed and in recliner; of wounds and trea documentation by ladditional note was staff were to contin firm, black with esc.  Review of the Shor form dated 8/1/17, buttock. Interventio skin daily, cleansed dressing change; (2) every 3-5 days and and repositioning severy 2 hours to every 2 hours to ever lieving mattress wand (5) a referral to cocupational theraphysician at this time documentation by a weekly inspection of the staff to transfer him transportation to the interviewed at this time.	t Term Care Plan Skin Integrity revealed R48 had decreased ility and a pressure ulcer (PU) reventions included: (1) ly, cleanse the wound initially ng change (2) turn and redule; however, the frequency apply heel protector while in (4) Notify physician and family tments; and (5) weekly icensed nurse. On 8/18/17, an added to the form indicating ue to monitor as the area was har.  It Term Care Plan Skin Integrity indicated R48 has a PU his left ns included: (1) inspect the the wound initially and at each (2) apply a Mepilex dressing as needed (PRN) (3) turning chedule was changed from ery 1.5 hours; (4) a pressure was added to his bed (8/1/17); o physical therapy (PT) py (OT); (6) notify the ne; and (7) weekly a licensed nurse from the	F 2	282	ADON Care Coordinator. Reposition standards of care reviewed. License Nurse staff meeting 9/20/2017 inclusion standard for physician notification to assess injury site. Contributing cause pressure injury, interventions to implement for prevention as well as documentation standards reviewed. Medical Staff meeting 9/12/2017 increview of process for provider notificing in the event a pressure injury is ider and/or reflective of status update reprovider assessment and update in medical plan of care if indicated.  ADON WOCN and ADON Care Coordinator in process of reviewing wound care management program inclusive of Skin Policy in consultating with Medical Director. Policy and procedure reviewed and updated to WOCN role. A weekly Interdisciplinate Team meeting includes updates on resident skin care issues and subsectare planning. Upcoming Medical Section Provider meeting is scheduled 10/3 for purposes of engaging medical section with regard to their role in skin care management.  Director and ADONs will be response oversee bi-monthly quality assurance monitoring relevant to pressure prevention, assessments, interventicare plan review.	on reflect ary reads to the first taff reads taff reads to the first taff reads taff reads to the first taff reads	

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F 282	in the recliner, whe that R48 was wear right foot.  The following more R48 was seated in breakfast. R48 was When interviewed had not yet helped dependent for acti getting dressed, to wheeling in his chaawakened him at check and transfer verified he was ab while in bed but no confirmed he had chair since staff had 1/2 hours earlier). 8/22/17, at 9:50 a. the recliner, waitind dressing and repoor On 8/22/17, at 11:4 (RN)-A was observed for R48's buttock at the recliner of R48's buttock at the	elchair or bed. It was noted ring a heel protector boot on his ning on 8/22/17, at 9:31 a.m. his recliner consuming as clothed in a hospital gown. R48 stated he was upset staff I him dress as he was vities of daily living (ADL's) like bileting, transferring, and air. R48 explained staff had 7:00 a.m. for a blood sugar rred him into the recliner. R48 le to make slight movements but while in his chair. R48 not changed positions in his ad assisted him at 7:00 a.m. (2) Further observation on m. noted that R48 remained in g for staff assistance with sitioning.	F 2	,		
	pressure-relieving relieving air mattre interviewed on 8/2 explained that wou typically measure R48's wound docu following from the observation of RN wound-unstageable black scab, starting	his wheelchair without a cushion nor was a pressure ess noted on the bed. When 2/17, at 11:40 a.m. RN-A und nurse (WN)-C would and provide all wound care. Immentation identified the 8/22/17, dressing change -A: (1) right (R) foot le; measured 3.5 cm x 6 cm, g to peel on the edge; no RN-A painted R48's heel with				

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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 282	0.5 cm x 0.5 cm ar unopened. RN-A a Mepilex dressing of the resident was drais wheelchair, with device utilized as in while eating the notation. Plan of carelieving device has Review of the currecare plan, indicated repositioning nor to ambulate x 1 with a wheelchair); (2) read ADL's; and (3) requirements as a fall property of the currecare plan, indicated repositioning nor to ambulate x 1 with a wheelchair); (2) read ADL's; and (3) requirements as a fall property of R48's nuphysician communication: (1) On 6/15/17, a residual property of the currecare plan, indicated repositioning nor to ambulate x 1 with a wheelchair); (2) read the currecare plan, indicated repositioning nor to ambulate x 1 with a wheelchair); (2) read and (3) requirements as a fall property of R48's nuphysician communication: (1) On 6/15/17, a residual property of the currecare with the currecare and the currecare with the currecare and the currecare and the currecare with the currecare and the currecare and the currecare with the currecare and the curre	eft buttock ulcers revealed a ea with another area resolving, pplied a skin prep and placed a ver the area.  22/17, at 12:20 p.m. indicated ressed, but was now seated in a no pressure relieving cushion adicated on the plan of care on meal.  servations on 8/23/17 and rours of 8:00 a.m. through 1:30 R48 was in a seated position, chair and/or recliner without a re not followed as a pressure d not been utilized.  ent, undated nurse aide (NA) d R48 was not on a scheduled bileting plan; it included; (1) a walker (no mention of quired minor assistance with uired 2 staff assistance with	F 28	32		
	6/29/17, indicated I	hysician progress note dated R48 had been seen by his cian (PCP) and the PCP noted				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		TE SURVEY MPLETED	
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F 282	planned to order planuscle function.  (4) On 7/8/17, (18 of and documented a purple bruising aro (cm) x 2 cm. WN-0 Betadine and left oprotector for R48 to off-load pressure.  (5) On 7/21/17, it wphysician order for every 3 days and a be evaluated on 6/documentation indivivolved.  (6) On 7/31/17, (10 worsened with two measuring (#1) 0.7 0.3 cm. Drainage wremoval by the WN (7) On 8/9/17, (9 daleft buttocks wound cm and (#2)0.1 cm air, a barrier cream application. Right hunstageable and mwas dry, black-dark (8) Review of faxed a telephone order for evaluate and tre reduction system for was signed by the (9) On 8/18/17, (9 documented left but cm x 0.5 cm and (#PU-3.5 cm x 6 cm on the edge. No physical purple signed as the edge. No physical purple signed and the purple signed by the signed by the (9) On 8/18/17, (9 documented left but cm x 0.5 cm and (#PU-3.5 cm x 6 cm on the edge. No physical purple signed as the physical purple signed as the p	days later), WN-C re-assessed Stage II heel PU with slight und edges 3.5 centimeters painted the heel with pen to air; added a heel of wear when in bed and/or to was noted there was a Mepilex to the left buttock is needed. PT/OT/ST were to 15/17. There was no locating that therapies had been of days later) left buttock stage II areas noted, from x 0.5 cm and (#2) 2 cm x was noted to the Mepilex upon II-C. ays later), WN-C re-assessed, its measured (#1) 0.3 cm x 0.1 in x 0.1 cm. Treatment-open to applied prior to brief neel PU-described as neasured at 3.5 cm x 5 cm, its purple heel. It records revealed on 8/16/17, for occupational therapy (OT) at on 8/16/17, for a pressure or R48's bed, chair, and w/c	F 28	32			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION  NG		TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER CKS COMMUNITY HO	OSPITAL	STREET ADDRESS, CITY, STATE, ZIP C 503 E LINCOLN STREET HENDRICKS, MN 56136			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 282	nursing staff) related documented except which had not beer identified in the plate. When interviewed assistant director of confirmed there was administer treatment. Treatment was bast WN-C acknowledge valuated the wour Pressure Ulcer (Puberself, as there was involvement in the wounds.  Upon further interviewed they were pressure relieving of the wheelchair and R48 had a pressure the wheelchair and R48 had a pressure in the building, R48 They [staff] "forgot" when they got him admission. The AD lacked access to the their own NA care plan, the ADO cares nor intervent treatment/prevention responsible.	progress notes (by any ed to PU monitoring were of by the wound nurse (WN-C), in implemented weekly as not care.  On 8/24/17, at 12:24 p.m. the f nursing (ADON) and WN-C as no Standing Order to not for skin issues and PU's. Seed upon WN-C judgment. The ed she had not always and at least weekly and the JJ team consisted of only as no interdisciplinary team management of R48's  siew both the ADON and WN-C are unaware R48 that a cushion had not been placed in Jor the recliner. Both thought are relieving cushion placed in Jor the recliner. The ADON and air mattresses available are relieving cushion placed in Jor to get him an air-mattress the larger bed after his ON confirmed the CNA staffing EMR care plan and utilized of John. After review of the NA IN it made no mention of any	F 28	32		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		E SURVEY MPLETED
		245467	B. WING _		08/	/24/2017
	PROVIDER OR SUPPLIER	SPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 503 E LINCOLN STREET HENDRICKS, MN 56136	·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 282	nursing assistant (Newer seen a press wheelchair nor recli NA-A verified there for R48. NA-A state as she was his regustaff would assist Rassist him into the NA-A stated that state offload pressure where the results of the reposition R48 as care.  Review of the 2009 Hendricks Nursing care staff shall be infor each resident and brought to the interducer team).  483.25(b)(1) TREA PREVENT/HEAL P	NA)-A confirmed she had ure relieving cushion in the iner since admission of R48. was no repositioning schedule id she knew R48's cares well ular NA. She explained that NA 48 to the bathroom and then recliner from the wheelchair. aff had not attempted to nile he remained seated in any she had not been instructed is identified in the EMR plan of Skin Policy and Procedure Home policy included: direct instructed on all interventions and monitoring results will be disciplinary team (Pressure TMENT/SVCS TO RESSURE SORES	F 28	2		10/3/17
	professional standa pressure ulcers and ulcers unless the in demonstrates that t	es care, consistent with ords of practice, to prevent d does not develop pressure dividual's clinical condition hey were unavoidable; and				
	necessary treatmer	ressure ulcers receives nt and services, consistent with ards of practice, to promote				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		E SURVEY PLETED
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				503 E LINCOLN STREET		
HENDRIG	CKS COMMUNITY HO	DSPITAL		HENDRICKS, MN 56136		
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F 314	healing, prevent in from developing.	fection and prevent new ulcers	F 3	14		
	by: Based on observareview, the facility assess and implem 1 of 1 resident (R4 pressure ulcers locunstageable heel Findings include: R48's electronic mindicated he'd beel diagnoses includin chronic kidney disconterview of Mental identified on the action (MDS) dated 6/21/indicating intact con Assessment form that a reddened are considered in a chair in transfer him into a evening meal. Who R48 stated he was During the observation reveal device/cushion was wheelchair or on the Con 8/22/17, at 9:30 seated in a recliner R48 was dressed in R48 was dressed in R48 was dressed in the facility of the facilit	edical record (EMR) face sheet in admitted on 6/15/17 with g: coronary artery disease, ease and diabetes. The Brief I Status (BIMS) assessment dimission Minimum Data Set 17, identified a score of 11/15, gnition. A Resident dated 6/15/17, indicated R48 ea on the left buttock.  S p.m. R48 was observed in his room waiting for staff to wheelchair for transport to the en interviewed at that time, in dependent on staff for cares, ation, R48 was wearing a heel his right foot. Additionally, ed no pressure relieving is evident in the recliner, in the		R48 buttock injury resolved Had pressure reduction air of bed. Rook boot ordered 9/2 OT assessment as resident to push with toes to reposition Concern for pressure injury this area. Has pressure red protector on until Rook boot continues to work with reside therapeutic intervention. Bracessment repeated 9/19/2 again on 9/25/2017. R48 re in bed to his side, but does roughly a side of the repositioning schedule of every besides toileting times.  Education completed with C 9/12/2017 regarding notificates supervisor nurse regarding a identification of new or problicates. Education completed with C 9/12/2017 regarding notificates supervisor nurse regarding a identification of new or problicates. Education on contribution of the pressure injuries of the pressure injuries of the pressure injuries of the pressure injuries of the pressure injury, interventions implement for prevention as implement for prevention as incompleted in the pressure injury, interventions implement for prevention as incompleted in the pressure injury, interventions implement for prevention as incompleted injury interventions implement for prevention as incomplement for prevention as injury interventions in the pressure injury, intervention in the pressure injury intervention in the	overlay on 20/2017 per has tendency on self in bed. occurrence to uction heel arrives. OT ent for aden 2017 and positions self require assist to lay down lan updated distances; to bathroom ling weak; ery 2 hours  NA staff tion to any ematic skin outing factors or and epositioning Licensed 17 included cation to sing causes for sto	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
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	PROVIDER OR SUPPLIER CKS COMMUNITY HO	SPITAL		50	TREET ADDRESS, CITY, STATE, ZIP CODE 03 E LINCOLN STREET IENDRICKS, MN 56136		-
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	not yet helped him verified he was dep daily living (ADL's) transferring, and whexplained staff had that morning for a betransferred him into he was able to move he was not able to chair. R48 confirme positions since staff a.m. (2 1/2 hours expositions since staff a.m. (2 1/2 hours expositions of the recomposition of the r	get dressed for the day, and endent on staff for activities of like getting dressed, toileted, neeling in his wheel chair. R48 awakened him at 7:00 a.m. blood sugar check and had the recliner. R48 stated while the himself slightly while in bed, move himself while in his ed he had not changed for had assisted him at 7:00 earlier). During further a.m. on 8/22/17, R48 liner and verified he was still istance with dressing and on a.m. registered nurse end to conduct dressing and on a.m. registered with end to conduct dressing and on a.m. registered with end to conduct dressing and on a.m. registered with end to conduct dressing and on a.m. registered with end to conduct dressing and on a.m. registered with end to conduct dressing and on a.m. registered with end to a.m. registered with end t	F3	314	documentation standards reviewed Medical Staff meeting 9/12/2017 in review of process for provider notif in the event a pressure injury is ide and/or reflective of status update reprovider assessment and update in medical plan of care if indicated.  ADON WOCN and ADON Care Coordinator in process of reviewing wound care management program consultation with Medical Director. and procedure reviewed and updat reflect WOCN role. A weekly Interdisciplinary Team meeting inclupdates on resident skin care issue subsequent care planning. Upcom Medical Staff Provider meeting is scheduled 10/3/2017 for purposes engaging medical staff with regard role in skin care management.  ADONs and Director will be responding relevant to pressure prevention, assessments and interference in the provider meeting is subsequent care management.	cluded ication entified equiring in Policy ed to udes es and ling of to their esible to ce	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION  G		TE SURVEY MPLETED	
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	PROVIDER OR SUPPLIER	OSPITAL	STREET ADDRESS, CITY, STATE, ZIP COI 503 E LINCOLN STREET HENDRICKS, MN 56136				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 314	After the dressing was transferred ba wheelchair. A presevident in the chair 8/22/17, at 12:20 pseated in his wheel and/or pressure reduction of pressure reduction of pressure reduction.  The Comprehensing Assessment dated reddened area on a pressure points at The sections labeled and Skin Condition Comprehensive Skin Condition Comprehensive Skin factors and Influenced R48 was 1-2 staff assistance transfer between short distances.  The Braden Score dated 6/15/17, was R48 was not at risk However, the inform Braden Score assewith the assessment Admission Care Pl Braden assessment impairment related	change was completed, R48 ck into a seated position in the sure relieving cushion was not a. Later, it was noted on .m. that R48 was dressed and Ichair, still without a cushion lieving device in place.  Servations on 8/23/17 and ined in a seated position, a cated in the wheelchair and/or a cated in the wheelchair and/or expressive Ulcer Risk 6/15/17, indicated R48's his left buttock continued after assessment after 2.5 hours. The cated History of Pressure Ulcers and Summary of a cated in Assessment were left blank. Iterventions were also left blank.	F 314	4			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		TE SURVEY MPLETED
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F 314	require staff assists wheelchair (only slindicated R48 requirementation that would have reconstructed and reconstructed	ance into chair and/or ightly limited). The plan of care lired 1-2 staff assistance with len assessment identified that any problem or potential on or sheer, or skin concern quired repositioning.  ian progress note dated entified nurse practitioner R48 had a monofilament test the detection of peripheral med on his feet. CNP-D was response from R48's left foot, rensation in his left foot. This conflict with the "no to sensory perception" noted e. Review of laboratory data cated R48's albumin level was may affect wound healing.  ission Care Area Assessment 17, identified that R48 required that R48 req	F 31	4		
	any new area of sk					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		TE SURVEY MPLETED	
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	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 503 E LINCOLN STREET HENDRICKS, MN 56136				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 314	(5) "needs a press wheelchair (w/c)". (6) "needs to turn/r more often as need (7) needs 1-2 staff repositioning, turnii in bed. (8) needs the assist distances in his roche was utilizing his around his house."  The care plan was [R48] had a Stage also to wear a heed aily treatment. No R48's care plan.  Review of the Short form dated 7/8/17, sensation and most to the right heel. In inspect the skin da and at each dressi reposition on a schwas left blank; (3) bed and in recliner of wounds and tread documentation were 8/18/17, an addition indicating staff were area was firm, black. Interventic skin daily, cleanse dressing change; (	ure reduction cushion in his reposition at least every 2 hrs, ded or requested." assistance to help with ng, and lying down or sitting up stance of 1-2 staff to walk short om. "Per [R48] and his family, walker or wheelchair to get updated on 7/8/17, to reflect II PU to the right heel and was I protector/boot to area as a further updates were made to the term of th		4			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	LE CONSTRUCTION		E SURVEY PLETED
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	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COI 503 E LINCOLN STREET HENDRICKS, MN 56136			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 314	and repositioning severy 2 hours to every 2 hours to ever relieving mattress and (5) a referral to loccupational theraphysician at this tirdocumentation by weekly inspection note at the bottom later, indicated one cm x 1 cm in size vestaff would continuate with the currocare plan, indicate repositioning nor to ambulate x 1 with a wheelchair); (2) red ADL's; and (3) rectransfers as a fall part of the currocare plan, indicate repositioning nor to ambulate x 1 with a wheelchair); (2) red ADL's; and (3) rectransfers as a fall part of the currocare plan, indicate repositioning nor to ambulate x 1 with a wheelchair); (2) red ADL's; and (3) rectransfers as a fall part of the currocare plan, indicate repositioning nor to ambulate x 1 with a wheelchair); (2) red ADL's; and (3) rectransfers as a fall part of the currocare plan in the	schedule was changed from very 1.5 hours; (4) a pressure was added to his bed (8/1/17); o physical therapy (PT) apy (OT); (6) notify the me; and (7) weekly a licensed nurse from the of R48's skin. An additional dated 8/14/17, two weeks (1) open area measuring 0.5 with discoloration 7 cm x 3 cm.	F 314			
	physician commundocumentation: (1) On 6/15/17, a rbuttock; no physici (2) On 6/16/17, re repositioning in be (3) On 6/20/17, seand had developed buttock; WN-C's tr Cavilon barrier creshift weight when sphysician notificativ (4) Review of the present the pres	en by wound nurse (WN)-C d one Stage II PU to left eatment included adding the am and encouraging R48 to seated in the w/c or chair. No				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		TE SURVEY MPLETED	
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	PROVIDER OR SUPPLIER	DSPITAL		STREET ADDRESS, CITY, STATE, ZIP 503 E LINCOLN STREET HENDRICKS, MN 56136			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 314	did not address the nor that staff repor However, the PCP activity in his chair therapy (PT) to imp (5) On 7/8/17, (18 and documented a purple bruising aro (cm) x 2 cm. WN-C Betadine and left oprotector for R48 to off-load pressure. (6) Review of R48's lacked any related time, there was an heel and application 7/8/17, WN-C faxe office, indicating Restaff discovered a lom. WN-C further Betadine and place room, encouraging for repositioning in podiatry appointmentation of the was a box of requested. Documindicate podiatry seand/or follow-up of (7) On 7/14/17, Whouttocks had proground the base. WN-C coof Betadine treatmentation of the podiatry appointmentation of the base. WN-C coof Betadine treatmentation of the podiatry appointmentation of the base. WN-C coof Betadine treatmentation of the podiatry appointmentation of the base. WN-C coof Betadine treatmentation of the podiatry appointmentation of the base. WN-C coof Betadine treatmentation of the podiatry appointmentation of the base. WN-C coof Betadine treatmentation of the podiatry appointmentation of the podiatry appoint	buttock PU was examined ted the PU to the physician. noted R48 had prolonged and planned to order physical prove muscle function. days later), WN-C re-assessed Stage II heel PU with slight und edges 3.5 centimeters in painted the heel with pen to air; added a heel of wear when in bed and/or to see EMR physician's orders to PU's until 7/8/17. At that order for Betadine to the right of the heel protector. On the dinformation to the PCP's see a complained of heel pain and collister measuring 3.5 cm x 2 noted she had painted it with the day a heel protector in R48's in him not to use his right foot bed. WN-C also noted a cent was being considered. The heek marked YES for follow-up to the entation was also lacking to be ervices had been offered courred. N-C re-assessed and the left the essed to a Stage II, measuring the right heel PU had increased as cm. x 7.5 cm. and boggy at continued with the same course tent; R48 now complained of thation was lacking to indicate on had occurred related to the	F 31	4			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245467	B. WING			08/:	24/2017
NAME OF PROVIDER OR SUPPLIER  HENDRICKS COMMUNITY HOSPITAL				50	TREET ADDRESS, CITY, STATE, ZIP CODE 03 E LINCOLN STREET IENDRICKS, MN 56136		-
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	(skin protectant film (foam dressing). Ricm x 7.5 cm, purple boggy measuring 1 notification was dod (9) On 7/21/17, it with physician order for every 3 days and as be evaluated on 6/documentation indicompleted the eval (10) On 7/31/17, (1 worsened with two measuring (#1) 0.7 0.3 cm. Drainage with removal by the WN bath, skin prep appareas. Right heel of measured 4 cm x 6 continued to be bog before, with Betadir (11) Review of R48 communication rectax was sent to the R48 had a "Second measuring 2 cm x (11) areas. Will monitor status of the heel Pfollow-up requested indicating the physit treatment orders. (12) On 8/9/17, (9 cm assessed, left but 0.3 cm x 0.1 cm and Treatment-open to prior to brief applications as unstageable and	chatment to include a skin preparation barrier) and a small Mepilex ght heel size increased to 3.5 at in color, with the edge being cm x 3 cm. No physician cumented by the WN-C. as noted there was a Mepilex to the left buttock is needed. PT/OT/ST were to 15/17. There was no cating therapies had uations.  O days later) left buttock Stage II areas noted, cm x 0.5 cm and (#2) 2 cm x ras noted to the Mepilex upon -C. After R48 was given a tubolied and Mepilex covered both lescribed as Stage II PU, cm, purplish in color and gy. Treatment continued as the and air drying.  Is faxed and/or verbal ords revealed on 7/31/17, a PCP, with notification that I open area to left buttock 0.3 cm. Mepilex covering both till healed." However, the U was not mentioned. No I nor was there documentation cian had responded to the	F	314			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245467	B. WING _		08/	24/2017	
NAME OF PROVIDER OR SUPPLIER  HENDRICKS COMMUNITY HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 503 E LINCOLN STREET HENDRICKS, MN 56136		2 17 20 11	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  YMUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE	
F 314	notification documed (13) Review of faxes 8/16/17, a telephon therapy (OT) to eval a pressure reduction and w/c was signed. There were no other orders related to the bythe wound nursed (14) On 8/18/17, (9) documented left but cm x 0.5 cm and (#PU-3.5 cm x 6 cm on the edge.  No other weekly nursing staff) were wound nursed (WN-been implemented). Review of the April, Advisory Panel's profit http://www.npuap.oclinical-resources/nindicated a Stage I area of intact skin. partial-thickness location as an obsequence of the wound bed or utility for the wound bed or uti	e open to air. No physician ented. Ed records revealed on the order for occupational faluate and treat on 8/16/17, for on system for R48's bed, chair, of by the PCP on 8/17/17. For signed faxed or telephone to identified PU's documented entered (#1) 0.5 (#2) PU resolved. Right heel to black scab and starting to peel to signed progress notes (by any documented except by the C). The plan of care had not	F 31	4			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245467	B. WING		08	/24/2017	
NAME OF PROVIDER OR SUPPLIER  HENDRICKS COMMUNITY HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CO 503 E LINCOLN STREET HENDRICKS, MN 56136			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE	
F 314	When interviewed assistant director of agreed the compression performed upon an accurately. It was a had not ordered the WN-C stated would issues and PU's between WN-C added, "If the I'm using, they will different." There was to follow related to physician. WN-C wommunication with the PU nor that it composessed as the judgement regardid WN-C acknowledge evaluated the would pressure Ulcer (Plantself, as there wordserviewed the wordserviewed the would be supposed to the composition of the progressed as the judgement regardid the would be supposed to the progression of the progressed as the judgement regardid the would be supposed to the progressed as the judgement regardid the would be supposed to the progressed to the progr	on 8/24/17, at 12:24 p.m. the of nursing (ADON) and WN-C chensive skin assessment dmission was not completed also confirmed the physician e treatments for wound care. d administer treatment for skin ased upon her judgment. he physician's doesn't like what tell me to use something was no Standing Orders for her wound care signed by the was unable to verify the physician at the onset of occurred regularly as the wound physicians relied upon her ng the proper treatments. The ged she had not always and at least weekly and the J) team consisted of only as no interdisciplinary team management of R48's	F3	314			
	confirmed they we pressure relieving the wheelchair and thought R48 had a placed in his chair ADON stated although available in the buframed bed. They air-mattress when after his admission staff lacked access utilized their own Nathe NA care plan, the summer of the staff lacked access the summer of the summer	riew both the ADON and WN-C re unaware R48 that a cushion had not been placed in dor the recliner. Both staff pressure relieving cushion initially, but weren't sure. The bugh they had air mattresses ilding, R48 required a larger [staff] "forgot" to get him an they got him the larger bed in The ADON confirmed the NA is to the EMR care plan and IA care plan. After review of the ADON agreed this care plan of any cares nor interventions					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		245467	B. WING _		80	3/24/2017	
	PROVIDER OR SUPPLIER	OSPITAL		STREET ADDRESS, CITY, STATE, ZIF 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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 314	related to PU treative were responsible.  When interviewed nursing assistant (Inever seen a pression wheelchair nor reconstruction of the NA-A verified there for R48. NA-A state as she was his registaff would assist Fassist him into the NA-A stated that stoffload any pressuremained seated. It was repositioning for the bathroom 3-4 to repositioned the restoileting needs and instructed to repositional information.	on 8/24/17, at 2:30 p.m. NA)-A confirmed she had sure relieving cushion in the liner since admission of R48. was no repositioning schedule ed she knew R48's cares well ular NA. She explained that NA R48 to the bathroom and then recliner from the wheelchair. aff had not attempted to re on his buttocks while he NA-A stated she felt toileting R48 since he was assisted to imes/ day. NA staff only sident upon his request for indicated she had not been ition R48 in any other way. No ion was available to NA staff ulcer care or interventions on	F 31	4			
	identified that a bar resident's skin wou admission. This ex examination of a re assessment, and a of the resident's his The results of the t help determine the Further assessment after admission, incresidents skin, alor assessment. Nursi those results and to	Skin Policy and Procedure seline assessment of the all be completed upon am would include a physical esident's skin, a Braden risk a comprehensive assessment story and physical condition. issue tolerance testing would repositioning schedule. In the work of the many staff were to have utilized rained front-line care-givers immediate prevention plan.					

