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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: O87E

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00340

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

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

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

4. TYPE OF ACTION: **7** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/13/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Kathryn Serie, Unit Supervisor 10/24/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Certification Specialist 10/24/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
10/06/2017
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

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

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

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

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

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

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: O87E

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00340

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/24/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date :
Wendy Buckholz, HFE-NE II — 09/27/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Joanne Simon, Certification Specialist — 10/06/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245467	A. BUILDING _____ B. WING _____	08/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 8/21, 8/22, 8/23 and 8/24/17, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Upon receipt of an acceptable POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is,	F 157		10/3/17

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

Electronically Signed | 09/26/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245467	A. BUILDING _____ B. WING _____	08/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 1 a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This 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. Findings include:	F 157	R48 wound status has been reviewed by medical provider along with ADON WOCN monitoring. Provider is scheduled to see R48 on 9/29/2017 to reassess pressure sites. Skin Care and Pressure Ulcer Prevention policies reviewed. CNA staff meeting 9/12/2017 included staff role in effective	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245467	A. BUILDING _____ B. WING _____	08/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 2 R48 was admitted on 6/15/17. Review of his electronic medical record (EMR) indicated his diagnoses at the time of admission were coronary artery disease, chronic kidney disease and diabetes. The Resident Assessment form dated 6/15/17, indicated that R48 had a reddened area on the left buttock. Review of R48's Short Term Care Plan Skin Integrity form dated 7/8/17, indicated R48 had decreased sensation and mobility. He had a pressure ulcer (PU) to the right heel. Interventions included: notify physician of wounds and treatments. Review of the Short Term Care Plan Skin Integrity form dated 8/1/17, indicated R48 had PU to left buttock. Interventions noted included the physician was to be notified at that time. 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 physician notification documented. (3) 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	F 157	communication to supervising nurse relevant to status of resident skin issues. Licensed Nursing Staff education at 9/20/2017 staff meeting on requirement for provider notification in the event a new or update in status of a pressure injury is identified requiring physician assessment and update in orders if indicated to resident's medical plan of care. This will be accomplished by Nursing completing an encounter form with nursing documenting wound status and referral for medical evaluation. Medical Staff meeting 9/12/2017 included standard of care requirement for provider assessment of new or status changed pressure injury for purposes of confirming or updating medical plan of care. ADON WOCN and Medical Director met on 9/26/17 confirming process update. This will be reviewed at 10/3/2017 Medical Staff meeting. Periodic provider rounds to be inclusive of assessment, order review and documentation of wound status as it applies to the resident. ADONs and Director to oversee quality monitoring on a weekly basis to assure timely referral by nursing staff for any pressure injuries requiring provider evaluation.	

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nor that staff reported the PU to the physician. However, the PCP noted R48 had prolonged activity in his chair and planned to order physical therapy (PT) to improve muscle function. WN-C made no mention of contacting the physician.
(4) On 7/8/17, (18 days later), WN-C re-assessed and documented a Stage II heel PU with slight purple bruising around edges 3.5 centimeters (cm) x 2 cm. WN-C painted the heel with Betadine and left open to air; added a heel protector for R48 to wear when in bed and/or to off-load pressure. WN-C also noted a podiatry appointment was being considered. There was a box check marked YES for follow-up requested. 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

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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-open 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.
(9) On 8/18/17, (9 days later), the WN-C documented left buttock PU measured (#1) 0.5 cm x 0.5 cm and (#2)PU resolved. Right heel PU-3.5 cm x 6 cm black scab and starting to peel on the edge. No physician notification documented.

No other progress notes by any other nursing staff were made except by WN-C.

Interview and document review on 8/24/17, at 12:24 p.m. with the assistance director of nursing (ADON) and WN-C confirmed physician notification at PU onset and/or at the time the wounds had changed had occurred.

Review of the 2009 Skin Policy and Procedure indicated upon identification of a skin ulcer, the physician was to identify the type of ulcer and if not improved within 2 weeks, staff were to notify the provider and seek an order for a wound consult.

Review of the Pressure Ulcer Prevention policy dated August 2013, indicated if the wound had not improved within 2 weeks, the provider was to be notified.

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F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the	F 279		10/3/17

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F 279	Continued From page 6 findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a care plan was developed related to anticoagulant therapy for 1 of 1 resident (R42) reviewed for unnecessary medications. Findings include: R42's quarterly Minimum Data Set (MDS) assessment, dated 5/24/17, identified R42 was receiving an anticoagulant medication. R42's current physicians orders dated 7/27/17, included an order for warfarin sodium (blood thinner) 4 milligrams (mg) every Wednesday and Saturday and 5 mg every Monday, Tuesday, Thursday, Friday, and Sunday for diagnosis of atrial fibrillation (irregular heartbeat).	F 279	R42 care plan updated as of 8/25/2017 to include monitoring for increased risk for bleeding relevant to anticoagulant therapy. Care Plan policy reviewed and confirmed as up to date. 9/12/2017 CNA staff meeting included importance to communicate to supervisory nurse any observation and/or identification of resident condition changes that could be related to medication side effects. 9/20/2017 Licensed nurse meeting included role of nurses to engage in updating care plans as resident condition changes. Care plan documentation education has been initiated with nursing staff. Report processes under review to	