STATEMENT OF DEFICIENCIES ( AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		245467	B. WING		08/24/2017	
	PROVIDER OR SUPPLIER	DSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 503 E LINCOLN STREET HENDRICKS, MN 56136		- ·· <b>-</b> · · ·
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F 314	to identify the type treatment orders. Tre-assessed weekly weeks, staff were to and seek an order plan was to have in mobility, pressure rinterventions, incorrichecks, treatment, of resident and famprovide care were to Direct care staff we interventions for each	is identified, the physician was of ulcer and provide skin the wound was to have been by, and if not improved within 2 to have notified the provider for a wound consult. The care cluded the resident's impaired elief, nutritional status and attinence, skin condition pain, infection, and education filly. Nursing personnel who to have pressure ulcer training are to be instructed on all the resident. Monitoring results to the interdisciplinary team	F 31	4		
F 323 SS=E	dated August 2013 will be completed weeks, then quarte assessments. The Analysis Tool was t determine potential pressure ulcer(s). I within 2 weeks, the notified. 483.25(d)(1)(2)(n)(HAZARDS/SUPER)(d) Accidents. The facility must enfrom accident haza		F 323	3		10/3/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING (X3)			(3) DATE SURVEY COMPLETED	
	24546		B. WING		08/:	24/2017	
	PROVIDER OR SUPPLIER	DSPITAL		STREET ADDRESS, CITY, STATE, ZIP CO 503 E LINCOLN STREET HENDRICKS, MN 56136			
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F 323	Continued From particles (n) - Bed Rails. The appropriate alternated bed rail. If a bed of must ensure correct maintenance of beto the following electron bed rails prior (2) Review the risk the resident or resignation formed consent particles (3) Ensure that the appropriate for the This REQUIREME by:  Based on observative review, the facility of bedrails had been and periodically the residents (R4, R6, had bedrails attach Findings include:	e facility must attempt to use tives prior to installing a side or riside rail is used, the facility of installation, use, and drails, including but not limited ments.  Ident for risk of entrapment to installation.  Is and benefits of bed rails with dent representative and obtain prior to installation.  Is dimensions are resident's size and weight.  In it is not met as evidenced tion, interview, and document failed to ensure the use of assessed upon admission, preafter for safety for 5 of 5 R22, R31, R48) reviewed who are to installation.	F 32	Review of side rail utilization facility completed 9/17/2017. grab bars removed 9/22/201 side rails on beds similar to the bed scheduled for removal. rail assessments completed R31 and noted that these resuse their side rails for safe be and are dependent on the rail	within the R4 and R22 7. Identified hose on R6 Resident side for R6 and sidents do ed mobility ils for transfer		
	room indicated that attached to the bed into two halves, top bedrail is Zone 1. T 3.75 inches (in) x 2 4 in. x 33 in. Revie assessment indica re-assessed/re-eva since 12/18/15. The	11/17, at 5:04 p.m. in R6's two half side rails were frame. Each rail was divided and bottom. Within the he top of the area measured on and the bottom measured of R6's 6/18/15, Side Rail ted it had not been aluated for appropriateness ere was no physician's order 16 was noted to have		assist. R6 side rails and grab ordered to be padded due to hemiathrosis. Since these w R6 has not had recurrence or related to side rail physical in does not have diagnosis of A dementia. She does have ar cognitive status. R6 has demorying behaviors and cited fe out of bed as noted 7/22/201 had a temporary alternative to	diagnosis of ere padded, f ecchymosis npact. R6 lzhiemer's or n impaired nonstrated ar of falling 7 when she		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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HENDIN		OOITIAL		HENDRICKS, MN 56136			
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F 323	-	<u> </u>	F 3				
	intermittent confus Alzheimer's.  Observation on 8/room indicated tha attached to the be Rail assessment of it had been evaluated use. R22 had not rails and it was obsutilize the rails at to "ok with leaving the remove." There will documented on the record.  Observation on 8/room indicated the attached to the be bottom section with measured 4.5 in. 2/11/13, Side Rail not been re-assessing physician's ord assessment. R31 impaired.  Observation on 8/room indicated the attached to the be Side Rail assessment. R31 impaired.	21/17, at 7:04 p.m. in R22's at two bilateral grab bars were d frame. Review of R22's Side dated 6/16/17, lacked indication ated for safety nor appropriate requested the use of any grab served she was unable to his time, but indicated she was em on when offered to as no physician's order e assessment nor evident in 21/17, at 7:17 p.m. in R31's at two bilateral side rails were d. Each side rail had a top and hin Zone 1. The top section 12.75 in. and the bottom of 12.75 in. Review of R31's assessment indicated it had sed since 8/12/14. There was er documented on the was noted to be cognitively 22/17, at 9:10 a.m. in R4's at two bilateral grab rails were d. Review of R4's 4/29/15, nent indicated it had not been e-evaluated since that date. R4 trequested the use of any rails		any assistive device attache and repositioning. This bed when her primary bed was in Once her primary bed with a returned, R6 was satisfied. Side rails and grab bars ord 9/21/2017; awaiting arrival to meet FDA guidelines.  R31 side rail utilization revies Awaiting alternative side rail determine whether will be a use for repositioning self in assist staff with transferring bed into wheelchair. Without bed, R31 would become de to complete bed mobility and tasks which would decrease abilities and potential subset in overall status.  R48 does not have a side rathave a grab bar. Device as completed 9/26/2017 with in utilizes the grab bar to turn suses bar to assist staff in trainto/out of bed. Without grawould become dependent of creating a decrease in ADL.  Order requirement reviewed provider order is required for a grab basafety perspective, utilization and grab bars will be done in the satisfactory of the safety perspective, utilization and grab bars will be done in the satisfactory of the safety perspective, utilization and grab bars will be done in the satisfactory of the safety perspective, utilization and grab bars will be done in the safety perspective, utilization and grab bars will be done in the safety perspective, utilization and grab bars will be done in the safety perspective.	was utilized n repair. side rails was Alternative ered o confirm they  ewed. I order to ppropriate to bed as well as into and out of ut device on pend on staff d transfer e R31 ADL quent decline  ail but does sessment ndication R48 self in bed and ansferring ab bar, R48 on staff thus status.  d noting a or side rails. It r. From a n of side rails		
	room indicated the	23/17, at 9:05 a.m. in R48's ere was one grab bar located on bed. Review of R48's 6/15/17,		with appropriate assessmer if indicated utilization of dev FDA guidelines.			

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	PROVIDER OR SUPPLIER	SPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 503 E LINCOLN STREET HENDRICKS, MN 56136			
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F 329 SS=D	requested the use of assessment conduction rails or physician's of a staff needed to have for side rail usage at re-assessed quarter change and as needensure rails were not there was no side provided at the time 483.45(d)(e)(1)-(2) FROM UNNECESS 483.45(d) Unnecessary drugs drug when used(1) In excessive dotterapy); or (2) For excessive dotterapy); or (2) For excessive dotterapy (3) Without adequation (4) Without adequation (5) In the presence which indicate the of discontinued; or	ent indicated R48 had not of any rails. There was no cted for use or safety of bed order for R48.  ssistant director of nursing on m. indicated she was unaware e a physician's orders in place and stated bedrails should be erly, annually, with a significant ded for each resident to ot restraints or hazards.  rail assessment policy of the survey.  DRUG REGIMEN IS FREE SARY DRUGS  sary Drugs-General.  Ig regimen must be free from an unnecessary drug is any curation; or	F 329	Device assessment, provider ord requirement and utilization was d at Licensed Nurse Meeting 9/20/2 is on the agenda for the upcomin Provider Meeting 10/3/2017.  It is the goal of HCHA to maintain improve ADL status of the resider population while assuring safety pin equipment utilization.  The ADON Care Coordinator and will oversee quality assurance on monthly basis monitoring side rai grab bar utilization to include assecompletion.	iscussed 2017 and g or nt oractices I Director a I and	10/3/17	
		ns of the reasons stated in					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		E CONSTRUCTION (	(X3) DATE SURVEY COMPLETED	
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F 329	483.45(e) Psychotr Based on a compreresident, the facility (1) Residents who drugs are not given medication is necessional record;  (2) Residents who gradual dose reductions, unless an effort to discontional this REQUIREMED by:  Based on interview facility failed to ensimple who may be a compression of the facility failed to ensimple who was a compression of the facility failed to ensimple	opic Drugs. chensive assessment of a must ensure that have not used psychotropic these drugs unless the sarry to treat a specific sed and documented in the sed clinically contraindicated, in nue these drugs; NT is not met as evidenced and document review the ure an Abnormal Involuntary AIMS)-(an assessment used	F3	329	Licensed Nurse staff meeting 9/20/2 with review of medication order management. Clarity of medication		
	the use of anti-psyc completed to monit document the amo administered for 2 reviewed for unnect Findings include: R51's quarterly Min assessment dated Interview for Menta indicating severely the use of an anti-p	ry movements associated with chotic medication) was or for side effects and to unt of liquid medication of 5 residents (R51, R42) essary medications.  imum Data Set (MDS) 6/2/17, identified a Brief I Status (BIMS) score of 5, impaired cognition. It identified sychotic (AP) medication and g Alzheimer's disease and			orders can not include ranges without detailed provider instruction. This standard was also reviewed with the Pharmacist.  Nursing staff re-educated on require to document dose administered.  R51 assessment completed 8/25/20 TD assessment reflects no TD signs symptoms. Physician reviewed and signed 9/14/2017.  Pharmacist consultation to confirm medications requiring TD assessmendone. All residents requiring TD	ment 17. s or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER  CKS COMMUNITY HO	SPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 503 E LINCOLN STREET HENDRICKS, MN 56136			
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F 329	The physician progindicated R51 had a toward peers. R51 anti-psychotic meditwice a day (BID) with Falls psychiatry on The physician psychological psychologi	ress note dated 5/25/17, exhibited aggressive behavior was prescribed Seroquel (an cation) 25 milligrams (mg) with plan to follow up with Sioux 6/6/17.  hiatry progress note dated order to increase R51's D to Seroquel 25 mg in the AM g at bedtime.  hart did not reveal a baseline had been completed to dyskinesia (abnormal ents) as a potential side effect	F 329	monitoring have been completed up to date.  TD policy review completed. We contemplating change to policy wimplementation of the AIMS tool a opposed to using the TD scale. The addressed with Medical Staff.  Pharmacist prompted to review ploorders that require clarification dumonthly review.  ADONs and Director will oversee assurance monitoring with a week of medication administration prace Pending change to AIMS tool, will quality assurance monitoring for timeliness of TD assessment.	are ith as This will rysician ring his quality kly audit tices.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1)	L IDENTIFICATION NUMBER.		PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
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(MG)/5 milliliter (ml) 2-4 everyday.  Review of the medication (MAR) identified R42 with Maalox on a daily basis did not define the amount administered.  When interviewed on 8/ registered nurse (RN)-AR42 how much Maalox stomach was feeling. From administer a dose acconsymptoms. RN-A confinence of the control of the cont	orders dated 7/27/17, ar Strength (medication of 200-200-20 milligrams of teaspoons (tsp)  on administration record as being administered the as ordered; however, it int of Maalox being  (23/17, at 1:27 p.m. A stated she would ask she wanted or how her RN-A indicated she would rding to R42's response of med that nursing staff are the amount of Maalox verified this was lacking viewed.  (23/17, at 1:31 p.m. (LPN)-A indicated she of Maalox as R42 usually mount of Maalox ed the physician order out parameters; indicating arer.  (3/17, at 1:45 p.m. RN-B meters "leaves leeway" ecific and staff need to administered to	г Э	9				

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,	(X3) DATE SURVEY COMPLETED	
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-		F 32	29	
actual amount adm 483.45(c)(1)(3)-(5)	inistered to R42. DRUG REGIMEN REVIEW,	F 42	28	10/3/17
c) Drug Regimen R	Review			
` '				
brain activities asso and behavior. The	ociated with mental processes se drugs include, but are not			
to the attending phy facility's medical di	ysician and the rector and director of nursing,			
drug that meets the	criteria set forth in paragraph			
during this review n separate, written re attending physician director and director minimum, the resid	nust be documented on a eport that is sent to the and the facility's medical or of nursing and lists, at a ent's name, the relevant drug,			
	CONTINUED FOR SUPPLIER  SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE  Continued From pa to clarify the order a actual amount adm 483.45(c)(1)(3)-(5) REPORT IRREGUL  c) Drug Regimen R  (1) The drug regimer reviewed at least of pharmacist.  (3) A psychotropic of brain activities asso and behavior. The limited to, drugs in  (i) Anti-psychotic; (ii) Anti-depressant (iii) Anti-anxiety; an (iv) Hypnotic.  (4) The pharmacist to the attending phy facility's medical director and these reports r  (i) Irregularities incl drug that meets the (d) of this section for  (ii) Any irregularities during this review re attending physician director and director minimum, the resid	PROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 33 to clarify the order and nursing staff document the actual amount administered to R42.  483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON  c) Drug Regimen Review  (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.  (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:  (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and	PROVIDER OR SUPPLIER  CKS COMMUNITY HOSPITAL  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 33 to clarify the order and nursing staff document the actual amount administered to R42. 483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON  c) Drug Regimen Review  (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.  (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:  (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic.  (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.  (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.  (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director of nursing and lists, at a minimum, the resident's name, the relevant drug,	PROVIDER OR SUPPLIER  CKS COMMUNITY HOSPITAL  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 33  to clarify the order and nursing staff document the actual amount administered to R42. 483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON  C) Drug Regimen Review  (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.  (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:  (ii) Anti-anxiety; and  (iv) Hypnotic.  (iii) Anti-anxiety; and  (iv) Hypnotic.  (iii) The gularities include, but are not limited to, any drug that meets the criteria set forth in paragraph  (d) of this section for an unnecessary drug.  (iii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director of nursing and lists, at a separate, written report that is sent to the attending physician and the facility's medical director of nursing and lists, at a minimum, the resident's name, the relevant drug,

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F 428	(iii) The attending president's medical irregularity has been action has been tal be no change in the physician should determined the resident's med.  (5) The facility must and procedures for review that include frames for the diffesteps the pharmacidentifies an irregulate to protect the residentifies and indication pharmackers for antidentified and document of the protect that indicating severely the use of an anti-protect for mental indicating severely the use of an anti-protect for the protect for the pro	chysician must document in the record that the identified en reviewed and what, if any, ken to address it. If there is to be medication, the attending ocument his or her rationale in ical record.  It develop and maintain policies the monthly drug regimen, but are not limited to, time erent steps in the process and ist must take when he or she larity that requires urgent action ent.  NT is not met as evidenced and document review the cist failed to identify that the eary Movement Scale (AIMS)-seed to assess involuntary fated with the use of ication) had been conducted to a side effects and that acid administration were	F 4	Clarity of medication orders ca include ranges without detailed instruction. This standard was r with the Pharmacist. Pharmacis prompted to identify physician owithout parameters that require clarification during his monthly R42 order will be clarified 9/28/TD assessment completed 8/2 TD assessment reflects no TD symptoms. Physician reviewer signed 9/14/2017. Pharmacist r TD policy review completed. We contemplating change to policy implementation of the AIMS too opposed to using the TD scale, be addressed with Medical Staff Pharmacist consultation done r medications requiring TD assessments.	provider eviewed st orders review. 2017. 25/2017. signs or d and eviewed. re are with I as This will f. egarding		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	OSPITAL		50	TREET ADDRESS, CITY, STATE, ZIP CODE 03 E LINCOLN STREET ENDRICKS, MN 56136	, , ,		
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F 428	indicated R51 had toward peers. R51 anti-psychotic meditwice a day (BID) with Falls psychiatry on The physician psyc 6/6/17 included an Seroquel 25 mg Bll and Seroquel 50 m. A review of R51's concentration of the AIMS assessment monitor for tardive involuntary movem related to the use of Review of the constreviews dated, 5/30 not identify the lack. When interviewed assistant director of an AIMS assessment for R51, though the The ADON stated a completed upon additional transfer initiation.  The policy titled Correvised 2/10, included Baseline upon admit months thereafter. of new anti-psychological control of the control of the construction	ress note dated 5/25/17, exhibited aggressive behavior was prescribed Seroquel (an ication) 25 milligrams (mg) with plan to follow up with Sioux 6/6/17.  hiatry progress note dated order to increase R51's D to Seroquel 25 mg in the AM g at bedtime.  hart did not reveal a baseline had been completed to dyskinesia (abnormal ents) as a potential side effect	F4	-28	residents requiring TD monitoring heen completed and are up to date.  Medication order standards to be reviewed at 10/3/2017 Medical Stameeting  ADON Care Coordinator and Direct monitor monthly pharmacy reviews include pharmacist identification of medication orders lacking clearly diparameters.	e. ff tor will to any		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
<b>245467</b> B. WING				08/24/2017			
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(X4) ID PREFIX TAG			ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 428	assessment dated had a (BIMS) of 5 in impairment.  R42's current physi included Maalox Reused for stomach u (MG)/5 milliliter (ml everyday.  Review of the medi (MAR) identified R4 Maalox on a daily b did not define the a administered.  Review of the consirecommendations/r7/17/17 failed to iderelated to the Maalox of dose and/or lack dosage administered.  Review of the medi (MAR) identified R4 Maalox on a daily b did not define the a administered.  When interviewed or registered nurse (R42 how much Maastomach was feelin administer a dose a symptoms. RN-A dexpected to documents.	cian orders dated 7/27/17, egular Strength (medication pset) 200-200-20 milligrams 2-4 teaspoons (tsp)  cation administration record 2 was being administered the asis as ordered; however, it mount of Maalox being  ultant pharmacist monthly reviews from 6/16 through entify a recommendation for order including parameters of staff documentation of ed to monitor effectiveness.  cation administration record 2 was being administered the asis as ordered; however, it mount of Maalox being  on 8/23/17, at 1:27 p.m.  N)-A stated she would ask alox she wanted or how her g. RN-A indicated she would according to R42's response or onfirmed that nursing staff are ent the amount of Maalox She verified this was lacking	F 4	28			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		245467	B. WING _		08/	/24/2017
	PROVIDER OR SUPPLIER CKS COMMUNITY HO	SPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 503 E LINCOLN STREET HENDRICKS, MN 56136		-
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 441	licensed practical n would administer 4 wanted the maximula available. LPN-A viccontained a range vithe order should be.  During interview on stated the lack of particular propriately monitimedication.  During interview on director of nursing (expect staff to clarific consulting pharmacic concise/clear orders. She confirmed nursiactual amount administrative due to fand 483.80(a)(1)(2)(4)(e) PREVENT SPREAL (a) Infection preventation a minimum, the folion (1) A system for preinvestigating, and communicable dise	on 8/23/17, at 1:31 p.m. urse (LPN)-A indicated she tsp. of Maalox as R42 usually am amount of Maalox erified the physician order without parameters; indicating eclearer.  8/23/17, at 1:45 p.m. RN-B arameters "leaves leeway" especific and staff need to unt administered to or resident response to the  8/23/17, at 3:36 p.m. the (DON) indicated she would fy the order and/or the sist. She further indicated that is were a standard of practice. Sing staff should document the inistered to R42.  Oharmacist was unavailable for nily emergency.  (a)(f) INFECTION CONTROL, D, LINENS  Ition and control program.  Itablish an infection prevention in (IPCP) that must include, at	F 42			10/3/17