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F 279	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 3:09 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 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 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.	F 279	enhance care plan update communication for multi-disciplinary team. Weekly Multi-disciplinary team meetings to include relevant care plan updates. Pharmacist reviews medication profiles and provides input for medical and nursing consideration as to side effect and/or medication contraindication. Facility is striving to enhance electronic medical record documentation with plan to increase utilization of Point Click Care software system to support alerts for monitoring resident of potential risk for conditions relevant to medication side effects. ADON Care Coordinator and Director will be responsible to oversee bi-monthly quality assurance monitoring of care plan accuracy.	
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282		10/3/17

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F 282	Continued From page 8 (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, 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. Findings include: R48 was admitted to the facility on 6/15/17. Review of his electronic medical record (EMR) indicated his diagnoses at the time of admission were coronary artery disease, chronic kidney disease, and diabetes. R48's 6/15/17 Resident Assessment form indicated his left buttock had a reddened area. Review of the current EMR care plan, accessed only by licensed nurses, revealed on 6/22/17, the following interventions were to have been implemented for R48: (1) Administer treatments as ordered and monitor for effectiveness. (2) Assess/record/monitor wound healing weekly. Report improvements and declines to the doctor. (3) "needs a pressure reduction cushion in his wheelchair (w/c)". (4) "needs to turn/reposition at least every 2 hrs,	F 282	R48 buttock injury resolved 9/21/2017. Had pressure reduction air overlay on bed. Rook boot ordered 9/20/2017 per OT assessment as resident has tendency to push with toes to reposition self in bed. Concern for pressure injury occurrence to this area. Has pressure reduction heel protector on until Rook boot arrives. OT continues to work with resident for therapeutic intervention. Braden assessment repeated 9/19/2017 and again on 9/25/2017. R48 repositions self in bed to his side, but does require assist x 1-2 to boost up in bed and to lay down or sit up in bed. CNA care plan updated to reflect use of w/c for long distances; to use walker for ambulation to bathroom and in room, EZ stand if feeling weak; repositioning schedule of every 2 hours besides toileting times. Education completed with CNA staff 9/12/2017 regarding notification to supervisor nurse regarding any identification of new or problematic skin issues. Education on contributing factors leading to pressure injuries provided per ADON WOCN Staff Coordinator and	

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F 282	Continued From page 9 more often as needed or requested." Review of the Short Term Care Plan Skin Integrity form dated 7/8/17, revealed R48 had decreased sensation and mobility and a pressure ulcer (PU) to the right heel. Interventions included: (1) inspect the skin daily, cleanse the wound initially and at each dressing change (2) turn and reposition on a schedule; however, the frequency was left blank; (3) apply heel protector while in bed and in recliner; (4) Notify physician and family of wounds and treatments; and (5) weekly documentation by licensed nurse. On 8/18/17, an additional note was added to the form indicating staff were to continue to monitor as the area was firm, black with eschar. Review of the Short Term Care Plan Skin Integrity form dated 8/1/17, indicated R48 has a PU his left buttock. Interventions included: (1) inspect the skin daily, cleanse the wound initially and at each dressing change; (2) apply a Mepilex dressing every 3-5 days and as needed (PRN) (3) turning and repositioning schedule was changed from every 2 hours to every 1.5 hours; (4) a pressure 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. 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 interviewed at this time, R48 explained he was dependent upon staff for cares. It was noted there was no pressure relieving device/cushion evident	F 282	ADON Care Coordinator. Repositioning standards of care reviewed. Licensed Nurse staff meeting 9/20/2017 included standard for physician notification to assess injury site. Contributing causes for pressure injury, interventions to implement for prevention as well as documentation standards reviewed. Medical Staff meeting 9/12/2017 included review of process for provider notification in the event a pressure injury is identified and/or reflective of status update requiring provider 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 consultation with Medical Director. Policy and procedure reviewed and updated to reflect WOCN role. A weekly Interdisciplinary Team meeting includes updates on resident skin care issues and subsequent care planning. Upcoming Medical Staff Provider meeting is scheduled 10/3/2017 for purposes of engaging medical staff with regard to their role in skin care management. Director and ADONs will be responsible to oversee bi-monthly quality assurance monitoring relevant to pressure prevention, assessments, intervention and care plan review.	

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in the recliner, wheelchair or bed. It was noted that R48 was wearing a heel protector boot on his right foot.

The following morning on 8/22/17, at 9:31 a.m. R48 was seated in his recliner consuming breakfast. R48 was clothed in a hospital gown. When interviewed R48 stated he was upset staff had not yet helped him dress as he was dependent for activities of daily living (ADL's) like getting dressed, toileting, transferring, and wheeling in his chair. R48 explained staff had awakened him at 7:00 a.m. for a blood sugar check and transferred him into the recliner. R48 verified he was able to make slight movements while in bed but not while in his chair. R48 confirmed he had not changed positions in his chair since staff had assisted him at 7:00 a.m. (2 1/2 hours earlier). Further observation on 8/22/17, at 9:50 a.m. noted that R48 remained in the recliner, waiting for staff assistance with dressing and repositioning.