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245467	B. WING			08/:	24/2017
	PROVIDER OR SUPPLIER	OSPITAL		50	TREET ADDRESS, CITY, STATE, ZIP CODE 03 E LINCOLN STREET ENDRICKS, MN 56136		-
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		(X5) COMPLETION DATE
F 441	arrangement based conducted accordinaccepted national simplementation is F  (2) Written standar for the program, whimited to:  (i) A system of survive possible communicate before they can spread facility;  (ii) When and to whom to whom to be followed to provide to provide to be followed to provide to be followed to provide to provide to be followed to provide to pro	under a contractual d upon the facility assessment of the \$483.70(e) and following standards (facility assessment Phase 2);  ds, policies, and procedures nich must include, but are not reillance designed to identify cable diseases or infections read to other persons in the mom possible incidents of ease or infections should be ransmission-based precautions revent spread of infections;  isolation should be used for a but not limited to:  uration of the isolation, a infectious agent or organism that the isolation should be the esible for the resident under the skin lesions from direct ints or their food, if direct	F	141			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245467	B. WING _		08/2	24/2017	
	PROVIDER OR SUPPLIER	DSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 503 E LINCOLN STREET HENDRICKS, MN 56136		-	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO  (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 441	by staff involved in  (4) A system for reunder the facility's actions taken by th  (e) Linens. Persor process, and transspread of infection  (f) Annual review. annual review of its program, as necess This REQUIREME by:  Based on observation review, the facility implemented propeduring 1 of 1 reside proper disinfection resident equipmented propeduring the clean utility roof failed to implemented outbreak of Legion pneumonia caused facility which had the	ene procedures to be followed direct resident contact.  cording incidents identified IPCP and the corrective e facility.  anel must handle, store, port linens so as to prevent the term of the facility will conduct an incident in the facility will be a conducted in the facility will be a	F 44	,	ntrol er, and tice aires' toolkit ent owth		
	director of nursing currently lacked an Legionnaire's disea facility risk assessi	on 8/23/17, at 10:05 a.m. the (DON) confirmed the facility by policy related to ase and had not conducted a ment to identify where ens could grow and/or spread		assessment was initiated on 8/31/2 and completed 9/22/2017 to identify where opportunistic waterborne pathogens could grow. The assess inclusive of the resident living environments with expansion to the	sment is		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245467	B. WING			08/2	24/2017
NAME OF F	PROVIDER OR SUPPLIER	2	<u> </u>	S1	TREET ADDRESS, CITY, STATE, ZIP CODE		
				50	3 E LINCOLN STREET		
HENDRI	CKS COMMUNITY H	OSPITAL			ENDRICKS, MN 56136		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	Continued From p	age 40	F 4	41			
	in the water syster	m. The DON indicated the			adjacent hospital environment and		
		ager and emergency			ancillary departments on HCHA car	npus.	
		rdinator from the attached					
		ded a webinar titled Legionella			The facility's water system descript	ion and	
	Management Con	trol Plan on 6/20/17; however,			diagram of water flow throughout th		
	they had not yet de	eveloped and/or implemented			building has been completed.		
	such a program.						
					A facility checklist has been develo		
		alk through of the facility on			based on findings from environmer		
		m. it was noted that R56			rounding. Reorganization of the uti		
	utilized had a humidifier in his room. Interview with R56 and his family member at this time, rooms is being done to prevent supply and/or equipment contamination with						
		nidifier had been purchased			and/or equipment contamination wi bacteria. Plumbing fixtures and pip	and pipes	
		a few months ago. It was noted			have been evaluated. Replacemen		
		illed the humidifier with tap			faucet aerators and shower heads		
		k and no routine filter			being done. Procedure updates re		
		or equipment cleaning occurred.			to Infection Control cleaning of equ		
	<b>'</b>	11 3			and devices is being done. A work		
	Further observation	ons on 8/21/17, at 3:04 p.m.			checklist for cleaning and maintena		
	indicated resident	care items were stored under			identified areas including managem	nent of	
		re pipes. The central hall clean umbing pipes which were			equipment devices has been devel	oped.	
	corroded. The res	sident care items stored under			The HCHA Legionnaires' Disease:	Water	
		lean utility rooms included:			Management Program policy was		
		ers (used to measure urine			approved by Medical Staff 9/12/201		
		er bags when emptied),			This included discussion of disease	•	
		h basins. Also stored in the			diagnosis. Staff education on		
		utility room were visibly soiled			Legionnaires' as well as the water		
		s. Personal staff drinks and			management program relevant to	II Stoff	
		d on the counter in the clean whirlpool tub room located in			employee position is being done. Annual Education content will be up		
	, ,	dirty, soiled electric shaver with			to include Legionnaires' and our wa		
		in particles in the removable			management program.		
		It was noted the whirlpool tub			managomont program.		
		e oxygen tanks stored which			A quality assurance monitor is esta	blished	
		on the lower half of the tank and			to assure quarterly environmental		l
		on the floor beneath the tanks.			rounding is completed. This will inc	clude	
		and/or sterile respiratory and			measurement of timeliness in addre		
		es were stored in this room. At			environment conditions requiring at		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION	\ , ,	E SURVEY PLETED
		245467	B. WING		08/	24/2017
NAME OF F	PROVIDER OR SUPPLIEF	₹		STREET ADDRESS, CITY, STATE, ZII	•	
				503 E LINCOLN STREET		
HENDRIG	CKS COMMUNITY H	OSPITAL		HENDRICKS, MN 56136		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 441	Continued From p	age 41	F4	141		
	3:15 p.m., while in tub, a large hole wapproximately 3 fe hole had exposed electrical boxes in dirty with dust and surface area. A stalocated inside the On 8/21/17, at 3:2 toe nail trimmers appeare skin and nail debrihall had staff pers on the clean coun	the central hallway whirlpool was noted in the wall, bet high by 2 feet wide. This pipes, wood beams and the wall. It appeared visibly debris and was not a cleanable aff purse was stored on a chair whirlpool tub room.  5 p.m. it was noted that dirty were stored on the counter in coom in the east hall. These d severely rusted and contained is. The clean utility in the east onal drinks and purses located	Γ 4	inclusive of device and edutilization. The Director a Control practitioners will of monitoring compliance.  Infection Control with Dre Policy reviewed. Proceduchanging dressings place book in each of the two n stations. Aseptic technique dressing care reviewed a meeting 9/20/2017. RN-/dressing change protocol technique, hand hygiene, and medication cart mana Quality monitor established compliance with dressing protocol: ADONs and/or	essing Changes: are reference for the skin are work are relevant to the Nurse Staff Are-education on a utilizing aseptic device cleaning agement.  and Infection betom the skin are work are education are device cleaning agement.	
	visible nail trimmir counter.  On 8/21/17, at 6:2 the evening meal seated at a table i attempted to feed the resident declir stand up and mov sanitizing her hand another unidentific speaking to her ar to assist with feed the table and proca a bib apron from a NA-B failed to imphand sanitization I was noted that NA hands and then to	4: p.m. during observation of nursing assistant (NA)-B was in the dining room where she an unidentified resident. After need to eat, NA-B proceeded to ed away from the table without ds. NA-B proceeded to touch ed resident's shoulder while and returned to the first resident ing. NA-B then stood up from the table without defend assist with removal of a third unidentified resident. See the seeded to assist with removal of a third unidentified resident. See the seeden thandwashing and/or between resident contacts. It is the wiped her nose with bare suched another resident's arm. The resident from the dining		will oversee staff technique changes on a weekly bas demonstration of aseptic changing dressings @ 10 Staff education relevant to care will be provided indivindicated.  Cleaning of multi-used reequipment: Policy review clippers replaced. Cleaning information posted for staprovision of individualized Management of humidifie equipment allowed in the Resident notification of preequipment allowance, proapproval for use, maintent responsibility of said equiupdated as to facility police.	ue with dressing is. Goal: staff technique when 100%; target 95%. o standard of vidually as sident yed. Rusty ing procedure off as well as a leducation. For and like facility reviewed. Personal ocess for lance pment being	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		245467	B. WING			08/2	24/2017
NAME OF	PROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HENDO	CVC COMMUNITY H	OCDITAL		5	03 E LINCOLN STREET		
HENDKI	CKS COMMUNITY H	USPITAL		Н	IENDRICKS, MN 56136		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	registered nurse (F (coffee) located on during morning me medication cart, a f the dirty sharps co and syringes are rethe flashlight was a when neurological and brain activity) staff.  During an observa R48's foot on 8/23 down on the floor theel wound. After discarded the soile the floor, removed from his left lower proceeded to toucl face. After she tosthe garbage, RN-Ahim in his wheelch	ent's wheelchair.  1 8/23/17, at 7:46 a.m.  RN)-A had a personal drink a top of the medication cart edication administration. On the flashlight was stored on top of ntainer (where used needles outinely stored). It was learned used for multiple residents checks (used to assess mental were conducted by licensed tion of a dressing change on /17, at 8:00 a.m. RN-A laid to complete visualization of a this was completed, RN-A ed gloves and while sitting on R48's rolled gauze dressing leg with her bare hands. She in her hair, brushing it from her assed the soiled dressing into a returned to R48 and pushed air out of his room. RN-A then	F4	141	cleaning multi-used resident equipm reviewed at 9/12/2017 CNA Staff m and 9/20/2017 Nurse Staff meeting  Disinfecting Tubs: The respective manufacturer manuals have been secured for the whirlpool tubs. The disinfectant valve on the South tub has been repaired. Tub cleaning procedure posted in the tub rooms. education on procedure has been completed with primary staff assign bath aide duties. Additional staff train the event of being assigned bath duties is in process.  Exposed wall in central tub room in process of repair.  Utility Room Management: Reorganization of soiled and clean rooms being done. Staff walkie-talk relocated to staff locker area. Alter location secured for oxygen tank sta Plumbing fixtures and pipes evaluar	eeting room Staff ed aining aide utility kies native orage.	
	sanitizing her hand R48's blood glucos glucose check, RN picked up the gluco check blood glucos it clean with a disir	es without washing and/or de and proceeded to check se. After completing the blood I-A removed the soiled gloves, ometer (machine used to se) with bare hands and wiped affectant wipe. RN-A placed the medication cart next to her cup			along with the Legionnaires' Water Management Program policy work. Machine cleaning procedure update Machine is slotted for relocation to a planned renovated kitchen site locathe Nursing Home.  Nurses and TMAs informed to keep	Ice ed. Ice the tion in	
	of coffee and trans RN-A did not disinf placing the soiled of cart.	sported R48 to the dining room. fect the top of the cart prior to glucometer onto the medication			and dirty items separated on medic cart as well as compliance for disiniprotocol of the medication carts.  Hand hygiene standards reviewed a	ation fectant	
	When interviewed	on 8/23/17 at 0:41 a m RN-A			Sentember CNA and Nurse staff		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	245467	B. WING		08/	24/2017	
NAME OF PROVIDER OR SUPPLIER HENDRICKS COMMUNITY HOSE	PITAL		STREET ADDRESS, CITY, STATE, 503 E LINCOLN STREET HENDRICKS, MN 56136			
PREFIX (EACH DEFICIENCY M	MENT OF DEFICIENCIES IUST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
on the floor during a contamination of her indicated she was unagloves to remove R48 confirmed she was "ir indicated she was too coffee on the medical unaware this was an She confirmed that st light on top of the dirty unaware of any disinfithis equipment.  It was again noted on RN-C stored the flash checked on top of the located on the medical noted a box of Inter-dnext the container, avidid not fit inside the mRN-C.  When interviewed on director of nursing (Docross-contamination vnoted observations; doclean/soiled equipment handwashing. It was to follow appropriate induring dressing changagreed she expected handwashing and/or unbetween resident con When observed on 8/west nurses station, a	depractice to sit and/or lay dressing change to prevent clean scrub uniform. RN-A aware she had not used B's leg dressings, but in a hurry". RN-A also do by "everyone" that having tion cart was ok and was infection control concern. Taff routinely store the flash by sharps container and was fection procedure related to a 8/23/17, at 10:00 a.m. that alight used for neurological edirty sharps container action cart. In addition, it was lary dressings were located vailable for staff use since it nedication cart according to a 8/23/17, at 10:08 a.m. the ON) agreed that was a concern with the dressing change, storage of the expectation staff were infection control technique ges. The DON further NA-B to implement use of hand sanitizer	F4	meetings.  Personal beverages, for personal items such as etc. are not allowed in president care giving local medication distribution, areas or other locations stations where resident supplies may be located directive reviewed at 9/meeting and 9/201/2017.  Director will be responsive quality assurance monit Control standards releved Legionnaires': Water Surangement Disinfectant Compliance and Environ Maintenance. Monthly and the supplies where the supplies were supplied to the supplies where the supplies where the supplies were supplied to the supplies where the supplies where the supplies were supplied to the supplies where the sup	purses, phones, proximity to ations of supply/storage such as work care giving d. Information and 12/2017 CNA 7 Nurse meeting.  Tible to oversee toring of Infection ant to the upply Management Dressing Care, Procedure nment		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245467	B. WING		08	3/24/2017
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP C 503 E LINCOLN STREET HENDRICKS, MN 56136		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		N SHOULD BE	(X5) COMPLETION DATE
F 441	bag of an unident puffs stored on the refrigerator.  During observation when interviewed DON indicated shoot contamination of and confirmed the items stored benepipes, she identification uninary tract infector be a source of contamination of the analysis of the puring clean utility root are kept. The DO toenail trimmer walso visible hair non the whirlpool tub roor DON agreed staff.	page 44 unter a large 18 ounce opened ified staff member's cheese te floor next to the medication on of the noted concerns and on 8/23/17, at 1:00 p.m. the ne was unaware of the cross items in the clean utility rooms at after viewing the resident care eath the sink with corroded ted they had a higher number of tions. The DON agreed it could intamination to these items. The staff were to store personal ses in their breakroom and not ims where clean resident items. N confirmed the use of a rusty as unacceptable. There was oted inside the tub and powder ub chair seat in the central in when toured at 1:00 p.m. The final not properly cleaned nor nirlpool tub and seat after	F	141		
	cleaning and disingle located in the cernical NA-C proceeded Cen-Kleen from the would spray the would spray the would gather all them in the whirly was not according instructions, but the cernical location in the work was not according to the cernical location in the work was not according to the cernical location in the work was not according to the cernical location in the work was not according to the cernical location in the work was not according to the cernical location in the cernical	c:30 a.m. NA-C demonstrated infection of the whirlpool tub noral hall whirlpool tub room. It ograb a spray bottle of the cupboard and explained she whirlpool tub down, use the scrub is tub and then rinse the tub. That at the end of the day, she he combs and brushes and rinse tool tub. She acknowledged that go to manufacturer's guidelines or the process had been changed toon at least one year ago.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245467	B. WING	i		08/2	24/2017
	PROVIDER OR SUPPLIER CKS COMMUNITY HO	) SPITAL		5	TREET ADDRESS, CITY, STATE, ZIP CODE 03 E LINCOLN STREET IENDRICKS, MN 56136	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPORTION OF T	BE	(X5) COMPLETION DATE
F 441	disinfecting the while behind the tub indice chemical flow throut to be disinfected. It residents routinely NA-C also explainer outinely cleaned by an alcohol pad. NA combs and brushed Cen-Kleen and rins whirlpool tub at the disinfectant available resident care items.  R6 was bathed in the disinfected to left third to the Provider Visit NR6 was examined in infected to left third to the Silvadene [topical and Band-aid daily until Cephalexin [oral and capsule BID [twice while on oral antibide Interview on 8/24/1 revealed she agreed disinfecting the centural multi-use resident of unaware R6 had hid There was no manual the 3 whirlpool tubs survey.	uctions for cleaning and ripool tub, located on the wall cated staff were to have the 19th the jets, enabling the jets was noted that 31 of 56 bathed in this whirlpool tub. It do that nail clippers were 19th wiping them off briefly with 19th or would clean the residents 19th sing them off inside the 19th end of the day. Staff had no 19th or use on the multi-use 19th or with wound cleanse infected proximal nail 19th or with wound cleanser, apply 19th intibiotic] and cover with 19th condition resolves. 19th intibiotic daily 19th or will apply 19th or with 19th or will and 19th or with	F	441			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245467	B. WING		08.	/24/2017
	PROVIDER OR SUPPLIER CKS COMMUNITY HO	DSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 503 E LINCOLN STREET HENDRICKS, MN 56136		-
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ( (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	indicated cleaning a items (items that m mucous membrane a high level disinfer were to be sent to tin the adjacent hos be cleaned with a certain equipment immediately following item was contaminated infectious material humidifiers were not brought in for use.  Review of the Augupolicy indicated har performed by staff removing gloves, we contaminated. A hadecontaminate han residents, after conswhen staff member with resident care evicinity of a resident 483.70(b)(c) COMFEDERAL/STATE/IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	Care Equipment policy and disinfecting of semi-critical ay come into contact with es or non-intact skin) required ctant, and whenever possible the central supply reprocessing pital. Non-critical items were to quaternary product or bleach. was to be disinfected and patient use and when an atted with blood or potentially or body fluids. Room air of to be supplied to residents or ast 2015 Hand Hygiene facility and hygiene was to have been before and after donning or when hands were visibly dirty or and sanitizer was to be used to add shetween direct contact with a tact with a resident's skin, and are hands came into contact equipment in the immediate att.  PLY WITH LOCAL LAWS/PROF STD  the Federal, State, and Local	F 4			9/22/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245467	B. WING		08	/24/2017	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		72472017	
HENDRI	CKS COMMUNITY HO	OSPITAL		503 E LINCOLN STREET HENDRICKS, MN 56136			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ( (EACH CORRECTIVE ACTION SHOOK CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 492	(c) Relationship to In addition to complorth in this subpart the applicable provregulations, including pertaining to nondiscrimination of CFR part 84); nondage (45 CFR part 8	Other HHS Regulations.  Diance with the regulations set t, facilities are obliged to meet visions of other HHS ng but not limited to those scrimination on the basis of onal origin (45 CFR part 80); on the basis of disability (45 discrimination on the basis of 21); nondiscrimination on the r, national origin, sex, age, or part 92); protection of human ch (45 CFR part 46); and fraud R part 455) and protection of able health information (45 d 164). Violations of such other cult in a finding of th this paragraph.  NT is not met as evidenced w and document review, the sure the supplemental nursing NSA) utilized by the facility was Minnesota commissioner, as the potential to affect all 56 ded in the facility and received	F 4	Supplemental Staff Nursing Scandency registration of Fortus Confirmed Minnesota Department of Heal 9/22/2017. Other agency utiliz confirmed as an authorized ag ADON Staff Coordinator, ADO Coordinator and Director informed as an authorized ag ADON Staff Coordinator for suppagency staff registration with the Minnesota Department of Heal engagement in staff utilization. Staff Coordinator and ADON were sponsible to confirm SNSA roon a semi-annual basis to assucompliance that agencies mair appropriate SNSA registration	Group If by the th as of ation is ency. If Care ned of olemental ne th prior to ADON ill be egistration are		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245467	B. WING		08	/24/2017
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRODEFICIENCY)		HOULD BE	(X5) COMPLETION DATE
F 492	Nursing Services A Resources was no listed. DON furthe (NA)-B (hired throu	agency that Fortus Healthcare t one of the approved agencies r verified that nursing assistant igh Fortus) had been working 1/30/17 to the present	F 4	92		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered September 18, 2017

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

Re: Project Number S5467027

Dear Mr. Gollaher:

The above facility was surveyed on August 21, 2017 through August 24, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

Hendricks Community Hospital September 18, 2017 Page 2

the Suggested Method of Correction and the Time Period For Correction.

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

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Kathryn Serie at (507) 476-4233 or email kathryn.serie@state.mn.us .

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

Please 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.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist

Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit

Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

PRINTED: 09/27/2017 FORM APPROVED

(X6) DATE

Minnesota Department of Health

AND BLAN OF CORRECTION \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00340	B. WING		08/2	4/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
HENDRI	CKS COMMUNITY HO	SPITAI	NCOLN STRE CKS, MN 561			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the deficing herein are not corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the Minnesota MN Ruwhen a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result from orders provided tha the Department witl	hearing on any assessments n non-compliance with these it a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

09/26/17 **Electronically Signed** 

TITLE

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ` ′	LE CONSTRUCTION :		(X3) DATE SURVEY COMPLETED	
			A. DOILDING	•			
		00340	B. WING		08/2	24/2017	
NAME OF	PROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY,	STATE, ZIP CODE			
HENDRI	CKS COMMUNITY HO	)SPITAI	LINCOLN STRE RICKS, MN 56				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
2 000	you electronically, is necessary for State enter the word "cortext. You must then State licensure procompletion date, the corrected prior to e Minnesota Departm On 8/21/17, 8/22/1 surveyors of this Deabove provider and orders are issued, electronic plan of coreviewed these ord they will be comple Minnesota Departm the State Licensing federal software. The assigned to Minnesota Departm the State Licensing federal software. The assigned to Minnesota Departm the State Licensing federal software. The assigned to Minnesota Departm the State Licensing federal software. The state is a signed to Minnesota Departm the State Licensing federal software. The assigned tag in column entitled "ID statute/rule out of compare the statement evidence by." Followare the Suggested Time period for Control of the statement of the Suggested Time period for Control of the statement of the Suggested Time period for Control of the statement of the Suggested Time period for Control of the statement of the Suggested Time period for Control of the statement of the Suggested Time period for Control of the statement of the Suggested Time period for Control of the statement of the Suggested Time period for Control of the statement of the statement of the suggested Time period for Control of the statement of the suggested Time period for Control of the suggeste	alth orders being submitted to Although no plan of correction ate Statutes/Rules, please prected" in the box available indicate in the electronic cess, under the heading le date your orders will be electronically submitting to the electronical properties of the following correction. Please indicate in your orrection that you have elers, and identify the date where electronical compositions are statutes for electronical properties. Tag." The state compliance is listed in the electronical properties of the state statutes in violation of the state statute, "This Rule is not met as wing the surveyors findings Method of Correction and rection.  ARD THE HEADING OF TH	on for e nen ng				
	"PROVIDER'S PLA	N WHICH STATES, NN OF CORRECTION." TH ERAL DEFICIENCIES ONLY					

Minnesota Department of Health

STATE FORM 6899 O87E11 If continuation sheet 2 of 49

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					ATE SURVEY DMPLETED	
		00340	B. WING		08/2	4/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HENDRIG	CKS COMMUNITY HO	SPITAI	COLN STRE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	THIS WILL APPEA	R ON EACH PAGE.				
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 005	MN Rule 4658.0015 REGULATIONS AN	COMPLIANCE WITH D STANDARDS	2 005			9/22/17
	services in complia state, and local laws and with accepted p	st operate and provide ince with all applicable federal, s, regulations, and codes, professional standards and to professionals providing and home.				
	by: Based on interview facility failed to ensu service agency (SN registered with the I required. This had	ent is not met as evidenced and document review, the ure the supplemental nursing SA) utilized by the facility was Minnesota commissioner, as the potential to affect all 56 ed in the facility and received upplemental staff.		Corrected		
	Findings include:					
	2:59 p.m. director o facility utilized the F	e conference on 8/21/17, at f nursing (DON) stated the ortus Healthcare Resources rovide nursing coverage.				
	DON verified via the	on 8/22/17, at 3:40 p.m. the e Minnesota Department of f Registered Supplemental				

Minnesota Department of Health

STATE FORM 6899 O87E11 If continuation sheet 3 of 49

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00340	B. WING		08/2	4/2017
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
HENDRIC	CKS COMMUNITY HO	)SPITAI	COLN STRE KS, MN 561			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE	(X5) COMPLETE DATE
2 005	Nursing Services A Resources was not listed. DON further (NA)-B (hired through at the facility from 1 providing direct pation SUGGESTED MET The administrator of revise policies and utilized from SNSAs registered agencies The administrator of educate staff and d	gency that Fortus Healthcare one of the approved agencies verified that nursing assistant gh Fortus) had been working 1/30/17 to the present ient care.  THOD OF CORRECTION: or designee could review and procedures to ensure staff are from approved with the State of Minnesota.	2 005			
2 265	Resident Health Star A nursing home mupolicies to guide star physicians, physician practitioners, and if legal representative member of a reside accident, or death. nursing services, an attending physician development of the have criteria which appropriate notifica  A. an accident results in injury and physician interventions.	ast develop and implement aff decisions to consult an assistants, and nurse known, notify the resident's e or an interested family ent's acute illness, serious. At a minimum, the director of and the medical director or an must be involved in the se policies. The policies must address at least the tion times for:  involving the resident which has the potential for requiring	2 265			10/3/17

6899

Minnesota Department of Health STATE FORM

O87E11 If continuation sheet 4 of 49

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00340	B. WING		08/2	24/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
HENDRI	CKS COMMUNITY HO	ISPITAL	NCOLN STRE CKS, MN 561			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 265	Continued From pa	ge 4	2 265			
	example, a deterior psychosocial status conditions or clinica  C. a need to all example, a need to of treatment due to begin a new form o  D. a decision tresident from the need to the second status of the second status	ter treatment significantly, for discontinue an existing form adverse consequences, or to f treatment;				
	This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure that physician notification occurred at onset of a pressure ulcer (PU) and with status change during the course of treatment for 1 of 1 resident (R48) reviewed who had two Stage II PU's located on the buttock and one unstageable right heel PU.			Corrected		
	Findings include:					
	electronic medical r diagnoses at the tin	on 6/15/17. Review of his record (EMR) indicated his ne of admission were coronary onic kidney disease and	′			
		ssment form dated 6/15/17, nad a reddened area on the				
		nort Term Care Plan Skin				

Minnesota Department of Health

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	· ,	(X3) DATE SURVEY COMPLETED	
		00340	B. WING		08/	24/2017
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE		
		503 F	LINCOLN STREI			
HENDRI	CKS COMMUNITY HO	ISPITAL HEND	RICKS, MN 5613	36		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 265	Continued From pa	ge 5	2 265			
	decreased sensation pressure ulcer (PU) Interventions include wounds and treatm	on and mobility. He had a ) to the right heel. led: notify physician of ents.				
	Integrity form dated to left buttock. Inter	rt Term Care Plan Skin 8/1/17, indicated R48 had I ventions noted included the e notified at that time.	PU			
	Review of R48's nursing progress notes and physician communication identified the following documentation: (1) On 6/15/17, a reddened area noted on left buttock; no mention of physician notification at this time. (2) On 6/20/17, seen by wound nurse (WN)-C and had developed one Stage II PU to left buttock; WN-C's treatment included adding the Cavilon barrier cream and encouraging R48 to shift weight when seated in the w/c or chair. No					
	6/29/17, indicated F primary care physic did not address the	on documented.  hysician progress note dated  R48 had been seen by his  sian (PCP). Documentation  buttock PU was examined  ed the PU to the physician.	i			
	activity in his chair a therapy (PT) to imp made no mention o	noted R48 had prolonged and planned to order physica rove muscle function. WN-C if contacting the physician. days later), WN-C re-assess				
	and documented a purple bruising arou (cm) x 2 cm. WN-C Betadine and left op protector for R48 to	Stage II heel PU with slight und edges 3.5 centimeters painted the heel with pen to air; added a heel wear when in bed and/or to				
	appointment was be	VN-C also noted a podiatry eing considered. There was YES for follow-up requested				

Minnesota Department of Health

STATE FORM 6899 O87E11 If continuation sheet 6 of 49

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Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  ### STREET ADDRESS COMMUNITY HOSPITAL  STREET ADDRESS CITY STATE STREET STREET ADDRESS CITY STATE STREET STATE STREET STATE STREET STATE STREET STATE STREET STATE STREET STATE S	AND DUAN OF CORRECTION IN TREMETICATION NUMBER.		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  HENDRICKS COMMUNITY HOSPITAL  503 E LINCOLN STREET			A. BUILDING:		OOWII	LLTLD	
HENDRICKS COMMUNITY HOSPITAL 503 E LINCOLN STREET			00340	B. WING		08/2	4/2017
HENDRICKS COMMUNITY HOSPITAL	NAME OF PRO	PROVIDER OR SUPPLIER	SUPPLIER STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
HENDRICKS COMMUNITY HOSPITAL	IENDDIOK		503 E LII	NCOLN STRE	ET		
HENDRICKS, MN 56136	HENDRICK	CKS COMMUNITY HO	HENDRI	CKS, MN 561	36		
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL	PRÉFIX	(EACH DEFICIENC	EFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	(X5) COMPLETE DATE
2 265 Continued From page 6 2 265	2 265 C	Continued From pa	From page 6	2 265			
Documentation was also lacking to indicate podiatry services had been offered and/or follow-up occurred with the physician.  (5) On 7/14/17, WN-C re-assessed and the left buttocks had progressed to a Stage II, measuring 0.1 cm x 0.1 cm. the right heel PU had increased in size measuring 3 cm. x 7.5 cm. and boggy at the base. WN-C continued with the same course of Betadine treatment; R48 now complained of foot pain. Documentation was lacking to indicate physician notification had occurred related to the worsening condition of the PU's.  (6) On 7/21/17, left buttock pressure ulcer measured 0.5 cm to 0.3 cm with superficial depth. WN-C changed treatment to include a skin prep (skin protectant film barrier) and a small Mepilex (foam dressing). Right heel size increased to 3.5 cm x 7.5 cm, purple in color, with the edge being boggy measuring 1 cm x 3 cm. No physician notification was documented by the WN-C.  (7) On 7/31/17, (10 days later) left buttock worsened with two Stage II areas noted, measuring (#1) 0.7 cm x 0.5 cm and (#2) 2 cm x 0.3 cm. Drainage was noted to the Mepilex upon removal by the WN-C. Right heel described as Stage II PU, measured 4 cm x 6 cm, purplish in color and continued to be boggy. Treatment continued as before, with Betadine and air drying.  (8) On 8/9/17, (9 days later), WN-C re-assessed, left buttocks wounds measured (#1) 0.3 cm x 0.1 cm and (#2)0.1 cm x 0.1 cm. Treatment-poen to air, a barrier cream applied prior to brief application. Right heel PU-described as unstageable and measured at 3.5 cm x 5 cm, was dry, black-dark purple heel. Treatment-Betadine and leave open to air. No physician notification documented.	D po foo (5 but 0. in the of for ph we (6 m W) (5 cross of contract of the original ph we model the original ph we we will be original ph we we will be original ph we we will be original ph will be original ph we will be original ph will be origin	Documentation wa podiatry services h follow-up occurred (5) On 7/14/17, Wh buttocks had proground on the base. WN-C consider the base of Betadine treatments foot pain. Documents physician notification worsening condition (6) On 7/21/17, left measured 0.5 cm that WN-C changed the (skin protectant film (foam dressing). R cm x 7.5 cm, purplication was do (7) On 7/31/17, (10) worsened with two measuring (#1) 0.7 0.3 cm. Drainage where we will be the worsened with two measuring (#1) 0.7 0.3 cm. Drainage where we will be the worsened with two measuring (#1) 0.7 0.3 cm. Drainage where we will be the worsened with two measuring (#1) 0.7 0.3 cm. Drainage where we will be the worsened with two measuring (#1) 0.7 0.3 cm. 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Drainage where we will be the worsened with two measuring (#1) 0.7 0.3 cm. Drainage where we will be the worsened with two measuring (#1) 0.7 0.3 cm. Drainage where we will be the worsened with two measuring (#1) 0.7 0.3 cm. Drainage where we will be the	ation was also lacking to indicate ervices had been offered and/or occurred with the physician.  A/17, WN-C re-assessed and the left and progressed to a Stage II, measuring 1 cm. the right heel PU had increased assuring 3 cm. x 7.5 cm. and boggy at WN-C continued with the same course of treatment; R48 now complained of Documentation was lacking to indicate notification had occurred related to the condition of the PU's.  A/17, left buttock pressure ulcer 0.5 cm to 0.3 cm with superficial depthinged treatment to include a skin preportant film barrier) and a small Mepilex sing). Right heel size increased to 3.5 m, purple in color, with the edge being assuring 1 cm x 3 cm. No physician was documented by the WN-C.  A/17, (10 days later) left buttock with two Stage II areas noted,  A/17, (10 days later) left buttock with two Stage II areas noted,  A/19, CRight heel described as J, measured 4 cm x 6 cm, purplish in continued to be boggy. Treatment as before, with Betadine and air drying 17, (9 days later), WN-C re-assessed, as wounds measured (#1) 0.3 cm x 0.1  A/2)0.1 cm x 0.1 cm. Treatment-open to er cream applied prior to brief  A/17, (9 days later), the WN-C  B/17, (9 days later), the WN-C				

Minnesota Department of Health

STATE FORM 6899 O87E11 If continuation sheet 7 of 49

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00340	B. WING		08/2	4/2017
	PROVIDER OR SUPPLIER	SDITAL 503 E LIN	DRESS, CITY, S COLN STRE KS, MN 561			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 265	PU-3.5 cm x 6 cm k on the edge. No ph documented.  No other progress r staff were made ex Interview and docur 12:24 p.m. with the (ADON) and WN-C notification at PU or wounds had changed.  Review of the 2009 indicated upon iden physician was to iden not improved within the provider and seconsult.  Review of the Presedated August 2013, not improved within the notified.  SUGGESTED MET director of nursing (develop systems for DON or designee of facility practices, por notifications of char could develop moniongoing compliance the quality assurance.	plack scab and starting to peel ysician notification  notes by any other nursing cept by WN-C.  ment review on 8/24/17, at assistance director of nursing confirmed physician neet and/or at the time the ed had occurred.  Skin Policy and Procedure tification of a skin ulcer, the entify the type of ulcer and if 2 weeks, staff were to notify ek an order for a wound  sure Ulcer Prevention policy indicated if the wound had 2 weeks, the provider was to the DON or designee could result inservice staff regarding plicy and procedures for nege. The DON or designee toring systems to ensure eand report those results to	2 265			

Minnesota Department of Health STATE FORM

6899 O87E11 If continuation sheet 8 of 49

AND DIAN OF CORRECTION . IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE COMPI		
		00340	B. WING		08/2	4/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
HENDRI	CKS COMMUNITY HO	SPITAI	ICOLN STRE IKS, MN 561			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 560	Continued From pa	ge 8	2 560			
2 560	MN Rule 4658.0409 Plan of Care; Conte	5 Subp. 2 Comprehensive ents	2 560			10/3/17
	comprehensive plate objectives and time long- and short-term and mental and psylidentified in the contassessment. The compassion of the contast include the increquired by Minness subdivision 14, para					
	by: Based on interview facility failed to ensi related to anticoagu	ent is not met as evidenced and document review, the ure a care plan was developed lant therapy for 1 of 1 resident unnecessary medications.		Corrected		
	Findings include:					
		imum Data Set (MDS) 5/24/17, identified R42 was agulant medication.				
	included an order for thinner) 4 milligram Saturday and 5 mg	cians orders dated 7/27/17, or warfarin sodium (blood s (mg) every Wednesday and every Monday, Tuesday, nd Sunday for diagnosis of egular heartbeat).				
	identified R42 had b	cation administration record been receiving warfarin losages since 11/11/16.				
		rrent care plan lacked any other care plan interventions				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00340	B. WING		08/2	24/2017
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
HENDRI	CKS COMMUNITY HO	SPITAI	ICOLN STRE KS, MN 561			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 560	Continued From pa	ge 9	2 560			
	related to the antico	pagulant use.				
	Review of R42's current treatment record dated 8/17, lacked monitoring for side effects of the warfarin sodium use.					
	(ADON) on 8/23/17 plan of care did not sodium or side effe- increased bleeding. anticoagulant monit	ssistant director of nursing , at 3:09 p.m. confirmed the include R42's use of warfarin ct monitoring due to risk of . The ADON indicated toring should have been an of care stating "honestly I				
	During interview on 8/23/17, at 3:36 p.m. director of nursing (DON) indicated her expectation is a care plan be developed for residents using anticoagulant medications.					
	care plans will inclu used as an interven needs, indications f used and how the e is being evaluated.	d Care Plans/Care evised 11/09, stated resident de how medications are being ation for resident's medical for use, goals for medication effectiveness of the medication It further directed care plans needed and reviewed at least				
	The director of nursing develop and implementated to the developon or designee, conursing staff related. The quality assessr	THOD OF CORRECTION: sing (DON) or designee, could nent policies and procedures opment of the care plan. The could provide training for all d to care plan development. ment and assurance erform random audits to				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					OATE SURVEY OMPLETED	
		00340	B. WING		08/2	4/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HENDRI	CKS COMMUNITY HO	SPITAI	COLN STRE KS, MN 561			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 560	Continued From pa	ge 10	2 560			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days.					
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use		2 565			10/3/17
		omprehensive plan of care personnel involved in the .				
	This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement the plan of care for 1 of 1 resident (R48) reviewed with two Stage II pressure ulcers (PU) and one unstageable heel PU.			Corrected		
	Findings include:					
	Review of his electrindicated his diagno	o the facility on 6/15/17. conic medical record (EMR) coses at the time of admission cy disease, chronic kidney ces.				
		dent Assessment form ttock had a reddened area.				
	only by licensed nur following intervention implemented for R4 (1) Administer treat for effectiveness.	nt EMR care plan, accessed rses, revealed on 6/22/17, the ons were to have been 48: ments as ordered and monitor monitor wound healing weekly.				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		00340	B. WING		08/2	4/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
HENDRI	CKS COMMUNITY HO	ISPITAI	COLN STRE KS, MN 561			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	(3) "needs a pressum wheelchair (w/c)". (4) "needs to turn/remore often as need. Review of the Shorform dated 7/8/17, sensation and mobito the right heel. Intinspect the skin dail and at each dressin reposition on a schwas left blank; (3) abed and in recliner; of wounds and tread documentation by liadditional note was staff were to continifirm, black with esc. Review of the Shorform dated 8/1/17, buttock. Interventionskin daily, cleansed dressing change; (2) every 3-5 days and and repositioning severy 2 hours to ever lieving mattress wand (5) a referral to loccupational theraphysician at this time documentation by a weekly inspection of the short	Ints and declines to the doctor.  Irre reduction cushion in his  Possition at least every 2 hrs, Ited or requested."  It Term Care Plan Skin Integrity Irevealed R48 had decreased Ility and a pressure ulcer (PU) Ireventions included: (1) Ily, cleanse the wound initially Ing change (2) turn and Itedule; however, the frequency Inply heel protector while in Items(4) Notify physician and family Items(5) weekly Itemsed nurse. On 8/18/17, an Inadded to the form indicating Items and (5) weekly Itemsed nurse. On 8/18/17, an Inadded to the form indicating Items included: (1) inspect the Item Care Plan Skin Integrity Indicated R48 has a PU his left Ins included: (1) inspect the Items and Initially and at each Items and Initially Initially and Initially Init	2 565			
	It was observed on 8/21/17, at 5:26 p.m. that R48 was seated in his chair in his room waiting for staff to transfer him into the wheelchair for transportation to the evening meal. When					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			
		00340	B. WING		08/2	4/2017
NAME OF PRO	OVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
HENDRICK	S COMMUNITY HO	SPITAI	COLN STRE KS, MN 561			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
ir d wirth ri TF b V h d g w a c v w c c 1 8 th d C (l o F p re ir e ty F fe o	lependent upon stavas no pressure rein the recliner, where hat R48 was wearing the following morning the following from the	ime, R48 explained he was aff for cares. It was noted there lieving device/cushion evident elchair or bed. It was noted ing a heel protector boot on his are cliner consuming as clothed in a hospital gown. R48 stated he was upset staff him dress as he was ities of daily living (ADL's) like leting, transferring, and ir. R48 explained staff had 100 a.m. for a blood sugar led him into the recliner. R48 ex to make slight movements while in his chair. R48 ot changed positions in his d assisted him at 7:00 a.m. (2) Further observation on in noted that R48 remained in for staff assistance with	2 565			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
				B WINC			
		00340		B. WING		08/2	24/2017
NAME OF I	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
HENDRI	CKS COMMUNITY HO	SPITAL		COLN STRE KS, MN 561			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
2 565	5 Continued From page 13		2 565				
	drainage or odor. RN-A painted R48's heel with Betadine, allowed it to air dry and covered it with his sock; and (2) left buttock ulcers revealed a 0.5 cm x 0.5 cm area with another area resolving, unopened. RN-A applied a skin prep and placed a Mepilex dressing over the area.						
	Observation on 8/22/17, at 12:20 p.m. indicated the resident was dressed, but was now seated in his wheelchair, with no pressure relieving cushion device utilized as indicated on the plan of care while eating the noon meal.						
	Further random observations on 8/23/17 and 8/24/17, from the hours of 8:00 a.m. through 1:30 p.m., revealed the R48 was in a seated position, either in his wheelchair and/or recliner without a cushion. Plan of care not followed as a pressure relieving device had not been utilized.						
	Review of the current, undated nurse aide (NA) care plan, indicated R48 was not on a scheduled repositioning nor toileting plan; it included; (1) ambulate x 1 with a walker (no mention of wheelchair); (2) required minor assistance with ADL's; and (3) required 2 staff assistance with transfers as a fall prevention.						
	Review of R48's nuphysician communidocumentation: (1) On 6/15/17, a rebuttock; (2) On 6/20/17, see and had developed buttock; WN-C's tre Cavilon barrier creashift weight when seed 10 (3) Review of the period of t	eddened area not by wound nur one Stage II Pleatment included am and encoura eated in the w/chysician progres	the following oted on left ase (WN)-C U to left adding the ging R48 to a or chair.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00340	B. WING		08/2	4/2017
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HENDRICKS COMMUNITY HO	503 E LIN	COLN STRE	ET		
HENDRICKS COMMUNITY HO	SPITAL HENDRIC	KS, MN 561	36		
PREFIX (EACH DEFICIENCY	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 565 Continued From pa	ge 14	2 565			
primary care physic R48 had prolonged planned to order physic and documented a purple bruising arou (cm) x 2 cm. WN-C Betadine and left opprotector for R48 to off-load pressure.  (5) On 7/21/17, it was physician order for every 3 days and as be evaluated on 6/1 documentation indicinvolved.  (6) On 7/31/17, (10 worsened with two measuring (#1) 0.7 0.3 cm. Drainage was removal by the WN (7) On 8/9/17, (9 daleft buttocks wound cm and (#2)0.1 cm air, a barrier cream application. Right hounstageable and may dry, black-dark (8) Review of faxed a telephone order for evaluate and treated at the evaluate at	ian (PCP) and the PCP noted activity in his chair and ysical therapy (PT) to improve lays later), WN-C re-assessed Stage II heel PU with slight and edges 3.5 centimeters painted the heel with ben to air; added a heel wear when in bed and/or to as noted there was a Mepilex to the left buttock aneeded. PT/OT/ST were to 5/17. There was no cating that therapies had been days later) left buttock Stage II areas noted, cm x 0.5 cm and (#2) 2 cm x as noted to the Mepilex upon -C. bys later), WN-C re-assessed, as measured (#1) 0.3 cm x 0.1 x 0.1 cm. Treatment-open to applied prior to brief eel PU-described as easured at 3.5 cm x 5 cm, purple heel. records revealed on 8/16/17, for occupational therapy (OT) at on 8/16/17, for a pressure or R48's bed, chair, and w/c	2 505			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
_		00340	B. WING		08/2	4/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
HENDRIG	CKS COMMUNITY HO	)SPITAI	COLN STRE KS, MN 561			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	COMPLETE DATE
2 565	Continued From pa	ge 15	2 565			
	system been impler	mented.				
	nursing staff) related documented except which had not been identified in the plan.  When interviewed consistent director of confirmed there was administer treatment. Treatment was bas WN-C acknowledge evaluated the wound Pressure Ulcer (PU herself, as there was	progress notes (by any ed to PU monitoring were t by the wound nurse (WN-C), implemented weekly as in of care.  On 8/24/17, at 12:24 p.m. the f nursing (ADON) and WN-C is no Standing Order to interest for skin issues and PU's, and at least weekly and the subject of only interest in				
	Wounds.  Upon further interview both the ADON and WN-C confirmed they were unaware R48 that a pressure relieving cushion had not been placed in the wheelchair and/or the recliner. Both thought R48 had a pressure relieving cushion placed in his chair initially, but weren't sure. The ADON stated although they had air mattresses available in the building, R48 required a larger framed bed. They [staff] "forgot" to get him an air-mattress when they got him the larger bed after his admission. The ADON confirmed the CNA staff lacked access to the EMR care plan and utilized their own NA care plan. After review of the NA care plan, the ADON it made no mention of any cares nor interventions related to PU treatment/prevention that NA staff were responsible.  When interviewed on 8/24/17, at 2:30 p.m. nursing assistant (NA)-A confirmed she had					