On 8/22/17, at 11:40 a.m. registered nurse (RN)-A was observed during a dressing change of R48's buttock and right heel. It was noted that R48 was seated in his wheelchair without a pressure-relieving cushion nor was a pressure relieving air mattress noted on the bed. When interviewed on 8/22/17, at 11:40 a.m. RN-A explained that wound nurse (WN)-C would typically measure and provide all wound care. R48's wound documentation identified the following from the 8/22/17, dressing change observation of RN-A: (1) right (R) foot wound-unstageable; measured 3.5 cm x 6 cm, black scab, starting to peel on the edge; no drainage or odor. RN-A painted R48's heel with Betadine, allowed it to air dry and covered it with

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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 nursing progress notes and physician communication indicated the following documentation:
(1) On 6/15/17, a reddened area noted on left buttock;
(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.
(3) Review of the physician progress note dated 6/29/17, indicated R48 had been seen by his primary care physician (PCP) and the PCP noted

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R48 had prolonged activity in his chair and planned to order physical therapy (PT) to improve muscle function.
(4) On 7/8/17, (18 days later), WN-C re-assessed and documented a Stage II heel PU with slight purple bruising around edges 3.5 centimeters (cm) x 2 cm. WN-C painted the heel with Betadine and left open to air; added a heel protector for R48 to wear when in bed and/or to off-load pressure.
(5) On 7/21/17, it was noted there was a physician order for Mepilex to the left buttock every 3 days and as needed. PT/OT/ST were to be evaluated on 6/15/17. There was no documentation indicating that therapies had been involved.
(6) 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.
(7) 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-open 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.
(8) Review of faxed records revealed on 8/16/17, a telephone order for occupational therapy (OT) to evaluate and treat on 8/16/17, for a pressure reduction system for R48's bed, chair, and w/c was signed by the PCP on 8/17/17.
(9) On 8/18/17, (9 days later), the WN-C documented left buttock PU measured (#1) 0.5 cm x 0.5 cm and (#2)PU resolved. Right heel PU-3.5 cm x 6 cm black scab and starting to peel on the edge. No physician notification had been documented nor had the pressure reduction

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system been implemented.

No weekly nursing progress notes (by any nursing staff) related to PU monitoring were documented except by the wound nurse (WN-C), which had not been implemented weekly as identified in the plan of care.

When interviewed on 8/24/17, at 12:24 p.m. the assistant director of nursing (ADON) and WN-C confirmed there was no Standing Order to administer treatment for skin issues and PU's. Treatment was based upon WN-C judgment. The WN-C acknowledged she had not always evaluated the wound at least weekly and the Pressure Ulcer (PU) team consisted of only herself, as there was no interdisciplinary team involvement in the management of R48's 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.

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F 282	Continued From page 14 nursing assistant (NA)-A confirmed she had never seen a pressure relieving cushion in the wheelchair nor recliner since admission of R48. NA-A verified there was no repositioning schedule for R48. NA-A stated she knew R48's cares well as she was his regular NA. She explained that NA staff would assist R48 to the bathroom and then assist him into the recliner from the wheelchair. NA-A stated that staff had not attempted to offload pressure while he remained seated in any chair and indicated she had not been instructed to reposition R48 as identified in the EMR plan of care. Review of the 2009 Skin Policy and Procedure Hendricks Nursing Home policy included: direct care staff shall be instructed on all interventions for each resident and monitoring results will be brought to the interdisciplinary team (Pressure ulcer team).	F 282		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote	F 314		10/3/17

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F 314	Continued From page 15 healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and implement the necessary services for 1 of 1 resident (R48) reviewed with two Stage II pressure ulcers located on the buttock and one unstageable heel PU. Findings include: R48's electronic medical record (EMR) face sheet indicated he'd been admitted on 6/15/17 with diagnoses including: coronary artery disease, chronic kidney disease and diabetes. The Brief Interview of Mental Status (BIMS) assessment identified on the admission Minimum Data Set (MDS) dated 6/21/17, identified a score of 11/15, indicating intact cognition. A Resident Assessment form dated 6/15/17, indicated R48 had a reddened area on the left buttock. On 8/21/17, at 5:26 p.m. R48 was observed seated in a chair in his room waiting for staff to transfer him into a wheelchair for transport to the evening meal. When interviewed at that time, R48 stated he was dependent on staff for cares. During the observation, R48 was wearing a heel protector boot on his right foot. Additionally, observation revealed no pressure relieving device/cushion was evident in the recliner, in the wheelchair or on the bed. On 8/22/17, at 9:31 a.m. R48 was observed seated in a recliner in his room eating breakfast. R48 was dressed in a hospital gown. When interviewed R48 stated he was upset staff had	F 314	R48 buttock injury resolved 9/21/2017. Had pressure reduction air overlay on bed. Rook boot ordered 9/20/2017 per OT assessment as resident has tendency to push with toes to reposition self in bed. Concern for pressure injury occurrence to this area. Has pressure reduction heel protector on until Rook boot arrives. OT continues to work with resident for therapeutic intervention. Braden assessment repeated 9/19/2017 and again on 9/25/2017. R48 repositions self in bed to his side, but does require assist x 1-2 to boost up in bed and to lay down or sit up in bed. CNA care plan updated to reflect use of w/c for long distances; to use walker for ambulation to bathroom and in room, EZ stand if feeling weak; repositioning schedule of every 2 hours besides toileting times. Education completed with CNA staff 9/12/2017 regarding notification to supervisor nurse regarding any identification of new or problematic skin issues. Education on contributing factors leading to pressure injuries provided per ADON WOCN Staff Coordinator and ADON Care Coordinator. Repositioning standards of care reviewed. Licensed Nurse staff meeting 9/20/2017 included standard for physician notification to assess injury site. Contributing causes for pressure injury, interventions to implement for prevention as well as	