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00340	B. WING		08/24/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
HENDRIG	CKS COMMUNITY HO	)SPITAI	COLN STRE KS, MN 561			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE COM		(X5) COMPLETE DATE
2 565	never seen a press wheelchair nor recli NA-A verified there for R48. NA-A state as she was his regustaff would assist R assist him into the r NA-A stated that sta offload pressure which air and indicated to reposition R48 ascare.  Review of the 2009 Hendricks Nursing care staff shall be infor each resident arbrought to the interdulcer team).  SUGGESTED MET The director of nursing care staff shall be informed to the interdulcer team.	ure relieving cushion in the iner since admission of R48. was no repositioning schedule of she knew R48's cares well ular NA. She explained that NA R48 to the bathroom and then recliner from the wheelchair. aff had not attempted to nile he remained seated in any she had not been instructed is identified in the EMR plan of a Skin Policy and Procedure Home policy included: direct instructed on all interventions and monitoring results will be disciplinary team (Pressure	2 565			
	monitoring system to care as directed by results could be dis assurance committee	e staff and develop a to ensure staff are providing the written plan of care. The ccussed at the quality ee.  R CORRECTION: Twenty-one				
2 830	Proper Nursing Car		2 830			10/3/17
	receive nursing care custodial care, and individual needs an	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X: A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00340	B. WING		08/2	4/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE			
HENDRI	CKS COMMUNITY HO	SPITAI	COLN STRE				
			KS, MN 561	PROVIDER'S PLAN OF CORRECTION	- N	(VE)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 830	Continued From pa	ge 17	2 830				
	4658.0405. A nursi of bed as much as written order from t	scribed in parts 4658.0400 and ng home resident must be out possible unless there is a he attending physician that the in in bed or the resident bed.					
	This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the use of bedrails had been assessed upon admission, and periodically thereafter for safety for 5 of 5 residents (R4, R6, R22, R31, R48) reviewed who had bedrails attached to their beds.			Corrected			
	Findings include:						
	room indicated that attached to the bed into two halves, top bedrail is Zone 1. T 3.75 inches (in) x 2 4 in. x 33 in. Revie assessment indicat re-assessed/re-eva since 12/18/15. The documented and R	1/17, at 5:04 p.m. in R6's two half side rails were frame. Each rail was divided and bottom. Within the he top of the area measured 9 in. and the bottom measured w of R6's 6/18/15, Side Rail ed it had not been luated for appropriateness ere was no physician's order 6 was noted to have on with diagnosis of					
	room indicated that attached to the bed Rail assessment da	1/17, at 7:04 p.m. in R22's two bilateral grab bars were frame. Review of R22's Side ated 6/16/17, lacked indication ed for safety nor appropriate					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00340	B. WING		08/	24/2017
	PROVIDER OR SUPPLIER	SPITAI 503 E LIN	DDRESS, CITY, ST ICOLN STREE CKS, MN 5613	ET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 830	use. R22 had not re rails and it was obsutilize the rails at th "ok with leaving the remove." There wadocumented on the the record.  Observation on 8/2 room indicated that attached to the bed bottom section with measured 4 in. x 12 measured 4.5 in. x 2/11/13, Side Rail a not been re-assess no physician's orde	equested the use of any grab erved she was unable to is time, but indicated she was m on when offered to so no physician's order assessment nor evident in 1/17, at 7:17 p.m. in R31's two bilateral side rails were. Each side rail had a top and in Zone 1. The top section 2.75 in. and the bottom 12.75 in. Review of R31's ssessment indicated it had ed since 8/12/14. There was redocumented on the vas noted to be cognitively	2 830			
	Observation on 8/22/17, at 9:10 a.m. in R4's room indicated that two bilateral grab rails were attached to the bed. Review of R4's 4/29/15, Side Rail assessment indicated it had not been re-assessed nor re-evaluated since that date. R4 stated she had not requested the use of any rails when interviewed at this time.  Observation on 8/23/17, at 9:05 a.m. in R48's					
	the left side of the baside Rail assessment requested the use of assessment conduction rails or physician's of Interview with the a 8/24/17, at 10:30 asstaff needed to have	re was one grab bar located on ped. Review of R48's 6/15/17, ent indicated R48 had not of any rails. There was no cted for use or safety of bed order for R48.  ssistant director of nursing on m. indicated she was unaware a physician's orders in place and stated bedrails should be				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00340	B. WING		08/2	08/24/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•		
HENDRIG	CKS COMMUNITY HO	ISPITAI	COLN STRE				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	KS, MN 561	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)	
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE	
2 830	Continued From pa	ge 19	2 830				
	re-assessed quarterly, annually, with a significant change and as needed for each resident to ensure rails were not restraints or hazards.						
	There was no side rail assessment policy provided at the time of the survey.						
	SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could educate staff regarding the importance of a safe and functional environment. The DON or designee, could audit resident side rails to ensure they meet Food and Drug Administration recommendations to prevent entrapment, and audit side rail assessments to ensure they are accurate and reflect the current condition of the equipment. The DON could report findings to the quality assurance committee for further recommendations to ensure ongoing compliance.						
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one					
2 900	MN Rule 4658.0529 Ulcers	5 Subp. 3 Rehab - Pressure	2 900			10/3/17	
	comprehensive res of nursing services	sores. Based on the ident assessment, the director must coordinate the ursing care plan which					
	without pressure so pressure sores unle condition demonstr	o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and					
	B. a resident w	ho has pressure sores					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00340	B. WING		08/2	4/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
HENDRI	CKS COMMUNITY HO	SPITAI	COLN STRE KS, MN 561			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	receives necessary promote healing, promote healing health for the health for hea	y treatment and services to revent infection, and prevent veloping.  ent is not met as evidenced on, interview and document ailed to comprehensively ent the necessary services for 3) reviewed with two Stage II ated on the buttock and one U.  edical record (EMR) face sheet admitted on 6/15/17 with groonary artery disease, ase and diabetes. The Brief Status (BIMS) assessment mission Minimum Data Set 7, identified a score of 11/15, gnition. A Resident lated 6/15/17, indicated R48 are on the left buttock.  p.m. R48 was observed his room waiting for staff to wheelchair for transport to the in interviewed at that time, dependent on staff for cares. Ition, R48 was wearing a heel is right foot. Additionally, and no pressure relieving sevident in the recliner, in the	2 900	Corrected		
		a.m. R48 was observed in his room eating breakfast.				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		00340	B. WING		08/2	4/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HENDRI	CKS COMMUNITY HO	)SPITAI	COLN STRE KS, MN 561			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	R48 was dressed in interviewed R48 stanot yet helped him verified he was dep daily living (ADL's) transferring, and whe explained staff had that morning for a latransferred him into he was able to move he was not able to chair. R48 confirme positions since staff a.m. (2 1/2 hours cobservation at 9:50 remained in the recombination was noted that R48 without a pressure relieving a When interviewed explained that would typically measure at R48's wound docur following from the 8 observation of RN-wound-unstageable black scab, starting drainage or odor. Retadine, allowed in his sock; and (2) le 0.5 cm x 0.5 cm are	n a hospital gown. When ated he was upset staff had get dressed for the day, and bendent on staff for activities of like getting dressed, toileted, heeling in his wheel chair. R48 awakened him at 7:00 a.m. blood sugar check and had of the recliner. R48 stated while we himself slightly while in bed, move himself while in his ed he had not changed if had assisted him at 7:00 earlier). During further a.m. on 8/22/17, R48 sliner and verified he was still sistance with dressing and  10 a.m. registered nurse ed to conduct dressing and sistance with dressing and air mattress noted on the bed. On 8/22/17, at 11:40 a.m. RN-A and nurse (WN)-C would and provide all wound care.  11 mentation identified the 8/22/17, dressing change A: (1) right (R) foot er; measured 3.5 cm x 6 cm, at to peel on the edge; no and covered it with the to air dry and covered it with eft buttock ulcers revealed a lea with another area resolving, opplied a skin prep and placed a	2 900			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00340	B. WING		08/	24/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE			
HENDRI	CKS COMMUNITY HO	SPITAI	ICOLN STREE KS, MN 5613				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETE DATE	
2 900	Continued From pa	ge 22	2 900				
	was transferred bac wheelchair. A pres- evident in the chair. 8/22/17, at 12:20 p. seated in his wheel and/or pressure reli	change was completed, R48 ck into a seated position in the sure relieving cushion was not. Later, it was noted on m. that R48 was dressed and chair, still without a cushion leving device in place.					
	During random observations on 8/23/17 and 8/24/17, R48 remained in a seated position, cushion was not located in the wheelchair an recliner.						
	Assessment dated reddened area on ha pressure points a The sections labele and Skin Conditions Comprehensive Sk	in Assessment were left blank. erventions were also left blank					
	indicated R48 was in 1-2 staff assistance	e Plan dated 6/15/17, incontinent of bowel, required with the wheelchair and urfaces and 1 staff to walk					
	dated 6/15/17, was R48 was not at risk However, the inform Braden Score asse with the assessme Admission Care Pla Braden assessmen impairment related	(pressure ulcer risk) score identified as 20, indicating for pressure ulcers. nation documented on the ssment was not consistent nt completed on the an form dated 6/15/17. The t identified that R48 had no to sensory perception, was d occasionally and did not					

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	IT OF DEFICIENCIES		R/SUPPLIER/CLIA	` ′	E CONSTRUCTION		SURVEY PLETED
AND PLAN	OF CORRECTION	IDENTIFIC	ATION NUMBER:	A. BUILDING:	<del></del>	COM	PLETED
		00340		B. WING		08/2	24/2017
NAME OF I	PROVIDER OR SUPPLIER	•	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	-	
				COLN STRE	,		
HENDRI	CKS COMMUNITY HO	SPITAL		KS, MN 561			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC\ REGULATORY OR L		CEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 900	Continued From pa	ige 23		2 900			
	require staff assista wheelchair (only sli indicated R48 requ transfer. The Brad R48 did not have a problem with frictio that would have red Review of a physicia 8/3/16, made by ce (CNP)-D indicated (used to assist in the neuropathy) performunable to elicit a reindicating loss of seinformation was in impairment related on the Braden scalidated 6/14/17, indicated to a 2.9, which mercent indication in the Braden scalidated and the Braden scalidated for the B	ance into cha ghtly limited). ired 1-2 staff en assessme ny problem o n or sheer, or quired reposit ian progress intified nurse p R48 had a m ne detection of med on his fe sponse from ensation in his conflict with the to sensory poets.	The plan of care assistance with ent identified that r potential r skin concerntioning.  The dated practitioner conofilament test of peripheral etc. CNP-D was R48's left foot, s left foot. This he "no erception" noted laboratory data albumin level was				
	Review of the admission Care Area Assessment (CAA) dated 6/21/17, identified that R48 required extensive assistance for bed mobility, was at risk for developing pressure ulcers and had a Stage II PU on that date (6/21/17).						
	Review of the curre only by licensed nu following interventic implemented for R4 (1) Administer treat for effectiveness. (2) Assess/record/r Report improvement (3) Inform the resid any new area of sk (4) Cavilon (a barriedaily.	rses, reveale ons were to h 48: tments as ord monitor woun nts and declir lent, family ar in breakdowr	d on 6/22/17, the lave been dered and monitor d healing weekly. hes to the doctor, and caregivers of h.				
	(5) "needs a pressi	ire reduction	cushion in his				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00340	B. WING		08/	24/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
HENDRI	CKS COMMUNITY HO	ISPITAL	NCOLN STREI CKS, MN 5613			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 900	wheelchair (w/c)".  (6) "needs to turn/re more often as need (7) needs 1-2 staff repositioning, turning in bed.  (8) needs the assist distances in his room he was utilizing his around his house."  The care plan was [R48] had a Stage I also to wear a heel daily treatment. No R48's care plan.  Review of the Short form dated 7/8/17, is sensation and mobito the right heel. Into inspect the skin dain and at each dressing reposition on a schewas left blank; (3) a bed and in recliner; of wounds and tread documentation week 8/18/17, an addition indicating staff were area was firm, black. Intervention skin daily, cleanse the dressing change; (2) every 3-5 days and and repositioning staff was staff every 3-5 days and and repositioning staff every 3-5 days and 3-5 days	eposition at least every 2 hrs, led or requested." assistance to help with ag, and lying down or sitting up tance of 1-2 staff to walk short m. "Per [R48] and his family, walker or wheelchair to get  updated on 7/8/17, to reflect I PU to the right heel and was protector/boot to area as a further updates were made to the Term Care Plan Skin Integrity revealed R48 had decreased ility and a pressure ulcer (PU) erventions included: (1) ly, cleanse the wound initially ag change (2) turn and edule; however, the frequency apply heel protector while in (4) Notify physician and family the term of the term of the to continue to monitor as the	, , , , , , , , , , , , , , , , , , ,			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUIL	IULTIPLE CONSTRUCTION ILDING:	(X3) DATE SURVEY COMPLETED	
00340 B. WIN	NG	08/24/2017	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, 0	, CITY, STATE, ZIP CODE		
HENDRICKS COMMUNITY HOSPITAL 503 E LINCOLN S	STREET		
HENDRICKS, MN	N 56136		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREI TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	EFIX (EACH CORRECTIVE ACTION SHOUL	D BE COMPLETE	
relieving mattress was added to his bed (8/1/17); and (5) a referral to physical therapy (PT) /occupational therapy (OT); (6) notify the physician at this time; and (7) weekly documentation by a licensed nurse from the weekly inspection of R48's skin. An additional note at the bottom, dated 8/14/17, two weeks later, indicated one (1) open area measuring 0.5 cm x 1 cm in size with discoloration 7 cm x 3 cmstaff would continue to monitor.  Review of the current, undated nurse aide (NA) care plan, indicated R48 was not on a scheduled repositioning nor toileting plan; it included; (1) ambulate x 1 with a walker (no mention of wheelchair); (2) required 2 staff assistance with ADL's; and (3) required 2 staff assistance with transfers as a fall prevention. No skin issues were identified that NA staff were to be made aware.  Review of R48's nursing progress notes and physician communication identified the following documentation: (1) On 6/15/17, a reddened area noted on left buttock; no physician notification documented. (2) On 6/16/17, required 2 staff assistance with repositioning in bed. (3) On 6/20/17, seen by wound nurse (WN)-C and had developed one Stage II PU to left buttock; WN-C's treatment included adding the Cavilon barrier cream and encouraging R48 to shift weight when seated in the w/c or chair. No physician notification documented. (4) Review of the physician progress note dated 6/29/17, indicated R48 had been seen by his primary care physician (PCP). Documentation did not address the buttock PU was examined nor that staff reported the PU to the physician. However, the PCP noted R48 had prolonged	,		

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	NT OF DEFICIENCIES		(V2) MULTIPL	E CONSTRUCTION	(X3) DATE	CLIDVEV
	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′			LETED
			A. BUILDING:	<del></del>		
		00340	B. WING		08/2	4/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		503 E LIN	COLN STRE	ET		
HENDRI	CKS COMMUNITY HO	SPITAI	KS, MN 561			
()(4) ID	CLIMMA DV CTA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION		(VE)
(X4) ID PREFIX		MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO		DATE
				DEFICIENCY)		
2 900	Continued From pa	ae 26	2 900			
		and planned to order physical				
		rove muscle function.				
		lays later), WN-C re-assessed				
		Stage II heel PU with slight				
		und edges 3.5 centimeters				
		painted the heel with				
		pen to air; added a heel				
		wear when in bed and/or to				
	off-load pressure.	CMD physician's orders				
		EMR physician's orders				
		to PU's until 7/8/17. At that order for Betadine to the right				
		order for betadine to the right				
		d information to the PCP's				
		8 complained of heel pain and				
		olister measuring 3.5 cm x 2				
		noted she had painted it with				
		d a heel protector in R48's				
		him not to use his right foot				
		bed. WN-C also noted a				
		nt was being considered.				
		neck marked YES for follow-up				
		entation was also lacking to				
		rvices had been offered				
	and/or follow-up oc	curred.				
	(7) On 7/14/17, WN	I-C re-assessed and the left				
	buttocks had progre	essed to a Stage II, measuring				
	0.1 cm x 0.1 cm. th	e right heel PU had increased				
		cm. x 7.5 cm. and boggy at				
		ntinued with the same course				
		ent; R48 now complained of				
		tation was lacking to indicate				
		n had occurred related to the				
	worsening condition					
		buttock pressure ulcer				
		0.3 cm with superficial depth.				
		atment to include a skin prep				
		barrier) and a small Mepilex				
		ght heel size increased to 3.5				
	cm x 7.5 cm, purple	e in color, with the edge being				

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wiinnesc	ita Department of He	eaitii			т	
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	<del></del>	COMP	LETED
		00340	B. WING		08/2	4/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE		
TW WILL OT	NOVIDEN ON COLL FIEN		COLN STRE			
HENDRI	CKS COMMUNITY HO	SPITAI				
			KS, MN 561			
(X4) ID	_	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROI		DATE
		·		DEFICIENCY)		
2 900	Continued From pa	ge 27	2 900			
2 300	-		2 300			
		cm x 3 cm. No physician				
		cumented by the WN-C.				
		as noted there was a				
		Mepilex to the left buttock				
		s needed. PT/OT/ST were to				
		15/17. There was no				
		cating therapies had				
	completed the evaluation					
		0 days later) left buttock				
		Stage II areas noted,				
		cm x 0.5 cm and (#2) 2 cm x				
		ras noted to the Mepilex upon				
		-C. After R48 was given a tub				
		blied and Mepilex covered both				
		lescribed as Stage II PU,				
		cm, purplish in color and ggy. Treatment continued as				
	before, with Betadir					
		's faxed and/or verbal				
		ords revealed on 7/31/17, a				
		PCP, with notification that				
		l open area to left buttock				
		0.3 cm. Mepilex covering both				
		till healed." However, the				
		U was not mentioned. No				
		I nor was there documentation				
		cian had responded to the				
	treatment orders.	·				
	(12) On 8/9/17, (9 c	lays later), WN-C				
		uttocks wounds measured (#1)				
		d (#2)0.1 cm x 0.1 cm.				
		air, a barrier cream applied				
		ation. Right heel PU-described				
		d measured at 3.5 cm x 5 cm,				
		purple heel. Treatment-				
		open to air. No physician				
	notification docume					
	(13) Review of faxe	ed records revealed on				
		e order for occupational				
		luate and treat on 8/16/17, for				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00340	B. WING		08/	24/2017	
	PROVIDER OR SUPPLIER CKS COMMUNITY HO	SPITAI 503 E LIN	DRESS, CITY, S ICOLN STRE EKS, MN 561:				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE	
2 900	a pressure reduction and w/c was signed. There were no other orders related to the by the wound nurse (14) On 8/18/17, (9) documented left but cm x 0.5 cm and (#PU-3.5 cm x 6 cm is on the edge.  No other weekly nunursing staff) were wound nurse (WN-been implemented)  Review of the April, Advisory Panel's profit http://www.npuap.oclinical-resources/nindicated a Stage I area of intact skin. partial-thickness los dermis. An unstage defined as an observation of some consultation of intact states are pressure ulconon-blanchable decisoloration of intacts.	n system for R48's bed, chair, I by the PCP on 8/17/17. It signed faxed or telephone is identified PU's documented it. I days later), the WN-C ttock PU measured (#1) 0.5 2)PU resolved. Right heel plack scab and starting to peel rsing progress notes (by any documented except by the C). The plan of care had not	2 900				
	assistant director of agreed the compreservation performed upon ad accurately. It was a	on 8/24/17, at 12:24 p.m. the f nursing (ADON) and WN-C hensive skin assessment mission was not completed lso confirmed the physician a treatments for wound care.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00340	B. WING		08/	24/2017
	PROVIDER OR SUPPLIER  CKS COMMUNITY HO	SPITAI 503 E LIN	DORESS, CITY, ST ICOLN STREE CKS, MN 5613	ET .		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 900	WN-C stated would issues and PU's ba WN-C added, "If the I'm using, they will the different." There we to follow related to physician. WN-C we communication with the PU nor that it of progressed as the piudgement regarding WN-C acknowledge evaluated the wound Pressure Ulcer (PU herself, as there we involvement in the rewounds.  Upon further interviction for the wheelchair and will the would in the weelchair and will the wheelchair and will the would in the wheelchair and will the wheelchair and will the will the wheelchair and will the wheelchair and will the will the will the will the wheelchair and will the will th	I administer treatment for skin sed upon her judgment. The physician's doesn't like what sell me to use something as no Standing Orders for her wound care signed by the as unable to verify in the physician at the onset of ccurred regularly as the wound only sicians relied upon her go the proper treatments. The ed she had not always and at least weekly and the least weekly and the least of only as no interdisciplinary team management of R48's  ew both the ADON and WN-C is unaware R48 that a sushion had not been placed in for the recliner. Both staff				
	placed in his chair in ADON stated althout available in the build framed bed. They [stair-mattress when the tafter his admission staff lacked access utilized their own Notes to the NA care plan, the NA care plan, the tage of tage of the tage of tage of the tage of the tage of t	pressure relieving cushion nitially, but weren't sure. The ugh they had air mattresses ding, R48 required a larger staff] "forgot" to get him an hey got him the larger bed. The ADON confirmed the NA to the EMR care plan and A care plan. After review of the ADON agreed this care plan f any cares nor interventions the nent/prevention that NA staff on 8/24/17, at 2:30 p.m. NA)-A confirmed she had ure relieving cushion in the the ner since admission of R48.				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE	SURVEY LETED
74401 1544	OF CONTRACTION	BENTI TOXTTON NOMBER.	A. BUILDING:	<del></del>		LLILD
		00340	B. WING		08/2	4/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
HENDDI	CKS COMMUNITY HO	503 E LIN	COLN STRE	ET		
HENDKI	CKS COMMUNITY HC	HENDRIC	KS, MN 561	36		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 30	2 900			
	NA-A verified there for R48. NA-A state as she was his registaff would assist R assist him into the NA-A stated that state offload any pressur remained seated. Nowas repositioning R the bathroom 3-4 time repositioned the restolleting needs and instructed to repositional informational related to pressure	was no repositioning schedule of she knew R48's cares well cular NA. She explained that NA 148 to the bathroom and then recliner from the wheelchair. The aff had not attempted to be on his buttocks while he IA-A stated she felt toileting 148 since he was assisted to mes/ day. NA staff only sident upon his request for indicated she had not been tion R48 in any other way. No on was available to NA staff ulcer care or interventions on				
	Review of the 2009 Skin Policy and Procedure identified that a baseline assessment of the resident's skin would be completed upon admission. This exam would include a physical examination of a resident's skin, a Braden risk assessment, and a comprehensive assessment of the resident's history and physical condition. The results of the tissue tolerance testing would help determine the repositioning schedule. Further assessments were to be made 3 days after admission, including re-assessment of the residents skin, along with a bowel and bladder assessment. Nursing staff were to have utilized those results and trained front-line care-givers and developed an immediate prevention plan. When a skin ulcer is identified, the physician was to identify the type of ulcer and provide skin treatment orders. The wound was to have been re-assessed weekly, and if not improved within 2 weeks, staff were to have notified the provider and seek an order for a wound consult. The care plan was to have included the resident's impaired					