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F 314	Continued From page 16 not yet helped him get dressed for the day, and verified he was dependent on staff for activities of daily living (ADL's) like getting dressed, toileted, transferring, and wheeling in his wheel chair. R48 explained staff had awakened him at 7:00 a.m. that morning for a blood sugar check and had transferred him into the recliner. R48 stated while he was able to move himself slightly while in bed, he was not able to move himself while in his chair. R48 confirmed he had not changed positions since staff had assisted him at 7:00 a.m. (2 1/2 hours earlier). During further observation at 9:50 a.m. on 8/22/17, R48 remained in the recliner and verified he was still waiting for staff assistance with dressing and repositioning. On 8/22/17, at 11:40 a.m. registered nurse (RN)-A was observed to conduct dressing changes for a PU located on R48's right heel. It was noted that R48 was seated in his wheelchair without a pressure-relieving cushion nor was a pressure relieving air mattress noted on the bed. When interviewed on 8/22/17, at 11:40 a.m. RN-A explained that wound nurse (WN)-C would typically measure and provide all wound care. R48's wound documentation identified the following from the 8/22/17, dressing change observation of RN-A: (1) right (R) foot wound-unstageable; measured 3.5 cm x 6 cm, black scab, starting to peel on the edge; no 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.	F 314	documentation standards reviewed. Medical Staff meeting 9/12/2017 included review of process for provider notification in the event a pressure injury is identified and/or reflective of status update requiring provider assessment and update in medical plan of care if indicated. ADON WOCN and ADON Care Coordinator in process of reviewing wound care management program in consultation with Medical Director. Policy and procedure reviewed and updated to reflect WOCN role. A weekly Interdisciplinary Team meeting includes updates on resident skin care issues and subsequent care planning. Upcoming Medical Staff Provider meeting is scheduled 10/3/2017 for purposes of engaging medical staff with regard to their role in skin care management. ADONs and Director will be responsible to oversee bi-monthly quality assurance monitoring relevant to pressure prevention, assessments and intervention.	

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After the dressing change was completed, R48 was transferred back into a seated position in the wheelchair. A pressure relieving cushion was not evident in the chair. Later, it was noted on 8/22/17, at 12:20 p.m. that R48 was dressed and seated in his wheelchair, still without a cushion and/or pressure relieving device in place.

During random observations on 8/23/17 and 8/24/17, R48 remained in a seated position, a cushion was not located in the wheelchair and/or recliner.

The Comprehensive Pressure Ulcer Risk Assessment dated 6/15/17, indicated R48's reddened area on his left buttock continued after a pressure points assessment after 2.5 hours. The sections labeled History of Pressure Ulcers and Skin Conditions and Summary of Comprehensive Skin Assessment were left blank. Risk factors and Interventions were also left blank and not completed by nursing staff.

The Admission Care Plan dated 6/15/17, indicated R48 was incontinent of bowel, required 1-2 staff assistance with the wheelchair and transfer between surfaces and 1 staff to walk short distances.

The Braden Score (pressure ulcer risk) score dated 6/15/17, was identified as 20, indicating R48 was not at risk for pressure ulcers. However, the information documented on the Braden Score assessment was not consistent with the assessment completed on the Admission Care Plan form dated 6/15/17. The Braden assessment identified that R48 had no impairment related to sensory perception, was rarely moist, walked occasionally and did not

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require staff assistance into chair and/or wheelchair (only slightly limited). The plan of care indicated R48 required 1-2 staff assistance with transfer. The Braden assessment identified that R48 did not have any problem or potential problem with friction or sheer, or skin concern that would have required repositioning.

Review of a physician progress note dated 8/3/16, made by certified nurse practitioner (CNP)-D indicated R48 had a monofilament test (used to assist in the detection of peripheral neuropathy) performed on his feet. CNP-D was unable to elicit a response from R48's left foot, indicating loss of sensation in his left foot. This information was in conflict with the "no impairment related to sensory perception" noted on the Braden scale. Review of laboratory data dated 6/14/17, indicated R48's albumin level was low at 2.9, which may affect wound healing.

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 current EMR care plan, accessible only by licensed nurses, revealed on 6/22/17, the following interventions were to have been implemented for R48:
(1) Administer treatments as ordered and monitor for effectiveness.
(2) Assess/record/monitor wound healing weekly. Report improvements and declines to the doctor.
(3) Inform the resident, family and caregivers of any new area of skin breakdown.
(4) Cavilon (a barrier cream) to left buttock twice daily.

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(5) "needs a pressure reduction cushion in his wheelchair (w/c)".
(6) "needs to turn/reposition at least every 2 hrs, more often as needed or requested."
(7) needs 1-2 staff assistance to help with repositioning, turning, and lying down or sitting up in bed.
(8) needs the assistance of 1-2 staff to walk short distances in his room. "Per [R48] and his family, he was utilizing his walker or wheelchair to get around his house."

The care plan was updated on 7/8/17, to reflect [R48] had a Stage II PU to the right heel and was also to wear a heel protector/boot to area as a daily treatment. No further updates were made to R48's care plan.

Review of the Short Term Care Plan Skin Integrity form dated 7/8/17, revealed R48 had decreased sensation and mobility and a pressure ulcer (PU) to the right heel. Interventions included: (1) inspect the skin daily, cleanse the wound initially and at each dressing change (2) turn and reposition on a schedule; however, the frequency was left blank; (3) apply heel protector while in bed and in recliner; (4) Notify physician and family of wounds and treatments; and (5) documentation weekly by licensed nurse. On 8/18/17, an additional note was added to the form indicating staff were to continue to monitor as the area was firm, black with eschar.

Review of the Short Term Care Plan Skin Integrity form dated 8/1/17, indicated R48 has a PU his left buttock. Interventions included: (1) inspect the skin daily, cleanse the wound initially and at each dressing change; (2) apply a Mepilex dressing every 3-5 days and as needed (PRN) (3) turning

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and repositioning schedule was changed from every 2 hours to every 1.5 hours; (4) a pressure 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 cm. -staff 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 minor 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

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did not address the buttock PU was examined nor that staff reported the PU to the physician. However, the PCP noted R48 had prolonged activity in his chair and planned to order physical therapy (PT) to improve muscle function.
(5) On 7/8/17, (18 days later), WN-C re-assessed and documented a Stage II heel PU with slight purple bruising around edges 3.5 centimeters (cm) x 2 cm. WN-C painted the heel with Betadine and left open to air; added a heel protector for R48 to wear when in bed and/or to off-load pressure.
(6) Review of R48's EMR physician's orders lacked any related to PU's until 7/8/17. At that time, there was an order for Betadine to the right heel and application of the heel protector. On 7/8/17, WN-C faxed information to the PCP's office, indicating R48 complained of heel pain and staff discovered a blister measuring 3.5 cm x 2 cm. WN-C further noted she had painted it with Betadine and placed a heel protector in R48's room, encouraging him not to use his right foot for repositioning in bed. WN-C also noted a podiatry appointment was being considered. There was a box check marked YES for follow-up requested. Documentation was also lacking to indicate podiatry services had been offered and/or follow-up occurred.
(7) 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.
(8) On 7/21/17, left buttock pressure ulcer measured 0.5 cm to 0.3 cm with superficial depth.

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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.
(9) On 7/21/17, it was noted there was a physician order for Mepilex to the left buttock every 3 days and as needed. PT/OT/ST were to be evaluated on 6/15/17. There was no documentation indicating therapies had completed the evaluations.
(10) 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. After R48 was given a tub bath, skin prep applied and Mepilex covered both areas. 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.
(11) Review of R48's faxed and/or verbal communication records revealed on 7/31/17, a fax was sent to the PCP, with notification that R48 had a "Second open area to left buttock measuring 2 cm x 0.3 cm. Mepilex covering both areas. Will monitor till healed." However, the status of the heel PU was not mentioned. No follow-up requested nor was there documentation indicating the physician had responded to the treatment orders.
(12) 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-open 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-

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Betadine and leave open to air. No physician notification documented.
(13) Review of faxed records revealed on 8/16/17, a telephone order for occupational therapy (OT) to evaluate and treat on 8/16/17, for a pressure reduction system for R48's bed, chair, and w/c was signed by the PCP on 8/17/17. There were no other signed faxed or telephone orders related to the identified PU's documented by the wound nurse.
(14) On 8/18/17, (9 days later), the WN-C documented left buttock PU measured (#1) 0.5 cm x 0.5 cm and (#2)PU resolved. Right heel PU-3.5 cm x 6 cm black scab and starting to peel on the edge.

No other weekly nursing progress notes (by any nursing staff) were documented except by the wound nurse (WN-C). The plan of care had not been implemented as indicated.

Review of the April, 2016 National Pressure Injury Advisory Panel's pressure ulcer/injury stages, http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/, indicated a Stage I pressure ulcer is a reddened area of intact skin. A Stage II pressure ulcer is a partial-thickness loss of skin with exposed dermis. An unstageable pressure ulcer/injury is defined as an obscured by slough or eschar (black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges and may be either firmer or softer than surrounding skin). A deep tissue pressure ulcer/injury is a persistent non-blanchable deep red, maroon or purple discoloration of intact or non-intact skin. Pain and temperature change often precede skin color changes.