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00340	B. WING		08/2	4/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
HENDRIG	CKS COMMUNITY HO	)SPITAI	COLN STRE KS, MN 561			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	SHOULD BE COMPLETE	
2 900	checks, treatment, of resident and fam provide care were to Direct care staff we interventions for ea were to be brought (Pressure ulcer tea Review of the Pressure ulcer tea Review of the Pressure ulcer tea August 2013, will be completed weeks, then quarter assessments. The Analysis Tool was to determine potential pressure ulcer(s). It within 2 weeks, the notified.  SUGGESTED MET director of nursing (the pressure ulcer proculd provide educate importance of a implementing pressure ulcer procupied implemented. The cassurance committed the appropriate care	attinence, skin condition pain, infection, and education paily. Nursing personnel who to have pressure ulcer training. The to be instructed on all the resident. Monitoring results to the interdisciplinary team m).  Sure Ulcer Prevention policy the indicated the Braden scale weekly after admission for 4 rly and with comprehensive Pressure Ulcer Root Cause to have been utilized to the factors that caused the form the wound had not improved provider was to have been  THOD OF CORRECTION: The the protocol. In addition, the DON the protocol in addition, the DON the protocol in addition, the protocol in addition to the nursing staff on the sessing pressure ulcers and the sure reducing interventions. The protocol is a system for the nursing the protocol in a system for the	2 900	DETIGINATION OF THE PROPERTY O		
21375		0 Subp. 1 Infection Control;	21375			10/3/17

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION  ::		(X3) DATE SURVEY COMPLETED	
		00340	B. WING		08/	24/2017	
NAME OF	PROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY,	STATE, ZIP CODE			
HENDRI	CKS COMMUNITY HO	SPITAI	LINCOLN STR RICKS, MN 56				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
21375	Continued From pa	ge 32	21375				
	Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment.  This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility also failed to ensure staff implemented proper infection control technique during 1 of 1 resident (R48) dressing change, that proper disinfection procedures were followed for resident equipment (whirlpool tub, multi-use clippers/shavers, humidifier, etc.) and that dirty items were not intermingled with clean items located in the clean utility room and/or medication cart. This had the potential to affect the 56 residents who reside in the facility.						
			e hat or	Corrected			
	Findings include:						
	8/21/17, at 3:04 p.n utilized had a humid with R56 and his fa confirmed the humi from a local store a that nursing staff fill water from the sink replacement and/or	alk through of the facility on n. it was noted that R56 differ in his room. Interview mily member at this time, differ had been purchased few months ago. It was noted the humidifier with tap and no routine filter equipment cleaning occurrence.					
	indicated resident of the sink next to bar- utility room had plur corroded. The resident the sinks in all 3 cleans graduated containe	is on 8/21/17, at 3:04 p.m. care items were stored under pipes. The central hall clembing pipes which were dent care items stored under utility rooms included: rs (used to measure urine bags when emptied).	an				

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	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPI IDENTIFICATION		, ,	E CONSTRUCTION		SURVEY PLETED
		00340		B. WING		08/	24/2017
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE	,	
HENDRI	CKS COMMUNITY HO	SPITAL		COLN STRE			
(X4) ID PREFIX TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21375	Continued From particles bedpans and wash central hall clean ustaff walkie-talkies. purses were stored utility room. In the waster the central hall, a divisible hair and skir head was stored. It room had portable were visibly dirty or gravel was noted on In addition, clean a intravenous supplied 3:15 p.m., while in tub, a large hole was approximately 3 feet hole had exposed pelectrical boxes in the dirty with dust and surface area. A state located inside the work on 8/21/17, at 3:25 toe nail trimmers with the whirlpool tub root trimmers appeared skin and nail debrishall had staff persoon the clean counter.  On 8/21/17, at 3:35 located on the west visible nail trimming counter.  On 8/21/17, at 6:24 the evening meal in seated at a table in attempted to feed at the resident declined.	basins. Also stor- tility room were vis Personal staff drii on the counter in whirlpool tub room irty, soiled electric in particles in the re was noted the who oxygen tanks store in the floor beneath ind/or sterile respir is were stored in the the central hallway as noted in the wal et high by 2 feet wi oipes, wood beam is he wall. It appear debris and was no iff purse was store whirlpool tub room is p.m. it was noted ere stored on the om in the east hal severely rusted a is. The clean utility nal drinks and pur er. is p.m. the whirlpool thall also had nail gs evident when st it p.m. during obse ursing assistant (N the dining room was an unidentified resi	sibly soiled nks and the clean located in shaver with emovable nirlpool tub ed which the tank and he the tanks. Fatory and his room. At y whirlpool ll, ide. This s and red visibly of a cleanable d on a chair.  I that dirty counter in ll. These nd contained in the east rese located of tub room clippers with tored on the ervation of NA)-B was where she ident. After				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00340	B. WING		08/2	4/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HENDRI	CKS COMMUNITY HO	)SPITAI	COLN STRE KS, MN 561			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21375	stand up and move sanitizing her hand another unidentified speaking to her and to assist with feedir the table and proce a bib apron from a NA-B failed to implehand sanitization be was noted that NA-hands and then tou NA-B transported the room via the reside.  When observed on registered nurse (R (coffee) located on during morning me medication cart, a fleth dirty sharps cor and syringes are routhe flashlight was unwhen neurological and brain activity) with staff.  During an observate R48's foot on 8/23/down on the floor to heel wound. After discarded the soiled the floor, removed from his left lower legarbage, RN-A him in his wheelched donned clean glove sanitizing her hand.	d away from the table without s. NA-B proceeded to touch d resident's shoulder while d returned to the first resident ng. NA-B then stood up from seded to assist with removal of third unidentified resident. The ement handwashing and/or etween resident contacts. It B wiped her nose with bare ched another resident's arm. The resident from the dining	21375			

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00340	B. WING		08/	24/2017	
NAME OF	PROVIDER OR SUPPLIER			TATE, ZIP CODE			
HENDRI	CKS COMMUNITY HO	SPITAI	ICOLN STREI KS, MN 561:				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
21375	glucose check, RN- picked up the gluco check blood glucos it clean with a disinf glucometer on the r of coffee and transp RN-A did not disinfe placing the soiled g cart. When interviewed of	A removed the soiled gloves, meter (machine used to e) with bare hands and wiped fectant wipe. RN-A placed the medication cart next to her cup ported R48 to the dining room. ect the top of the cart prior to lucometer onto the medication on 8/23/17, at 9:41 a.m. RN-A					
	agreed it was not good practice to sit and/or lay on the floor during a dressing change to prevent contamination of her clean scrub uniform. RN-A indicated she was unaware she had not used gloves to remove R48's leg dressings, but confirmed she was "in a hurry". RN-A also indicated she was told by "everyone" that having coffee on the medication cart was ok and was unaware this was an infection control concern. She confirmed that staff routinely store the flash light on top of the dirty sharps container and was unaware of any disinfection procedure related to this equipment.						
	RN-C stored the fla checked on top of t located on the med noted a box of Inter next the container,	on 8/23/17, at 10:00 a.m. that shlight used for neurological he dirty sharps container ication cart. In addition, it was r-dry dressings were located available for staff use since it medication cart according to					
	director of nursing ( cross-contamination noted observations clean/soiled equipm	on 8/23/17, at 10:08 a.m. the (DON) agreed that n was a concern with the green green green green green and lack of proper as her expectation staff were					

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPI IDENTIFICATION		` '	E CONSTRUCTION	(X3) DATE COMF	SURVEY
		00340		B. WING		08/2	24/2017
NAME OF PRO	OVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HENDRICK	S COMMUNITY HO	SPITAL		COLN STRE KS, MN 561			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIEN ' MUST BE PRECEDED SC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
tod ah b V w w A a b p re D w D c a iti p u b D d ir a to a o w D d re C c lo	continued From particular properties of follow appropriate uring dressing charged she expected andwashing and/of etween resident convert nurses station where now located of diagreement to these diagreement of the efficient of t	e infection control anges. The DON anges. The DON and NA-B to implement use of hand sandontact.  8/23/17, at 11:59, a box of Inter-dry on the nurses static ressings was a cuter a large 18 ouned staff member's floor next to the most of the noted concent 8/23/17, at 1:00 was unaware of the missing the rest in the clean unafter viewing the rest in the sink with constant to the same and the sink with constant to the same and the same and the uses the confirmed the uses to confirmed the uses to confirmed the total and not properly clean of the when toured at 1:0 and not properly clean of the whirly all hall whirlpool turns and not properly clean of the whirly all hall whirlpool turns and not properly clean of the whirly all hall whirlpool turns and not properly clean the constant of the whirly all hall whirlpool turns and not properly clean the constant of the whirly all hall whirlpool turns and the constant of the whirly all hall whirlpool turns and the constant of the whirly all hall whirlpool turns and the constant of the whirly all hall whirlpool turns and the constant of the whirly all hall whirlpool turns and the constant of the whirly all hall whirlpool turns and the constant of the whirly all hall whirlpool turns and the constant of the co	further nent itizer  p.m. at the y dressings on counter. up of coffee ace opened a cheese nedication  erns and p.m. the he cross tillity rooms resident care broaded at could be items. The ersonal pm and not ident items and powder central condition on the eaned nor after constrated pool tub b room.	21375			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00340	B. WING		08/2	24/2017
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
HENDRI	CKS COMMUNITY HO	19DITAI	NCOLN STRE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUNDERSON THE APPROPRIES OF	JLD BE	(X5) COMPLETE DATE
21375	Cen-Kleen from the would spray the whould spray the whole brush to clean the ton NA-C explained the would gather all the them in the whirlpowas not according instructions, but the by the previous DC Review of the instructions of the instructions of the instructions of the instruction of the instru	e cupboard and explained she hirlpool tub down, use the scrultub and then rinse the tub. At at the end of the day, she is combs and brushes and rinse of tub. She acknowledged that to manufacturer's guidelines of the process had been changed on at least one year ago.  Auctions for cleaning and firlpool tub, located on the wall cated staff were to have the lighthe jets, enabling the jets was noted that 31 of 56 bathed in this whirlpool tub. The determinant of the day with the service of the day. Staff had no one for use on the multi-use of the day. Staff had no one for use on the multi-use of the clinic that day for an leanse infected proximal nail one with wound cleanser, apply antibiotic] and cover with condition resolves. Intibiotic] 500 [milligrams] mg 1 daily] x 7 days. Probiotic daily				
		ed staff were not appropriately atral hall whirlpool tub nor				

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	IT OF DEFICIENCIES OF CORRECTION		R/SUPPLIER/CLIA ATION NUMBER:	` ′	E CONSTRUCTION		SURVEY PLETED
				D WING			
		00340		B. WING		08/2	24/2017
NAME OF I	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
HENDRI	CKS COMMUNITY HO	SPITAL		COLN STRE KS, MN 561			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L		CEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
21375	Continued From pa	ge 38		21375			
	multi-use resident care items. The DON was also unaware R6 had history of a toe infection in June.						
	There was no manufacturer's manual for any of the 3 whirlpool tubs provided at the time of the survey.						
	Review of the June 2014 Disinfection of Non-critical Patient Care Equipment policy indicated cleaning and disinfecting of semi-critical items (items that may come into contact with mucous membranes or non-intact skin) required a high level disinfectant, and whenever possible were to be sent to the central supply reprocessing in the adjacent hospital. Non-critical items were to be cleaned with a quaternary product or bleach. Patient equipment was to be disinfected immediately following patient use and when an item was contaminated with blood or potentially infectious material or body fluids. Room air humidifiers were not to be supplied to residents or brought in for use.						
	Review of the Augustalian policy indicated har performed by staff removing gloves, we contaminated. A had decontaminate han residents, after conwhen staff member with resident care exicinity of a resident	nd hygiene water and and then hands wantizer was between a tact with a result hands can equipment in	as to have been fter donning or vere visibly dirty or was to be used to direct contact with sident's skin, and ne into contact				
	SUGGESTED MET The director of nurs staff responsible fo monitor for ongoing	sing could giv r preventing i	re education to all infection. Also to				
	TIME PERIOD FOR	R CORRECT	ION: Twenty-one				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00340	B. WING		08/2	4/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
HENDRIG	CKS COMMUNITY HO	ISPITAI	COLN STRE KS, MN 561			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21375	Continued From page 39		21375			
	(21) days.					
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control		21390			10/3/17
	control program muprocedures which pare collection to identify residents;  B. a system for control of outbreaks  C. isolation and reduce risk of trans  D. in-service exprevention and con  E. a resident he immunization progration of resident in part 465 procedures of resident the prevention and  F. the development of the procedures, including defined in part 4656.  G. a system for the products which affed disinfectants, antised incontinence products. In methods for a current standards of the collection of the procedures of the products which affed disinfectants, antised incontinence products.	ealth program including an am, a tuberculosis program as 8.0810, and policies and lent care practices to assist in treatment of infections; ment and implementation of olicies and infection control a tuberculosis program as 3.0815; reviewing antibiotic use; review and evaluation of lect infection control, such as eptics, gloves, and cts; and maintaining awareness of of practice in infection control.				
	by: Based on observati review, the facility to	ent is not met as evidenced on, interview, and document o implement a program to k of Legionnaires' Disease (a		Corrected		

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00340	B. WING		08/2	4/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
HENDRIG	CKS COMMUNITY HO	ISPITAI	COLN STRE KS, MN 561			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
21390	Continued From page 40		21390			
	type of pneumonia caused by legionella bacteria) in the water system which had the potential to effect all 56 residents residing in the facility, visitors, and staff.					
l	Findings include:					
	When interviewed on 8/23/17, at 10:05 a.m. the director of nursing (DON) confirmed the facility currently lacked any policy related to Legionnaire's disease and had not conducted a facility risk assessment to identify where waterborne pathogens could grow and/or spread in the water system. The DON indicated the hospital care manager and emergency preparedness coordinator from the attached hospital had attended a webinar titled Legionella Management Control Plan on 6/20/17; however, they had not yet developed and/or implemented such a program.					
	The director of nursing develop and implementated to Legionna facility risk assessmential could educate staff assessment and as	HOD OF CORRECTION: sing (DON) or designee, could nent policies and procedures ires' disease and ensure the nent is completed and ly. The DON or designee on the policies and the quality surance committee could dits to ensure compliance.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21530	MN Rule 4658.1310	A.B.C Drug Regimen Review	21530			10/3/17
	reviewed at least m	en of each resident must be onthly by a pharmacist y the Board of Pharmacy.				