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When interviewed on 8/24/17, at 12:24 p.m. the assistant director of nursing (ADON) and WN-C agreed the comprehensive skin assessment performed upon admission was not completed accurately. It was also confirmed the physician had not ordered the treatments for wound care. WN-C stated would administer treatment for skin issues and PU's based upon her judgment. WN-C added, "If the physician's doesn't like what I'm using, they will tell me to use something different." There was no Standing Orders for her to follow related to wound care signed by the physician. WN-C was unable to verify communication with the physician at the onset of the PU nor that it occurred regularly as the wound progressed as the physicians relied upon her judgement regarding the proper treatments. The WN-C acknowledged she had not always evaluated the wound at least weekly and the Pressure Ulcer (PU) team consisted of only herself, as there was no interdisciplinary team involvement in the management of R48's 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 staff 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 NA staff lacked access to the EMR care plan and utilized their own NA care plan. After review of the NA care plan, the ADON agreed this care plan made no mention of any cares nor interventions

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F 314	Continued From page 25	F 314		

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 never seen a pressure relieving cushion in the wheelchair nor recliner since admission of R48. NA-A verified there was no repositioning schedule for R48. NA-A stated she knew R48's cares well as she was his regular NA. She explained that NA staff would assist R48 to the bathroom and then assist him into the recliner from the wheelchair. NA-A stated that staff had not attempted to offload any pressure on his buttocks while he remained seated. NA-A stated she felt toileting was repositioning R48 since he was assisted to the bathroom 3-4 times/ day. NA staff only repositioned the resident upon his request for toileting needs and indicated she had not been instructed to reposition R48 in any other way. No additional information was available to NA staff related to pressure ulcer care or interventions on the NA's care plan.

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.

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F 314	Continued From page 26 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 mobility, pressure relief, nutritional status and interventions, incontinence, skin condition checks, treatment, pain, infection, and education of resident and family. Nursing personnel who provide care were to have pressure ulcer training. Direct care staff were to be instructed on all interventions for each resident. Monitoring results were to be brought to the interdisciplinary team (Pressure ulcer team). Review of the Pressure Ulcer Prevention policy dated August 2013, indicated the Braden scale will be completed weekly after admission for 4 weeks, then quarterly and with comprehensive assessments. The Pressure Ulcer Root Cause Analysis Tool was to have been utilized to determine potential factors that caused the pressure ulcer(s). If the wound had not improved within 2 weeks, the provider was to have been notified.	F 314		
F 323 SS=E	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		10/3/17

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F 323	Continued From page 27 (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This 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. Findings include: Observation on 8/21/17, at 5:04 p.m. in R6's room indicated that two half side rails were attached to the bed frame. Each rail was divided into two halves, top and bottom. Within the bedrail is Zone 1. The top of the area measured 3.75 inches (in) x 29 in. and the bottom measured 4 in. x 33 in. Review of R6's 6/18/15, Side Rail assessment indicated it had not been re-assessed/re-evaluated for appropriateness since 12/18/15. There was no physician's order documented and R6 was noted to have	F 323	Review of side rail utilization within the facility completed 9/17/2017. R4 and R22 grab bars removed 9/22/2017. Identified side rails on beds similar to those on R6 bed scheduled for removal. Resident side rail assessments completed for R6 and R31 and noted that these residents do use their side rails for safe bed mobility and are dependent on the rails for transfer assist. R6 side rails and grab rails were ordered to be padded due to diagnosis of hemiathrosis. Since these were padded, R6 has not had recurrence of ecchymosis related to side rail physical impact. R6 does not have diagnosis of Alzhiemer's or dementia. She does have an impaired cognitive status. R6 has demonstrated crying behaviors and cited fear of falling out of bed as noted 7/22/2017 when she had a temporary alternative bed without	

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F 323	Continued From page 28 intermittent confusion with diagnosis of Alzheimer's. Observation on 8/21/17, at 7:04 p.m. in R22's room indicated that two bilateral grab bars were attached to the bed frame. Review of R22's Side Rail assessment dated 6/16/17, lacked indication it had been evaluated for safety nor appropriate use. R22 had not requested the use of any grab rails and it was observed she was unable to utilize the rails at this time, but indicated she was "ok with leaving them on when offered to remove." There was no physician's order documented on the assessment nor evident in the record. Observation on 8/21/17, at 7:17 p.m. in R31's room indicated that two bilateral side rails were attached to the bed. Each side rail had a top and bottom section within Zone 1. The top section measured 4 in. x 12.75 in. and the bottom measured 4.5 in. x 12.75 in. Review of R31's 2/11/13, Side Rail assessment indicated it had not been re-assessed since 8/12/14. There was no physician's order documented on the assessment. R31 was noted to be cognitively impaired. 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 room indicated there was one grab bar located on the left side of the bed. Review of R48's 6/15/17,	F 323	any assistive device attached for turning and repositioning. This bed was utilized when her primary bed was in repair. Once her primary bed with side rails was returned, R6 was satisfied. Alternative side rails and grab bars ordered 9/21/2017; awaiting arrival to confirm they meet FDA guidelines. R31 side rail utilization reviewed. Awaiting alternative side rail order to determine whether will be appropriate to use for repositioning self in bed as well as assist staff with transferring into and out of bed into wheelchair. Without device on bed, R31 would become depend on staff to complete bed mobility and transfer tasks which would decrease R31 ADL abilities and potential subsequent decline in overall status. R48 does not have a side rail but does have a grab bar. Device assessment completed 9/26/2017 with indication R48 utilizes the grab bar to turn self in bed and uses bar to assist staff in transferring into/out of bed. Without grab bar, R48 would become dependent on staff thus creating a decrease in ADL status. Order requirement reviewed noting a provider order is required for side rails. It is not required for a grab bar. From a safety perspective, utilization of side rails and grab bars will be done in accordance with appropriate assessment for need and if indicated utilization of devices meeting FDA guidelines.	

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F 323	Continued From page 29 Side Rail assessment indicated R48 had not requested the use of any rails. There was no assessment conducted for use or safety of bed rails or physician's order for R48. Interview with the assistant director of nursing on 8/24/17, at 10:30 a.m. indicated she was unaware staff needed to have a physician's orders in place for side rail usage and stated bedrails should be 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.	F 323	Device assessment, provider order requirement and utilization was discussed at Licensed Nurse Meeting 9/20/2017 and is on the agenda for the upcoming Provider Meeting 10/3/2017. It is the goal of HCHA to maintain or improve ADL status of the resident population while assuring safety practices in equipment utilization. The ADON Care Coordinator and Director will oversee quality assurance on a monthly basis monitoring side rail and grab bar utilization to include assessment completion.	
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in	F 329		10/3/17

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F 329	Continued From page 30 paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure an Abnormal Involuntary Movement Scale (AIMS)-(an assessment used to assess involuntary movements associated with the use of anti-psychotic medication) was completed to monitor for side effects and to document the amount of liquid medication administered for 2 of 5 residents (R51, R42) reviewed for unnecessary medications. Findings include: R51's quarterly Minimum Data Set (MDS) assessment dated 6/2/17, identified a Brief Interview for Mental Status (BIMS) score of 5, indicating severely impaired cognition. It identified the use of an anti-psychotic (AP) medication and diagnoses including Alzheimer's disease and depression.	F 329	Licensed Nurse staff meeting 9/20/2017 with review of medication order management. Clarity of medication orders can not include ranges without detailed provider instruction. This standard was also reviewed with the Pharmacist. Nursing staff re-educated on requirement to document dose administered. R51 assessment completed 8/25/2017. TD assessment reflects no TD signs or symptoms. Physician reviewed and signed 9/14/2017. Pharmacist consultation to confirm medications requiring TD assessment done. All residents requiring TD	

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F 329	Continued From page 31 The physician progress note dated 5/25/17, indicated R51 had exhibited aggressive behavior toward peers. R51 was prescribed Seroquel (an anti-psychotic medication) 25 milligrams (mg) twice a day (BID) with plan to follow up with Sioux Falls psychiatry on 6/6/17. The physician psychiatry progress note dated 6/6/17 included an order to increase R51's Seroquel 25 mg BID to Seroquel 25 mg in the AM and Seroquel 50 mg at bedtime. A review of R51's chart did not reveal a baseline AIMS assessment had been completed to monitor for tardive dyskinesia (abnormal involuntary movements) as a potential side effect related to the use of Seroquel. When interviewed on 8/24/17, at 1:55 p.m. the assistant director of nursing (ADON) confirmed an AIMS assessment had never been completed for R51. The ADON stated a baseline screening is completed upon admission and every 6 months thereafter; further explaining that if a new antipsychotic medication is initiated, an AIMS screening is completed 30 days after initiation. The policy titled Completion of Assessments, revised 2/10, included: Tardive Dyskinesia: Baseline upon admission and then every six months thereafter. Thirty days after initialization of new antipsychotic and discontinuation. R42's quarterly Minimum Data Set (MDS) assessment dated 5/24/17, identified that R42 had a (BIMS) of 5 indicating severe cognitive impairment.	F 329	monitoring have been completed and are up to date. TD policy review completed. We are contemplating change to policy with implementation of the AIMS tool as opposed to using the TD scale. This will be addressed with Medical Staff. Pharmacist prompted to review physician orders that require clarification during his monthly review. ADONs and Director will oversee quality assurance monitoring with a weekly audit of medication administration practices. Pending change to AIMS tool, will drive quality assurance monitoring for timeliness of TD assessment.	

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F 329	Continued From page 32	F 329		

R42's current physician orders dated 7/27/17, included Maalox Regular Strength (medication used for stomach upset) 200-200-20 milligrams (MG)/5 milliliter (ml) 2-4 teaspoons (tsp) everyday.

Review of the medication administration record (MAR) identified R42 was being administered the Maalox on a daily basis as ordered; however, it did not define the amount of Maalox being administered.

When interviewed on 8/23/17, at 1:27 p.m. registered nurse (RN)-A stated she would ask R42 how much Maalox she wanted or how her stomach was feeling. RN-A indicated she would administer a dose according to R42's response or symptoms. RN-A confirmed that nursing staff are expected to document the amount of Maalox (tsp)administered. She verified this was lacking from documentation reviewed.