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	IT OF DEFICIENCIES OF CORRECTION		R/SUPPLIER/CLIA ATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				A. BUILDING:			
		00340		B. WING		08/2	4/2017
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HENDRI	CKS COMMUNITY HO	SPITAL		COLN STRE KS, MN 561			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC <sup>N</sup> REGULATORY OR L		CEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21530	with the pharmacis not provide adequal pharmacist believed being adversely afferefer the matter to diff the medical direct physician. If the methe attending physician does not must be referred for assessment and as by part 4658.0070. The medical direct must refer the matter assessment and as a sessment and as a sessm	e done in acceptate of Pharmanger Perm Care Health and Health and Health and Health and Health and the Minitex in the Minitex	ons Manual, acceutical Service re, published by uman Services, ration, April 1992. The reference of the reports of the next cated by the spart, "acted rejection of the great by the director and the rejection of the great of the next cated by the spart, "acted rejection of the great of the director adding physician. In does not concurred the reports of the next cated by the director and the rejection of the great of the director adding physician. In does not concurred the desire of the review attending or determines that the the attending or determines that the the attending or determines that the quality mittee required ing physician is ting pharmacist the quality mittee.	21530			
	This MN Requiremby:  Based on interview				Corrected		

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STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00340	B. WING		08/2	4/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
HENDRI	CKS COMMUNITY HO	ISPITAI	COLN STRE KS, MN 561			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21530	consulting pharmace Abnormal Involuntation (an assessment us movements associa anti-psychotic medimonitor medication parameters for antidentified and docureffectiveness for 2 reviewed for unneces. Findings include:  R51's quarterly Min assessment dated Interview for Menta indicating severely the use of an anti-pharmace diagnoses including depression.  The physician progindicated R51 had a toward peers. R51 anti-psychotic meditation and twice a day (BID) with Falls psychiatry on the physician psychological psycholog	cist failed to identify that the ary Movement Scale (AIMS)-sed to assess involuntary ated with the use of cation) had been conducted to side effects and that acid administration were mented to monitor of 5 resident (R51, R42) essary medications.  imum Data Set (MDS) 6/2/17, identified a Brief I Status (BIMS) score of 5 impaired cognition. It identified sychotic (AP) medication and graph Alzheimer's disease and ress note dated 5/25/17, exhibited aggressive behavior was prescribed Seroquel (an cation) 25 milligrams (mg) with plan to follow up with Sioux 6/6/17.  hiatry progress note dated order to increase R51's D to Seroquel 25 mg in the AM graph at bedtime.  hart did not reveal a baseline had been completed to dyskinesia (abnormal ents) as a potential side effect	21530			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00340	B. WING		08/	24/2017
	PROVIDER OR SUPPLIER	SPITAI 503 E	FADDRESS, CITY, S LINCOLN STREI RICKS, MN 5613	ET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21530	reviews dated, 5/30 not identify the lack When interviewed of assistant director of an AIMS assessment for R51, though the The ADON stated at completed upon addithereafter. If a new initiated, an AIMS safter initiation.  The policy titled Concevised 2/10, included Baseline upon addithereafter. of new anti-psychological process of the medical form of the policy titled Concevised 2/10, included Baseline upon addition months thereafter. Of new anti-psychological form of the policy titled Concevised 2/10, included Baseline upon addition assessment dated had a (BIMS) of 5 in impairment.  R42's current physical included Maalox Research upon additional months and the process of the medical form of the me	age 43 D/17, 6/29/17, and 7/16/17, of an AIMS assessment.  On 8/24/17, at 1:55 p.m. the finursing (ADON) confirmed that had never been complete the resident was "On her list". It is a baseline screening is lamission then every 6 month that anti-psychotic medication is creening is completed 30 days after initialization and then every six. Thirty days after initialization tic and discontinuation.  Simum Data Set (MDS) D/24/17, identified that R42 andicating severe cognitive dician orders dated 7/27/17, regular Strength (medication appears) 2-4 teaspoons (tsp)  Indication administration record that as a sordered; however, it is an ordered; however, it is an ordered that pharmacist monthly outlant pharmacist monthly o	ed s s s ays			
	recommendations/i	ultant pharmacist monthly reviews from 6/16 through entify a recommendation ox order including paramete	rs			

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00340	B. WING		08/	24/2017	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S				
HENDRI	CKS COMMUNITY HO	SPITAI	ICOLN STREE KS, MN 5613				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE	
21530	Continued From pa	ge 44	21530				
		of staff documentation of ed to monitor effectiveness.					
	(MAR) identified R4 Maalox on a daily b	cation administration record 2 was being administered the asis as ordered; however, it mount of Maalox being					
	registered nurse (R R42 how much Mad stomach was feelin administer a dose a symptoms. RN-A d expected to docum	on 8/23/17, at 1:27 p.m.  N)-A stated she would ask alox she wanted or how her g. RN-A indicated she would according to R42's response or onfirmed that nursing staff are ent the amount of Maalox She verified this was lacking a reviewed.					
	licensed practical n would administer 4 wanted the maximu available. LPN-A vo	on 8/23/17, at 1:31 p.m. urse (LPN)-A indicated she tsp. of Maalox as R42 usually am amount of Maalox erified the physician order without parameters; indicating e clearer.					
	stated the lack of pa and should be more document the amou	8/23/17, at 1:45 p.m. RN-B arameters "leaves leeway" e specific and staff need to unt administered to or resident response to the					
	director of nursing ( expect staff to clarif consulting pharmac concise/clear orders	8/23/17, at 3:36 p.m. the (DON) indicated she would by the order and/or the cist. She further indicated that is were a standard of practice.					

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00340	B. WING		08/2	4/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
HENDRI	CKS COMMUNITY HO	)SPITAI	COLN STRE KS, MN 561			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMBRIO  TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
21530	Continued From pa	ge 45	21530			
	actual amount adm	inistered to R42.				
	Facility consultant pharmacist was unavailable for interview due to family emergency.					
	SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper monitoring of medication usage. Nursing staff could be educated as necessary to the importance of the pharmacist's review. The DON or designee, along with the pharmacist, could audit medication reviews on a regular basis to ensure compliance.					
	(21) days.	R CORRECTION: Twenty-one				
21535	MN Rule4658.1315 Drug Usage; Genel	Subp.1 ABCD Unnecessary	21535			10/3/17
	must be free from unnecessary drug in A. in excessive therapy; B. for excessive therapy; B. for excessive therapy; C. without adece D. in the prese which indicate the codiscontinued. In addition to the dipart 4658.1310, the with provisions in the Code of Federal Ref 483.25 (1) found in Operations Manual Long-Term Care Fa	al. A resident's drug regimen unnecessary drugs. An sany drug when used: dose, including duplicate drug e duration; quate indications for its use; or nce of adverse consequences dose should be reduced or rug regimen review required in e nursing home must comply ne Interpretive Guidelines for egulations, title 42, section Appendix P of the State, Guidance to Surveyors for acilities, published by the Ith and Human Services,				

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	NT OF DEFICIENCIES OF CORRECTION			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00340	B. WING		08/2	4/2017
	PROVIDER OR SUPPLIER CKS COMMUNITY HO	SPITAI 503 E LIN	DRESS, CITY, S COLN STRE KS, MN 561			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21535	Health Care Finance This standard is incomovable through the	ing Administration, April 1992. corporated by reference. It is ne Minitex interlibrary loan te Law Library. It is not	21535			
	by: Based on interview facility failed to ensi Movement Scale (A to assess involunta the use of anti-psyc completed to monit document the amou administered for 2 of	and document review the ure an Abnormal Involuntary alMS)-(an assessment used ry movements associated with thotic medication) was or for side effects and to unt of liquid medication of 5 residents (R51, R42) essary medications.		Corrected		
	assessment dated Interview for Menta indicating severely the use of an anti-p	imum Data Set (MDS) 6/2/17, identified a Brief I Status (BIMS) score of 5, impaired cognition. It identified sychotic (AP) medication and g Alzheimer's disease and				
	indicated R51 had e toward peers. R51 anti-psychotic medi	ress note dated 5/25/17, exhibited aggressive behavior was prescribed Seroquel (an cation) 25 milligrams (mg) ith plan to follow up with Sioux 6/6/17.				
	6/6/17 included an	hiatry progress note dated order to increase R51's O to Seroquel 25 mg in the AM g at bedtime.				

Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00340	B. WING		08/2	4/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	l.	STATE, ZIP CODE		
HENDRI	CKS COMMUNITY HO	ISPITAI	COLN STRE KS, MN 561			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21535	Continued From pa	ge 47	21535			
	AIMS assessment monitor for tardive involuntary movemerelated to the use of t	hart did not reveal a baseline had been completed to dyskinesia (abnormal ents) as a potential side effect f Seroquel.  on 8/24/17, at 1:55 p.m. the f nursing (ADON) confirmed				
	an AIMS assessme for R51. The ADON is completed upon thereafter; further e antipsychotic medic	ent had never been completed a stated a baseline screening admission and every 6 months explaining that if a new cation is initiated, an AIMS eted 30 days after initiation.				
	revised 2/10, includ Baseline upon adm months thereafter.	mpletion of Assessments, led: Tardive Dyskinesia: ission and then every six Thirty days after initialization c and discontinuation.				
	included Maalox Reused for stomach u	cian orders dated 7/27/17, egular Strength (medication pset) 200-200-20 milligrams ) 2-4 teaspoons (tsp)				
	(MAR) identified R4 Maalox on a daily b	cation administration record 2 was being administered the asis as ordered; however, it mount of Maalox being				
	registered nurse (R R42 how much Mas stomach was feelin administer a dose a	on 8/23/17, at 1:27 p.m. N)-A stated she would ask alox she wanted or how her g. RN-A indicated she would according to R42's response or confirmed that nursing staff are				

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00340	B. WING		08/2	4/2017
	PROVIDER OR SUPPLIER	SPITAI 503 E LIN	DRESS, CITY, S COLN STRE KS, MN 561			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21535	expected to docume (tsp)administered. Such from documentation when interviewed of licensed practical in would administer 4 wanted the maximula available. LPN-A viccontained a range with the order should be buring interview on stated the lack of particular propriately monition medication.  During interview on of nursing (DON) in to clarify the order a actual amount administry of particular amount administry of psychellogical procedures and procedure and procedures, and aucompliance. The fathe quality assurance recommendations to the such procedures and procedures and procedures and procedures and aucompliance. The fathe quality assurance recommendations to the such procedures and procedures and procedures and aucompliance. The fathe quality assurance recommendations to the such procedures and procedures an	ent the amount of Maalox She verified this was lacking in reviewed.  on 8/23/17, at 1:31 p.m.  urse (LPN)-A indicated she tsp. of Maalox as R42 usually im amount of Maalox erified the physician order without parameters; indicating clearer.  8/23/17, at 1:45 p.m. RN-B arameters "leaves leeway" e specific and staff need to unt administered to or resident response to the  8/23/17, at 3:36 p.m. director dicated she would expect staff and nursing staff document the	21535			

6899

Minnesota Department of Health STATE FORM

F5467026

PRINTED: 09/27/2017 FORM APPROVED OMB NO. 0938-0391

	ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION NG <b>01 - MAIN BUILDING 01</b>	(X3) DATE SURVE COMPLETED	
		245467	B. WING		08/23/201	17
	PROVIDER OR SUPPLIER	DSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 503 E LINCOLN STREET HENDRICKS, MN 56136		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ( (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPL	(5) LETION ATE
K 000	INITIAL COMMEN	TS	К0	00		
	FIRE SAFETY					
	01 Main Building					
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH	OC WILL SERVE AS YOUR COMPLIANCE UPON THE ACCEPTANCE. YOUR HE BOTTOM OF THE FIRST IS-2567 WILL BE USED AS F COMPLIANCE.				
	ONSITE REVISIT OF CONDUCTED TO SUBSTANTIAL COREGULATIONS HA	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.				
	Minnesota Departn Fire Marshal Division Hendricks Commus was found not in correquirements for particular Medicare/Medicaid 483.70(a), Life Safe edition of National (NFPA) Standard 1 Chapter 19 Existing	articipation in at 42 CFR, Subpart ety from Fire, and the 2012 Fire Protection Association 01, Life Safety Code (LSC), g Health Care.				
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K	R THE FIRE SAFETY		LIVU		
	Health Care Fire In State Fire Marshal 445 Minnesota Stre	Division				
ABODATOD	/ DIDECTOR'S OF PROVIE	DED/SUDDITED DEDDESENTATIVE'S SIG	NATURE	TITI F	(X6) DA	TE.

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.

If continuation sheet Page 1 of 7

09/26/2017

TITLE

**Electronically Signed** 

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

PRINTED: 09/27/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A, BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED		
		245467	B, WING	-		08/2	23/2017
	PROVIDER OR SUPPLIER  CKS COMMUNITY HO	SPITAL		50	REET ADDRESS, CITY, STATE, ZIP CODE 3 E LINCOLN STREET ENDRICKS, MN 56136		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDERICIENCY)	) BE	(X5) COMPLETION DATE
K 000	DEFICIENCY MUS FOLLOWING INFO  1. A description of volto correct the deficition of volto correct the deficition.  2. The actual, or properties of the properties of the properties of the proving the province of the province	tate.mn.us  n@state.mn.us  RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION:  what has been, or will be, done ency.  oposed, completion date.  r title of the person rection and monitoring to ence of the deficiency  nity Hospital Nursing Home is follows: g was constructed in 1969, is asement, is fully fire sprinkler determined to be of Type ; as constructed in 1987, is asement, is fully fire sprinkler determined to be of Type ; n was constructed in 1993, is asement, is fully fire sprinkler determined to be of Type ; n was constructed in 1993, is asement, is fully fire sprinkler determined to be of Type	K	000			

Event ID: 087E21

PRINTED: 09/27/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		245467	B. WING		08/23/2017	
	ROVIDER OR SUPPLIER	SPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 503 E LINCOLN STREET HENDRICKS, MN 56136		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE COMPLETION	
K 000	self-closing, positive door assembly.  The facility has a fix detection in the corrector which is not department notifical protected with auto	consisted of a labeled, e latching, 90-minute fire rated re alarm system with smoke ridors and spaces open to the monitored for automatic fire tion. Resident Rooms are matic smoke detectors which to the building fire alarm	K 0	00		
K 346 SS=D	The requirement at NOT MET as evide NFPA 101 Fire Alarm - Out of Where required fire services for more the period, the authority notified, and the buapproved fire watch parties left unproted fire alarm system in 9.6.1.6 This STANDARD in Based on docume the Facility failed to accurate Fire Alarm deficient practice or residents.	42 CR, Subpart 483.70(a) is need by: m System - Out of Service e alarm system is out of nan 4 hours in a 24-hour y having jurisdiction shall be ilding shall be evacuated or an a shall be provided for all cted by the shutdown until the as been returned to service.  Is not met as evidenced by: Intation review and interview, a provide a current and an Out of Service Policy. This bould effect 56 of the 56	К3	Out of Service policy for fire alarm system has been updated with the Staff/Fire Marshall contact inform Maintenance will maintain policy a update as indicated.	e current ation.	

Facility ID: 00340

PRINTED: 09/27/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIE AND PLAN OF CORRECT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	COMP	LETED
		245467	B. WING_		08/2	3/2017
NAME OF PROVIDER O		OSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 503 E LINCOLN STREET HENDRICKS, MN 56136		
PREFIX (EACH	I DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
period, the notified, a approved parties let fire alarm 9.6.1.6  FINDING  On facilition 08/23, that the Contact in This define Maintena NFPA 10 System of contact in Where the extent and determing inspected recomme or design department of the bundapproved system has 3.5.1, This STA Based of the bundapsed of the	for more to the authority and the build fire watch of the system of the	han 4 hours in a 24-hour by having jurisdiction shall be uilding shall be evacuated or an high shall be provided for all cted by the shutdown until the has been returned to service.  DE:  ween 11:00 AM and 1:00 PM cumentation review revealed vice Policy for the Fire Alarm ave current Staff/Fire Marshaln.	K 34		ck-Up	9/26/17

Event ID: 087E21

PRINTED: 09/27/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED		
		245467	B. WING		08/2	23/2017
NAME OF PROVIDER OR SUPPLIER HENDRICKS COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 503 E LINCOLN STREET HENDRICKS, MN 56136			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETION DATE
K 354	54 Continued From page 4 K 354					
		turate Fire Sprinkler Out of Service Policy. This icient practice could effect 56 of the 56 staff/Fire Marshal contact information. The 10-hour out of service time has be		as been of Fire		
	extent and duration determined, areas of inspected and risks recommendations are or designated repredepartment and oth jurisdiction have be sprinkler system is 10 hours in a 24-ho portion of the building an approved fire was sprinkler system has	r system is impaired, the of the impairment has been or buildings involved are		maintain policy and update as ind	nance will	
	on 08/23/2017, doc that the Out of Serv Sprinkler System do Fire Marshal contact	veen 11:00 AM and 1:00 PM cumentation review revealed vice Policy for the Fire oes not have current Staff/ ct information and the 10 hour needs to be updated.				
K 711	Maintenance Direct	ice was verified by the Facility tor. ion and Relocation Plan	K 711			9/26/17
SS=E	patients and for the an emergency.	location Plan lan for the protection of all ir evacuation in the event of iodically instructed and kept				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G 01 - MAIN BUILDING 01		E SURVEY PLETED
		245467	B. WING _		08/	23/2017
	PROVIDER OR SUPPLIER	OSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 503 E LINCOLN STREET HENDRICKS, MN 56136		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
K 711	copy of the plan is operator or with sebasic response recand provides for al components per 18.7.1.1 through 18.7.2.3, 19.7.1.1 through 19.7.2.2, 19.7.2.3 This STANDARD Based on docume the Facility failed to Relocation Plan ac Code. This deficients for residents  Evacuation and Restriction and Facility failed to Relocation Plan ac Code. This deficients for residents  Evacuation and Restriction and Facility and for the an emergency. Employees are perinformed with their copy of the plan is telephone operator addresses the base per 18/19.7.2.1.2 as safety plan components. Through 18.7.2.3, 19.7.1.1 through 19.7.2.2, 19.7.2.3  FINDINGS INCLU  On facility tour better on 08/23/2017, do the Facility Fire En	duties under the plan, and a readily available with telephone curity. The plan addresses the quired of staff per 18/19.7.2.1.2 I of the fire safety plan 3/19.2.2. 8.7.1.3, 18.7.2.1.2, 18.7.2.1.2, through 19.7.1.3, 19.7.2.1.2, is not met as evidenced by: entation review and interview, or maintain a Evacuation and cording to the 2012 Life Safety it practice could affect 56 of the elocation Plan plan for the protection of all ein evacuation in the event of criodically instructed and kept duties under the plan, and a readily available with readily a	K 71	The Facility Fire Emergency Plant been updated to include respons the employee who discovers smand/or fire to call 911. Staff educed departments has been communic Maintenance will maintain policy update as indicated.	ibility of oke ation to cated.	

Facility ID: 00340

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				SURVEY PLETED		
		245467	B. WING	<del></del>	08/2	23/2017
	PROVIDER OR SUPPLIER	SPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 503 E LINCOLN STREET HENDRICKS, MN 56136		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
	Maintenance Direct NFPA 101 Electrical Systems List in the REMARK Chapter 6 Electrical are not addressed are deficient. This is applicable Life Safe citation, should be Chapter 6 (NFPA 9 This STANDARD is Electrical Systems List in the REMARK Chapter 6 Electrical are not addressed are deficient. This is applicable Life Safe citation, should be Chapter 6 (NFPA 9 effect 56 of the 56 FINDINGS INCLUITY On facility tour betwon 08/23/2017, item within 36 inches of shut off switches in Room.	ice was verified by the Facility tor.  Il Systems - Other  Other  (S section any NFPA 99 I Systems requirements that by the provided K-Tags, but information, along with the ety Code or NFPA standard included on Form CMS-2567.  9) Is not met as evidenced by: Other  (S section any NFPA 99 I Systems requirements that by the provided K-Tags, but information, along with the ety Code or NFPA standard included on Form CMS-2567.  9) This deficient practice could residents.  DE:  Veen 11:00 AM and 1:00 PM ins were observed being stored electrical access panels and the West Pod Mechanical	K 71		6 inch and shut	9/26/17

Facility ID: 00340