When interviewed on 8/23/17, at 1:31 p.m. licensed practical nurse (LPN)-A indicated she would administer 4 tsp. of Maalox as R42 usually wanted the maximum amount of Maalox available. LPN-A verified the physician order contained a range without parameters; indicating the order should be clearer.

During interview on 8/23/17, at 1:45 p.m. RN-B stated the lack of parameters "leaves leeway" and should be more specific and staff need to document the amount administered to appropriately monitor resident response to the medication.

During interview on 8/23/17, at 3:36 p.m. director of nursing (DON) indicated she would expect staff

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F 329	Continued From page 33 to clarify the order and nursing staff document the actual amount administered to R42.	F 329		
F 428 SS=D	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 and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.	F 428		10/3/17

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F 428	Continued From page 34 (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review the consulting pharmacist failed to identify that the Abnormal Involuntary Movement Scale (AIMS)-(an assessment used to assess involuntary movements associated with the use of anti-psychotic medication) had been conducted to monitor medication side effects and that parameters for antacid administration were identified and documented to monitor effectiveness for 2 of 5 resident (R51, R42) reviewed for unnecessary medications. Findings include: R51's quarterly Minimum Data Set (MDS) assessment dated 6/2/17, identified a Brief Interview for Mental Status (BIMS) score of 5 indicating severely impaired cognition. It identified the use of an anti-psychotic (AP) medication and diagnoses including Alzheimer's disease and depression.	F 428	Clarity of medication orders can not include ranges without detailed provider instruction. This standard was reviewed with the Pharmacist. Pharmacist prompted to identify physician orders without parameters that require clarification during his monthly review. R42 order will be clarified 9/28/2017. R51 assessment completed 8/25/2017. TD assessment reflects no TD signs or symptoms. Physician reviewed and signed 9/14/2017. Pharmacist reviewed. TD policy review completed. We are contemplating change to policy with implementation of the AIMS tool as opposed to using the TD scale. This will be addressed with Medical Staff. Pharmacist consultation done regarding medications requiring TD assessment. All	

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F 428	Continued From page 35 The physician progress note dated 5/25/17, indicated R51 had exhibited aggressive behavior toward peers. R51 was prescribed Seroquel (an anti-psychotic medication) 25 milligrams (mg) twice a day (BID) with plan to follow up with Sioux Falls psychiatry on 6/6/17. The physician psychiatry progress note dated 6/6/17 included an order to increase R51's Seroquel 25 mg BID to Seroquel 25 mg in the AM and Seroquel 50 mg at bedtime. A review of R51's chart did not reveal a baseline AIMS assessment had been completed to monitor for tardive dyskinesia (abnormal involuntary movements) as a potential side effect related to the use of Seroquel. Review of the consultant pharmacist's monthly reviews dated, 5/30/17, 6/29/17, and 7/16/17, did not identify the lack of an AIMS assessment. When interviewed on 8/24/17, at 1:55 p.m. the assistant director of nursing (ADON) confirmed an AIMS assessment had never been completed for R51, though the resident was "On her list". The ADON stated a baseline screening is completed upon admission then every 6 months thereafter. If a new anti-psychotic medication is initiated, an AIMS screening is completed 30 days after initiation. The policy titled Completion of Assessments, revised 2/10, included: Tardive Dyskinesia: Baseline upon admission and then every six months thereafter. Thirty days after initialization of new anti-psychotic and discontinuation. R42's quarterly Minimum Data Set (MDS)	F 428	residents requiring TD monitoring have been completed and are up to date. Medication order standards to be reviewed at 10/3/2017 Medical Staff meeting ADON Care Coordinator and Director will monitor monthly pharmacy reviews to include pharmacist identification of any medication orders lacking clearly defined parameters.	

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F 428	Continued From page 36	F 428		

assessment dated 5/24/17, identified that R42 had a (BIMS) of 5 indicating severe cognitive impairment.

R42's current physician orders dated 7/27/17, included Maalox Regular Strength (medication used for stomach upset) 200-200-20 milligrams (MG)/5 milliliter (ml) 2-4 teaspoons (tsp) everyday.

Review of the medication administration record (MAR) identified R42 was being administered the Maalox on a daily basis as ordered; however, it did not define the amount of Maalox being administered.

Review of the consultant pharmacist monthly recommendations/reviews from 6/16 through 7/17/17 failed to identify a recommendation related to the Maalox order including parameters of dose and/or lack of staff documentation of dosage administered to monitor effectiveness.

Review of the medication administration record (MAR) identified R42 was being administered the Maalox on a daily basis as ordered; however, it did not define the amount of Maalox being administered.

When interviewed on 8/23/17, at 1:27 p.m. registered nurse (RN)-A stated she would ask R42 how much Maalox she wanted or how her stomach was feeling. RN-A indicated she would administer a dose according to R42's response or symptoms. RN-A confirmed that nursing staff are expected to document the amount of Maalox (tsp)administered. She verified this was lacking from documentation reviewed.

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F 428	Continued From page 37 When interviewed on 8/23/17, at 1:31 p.m. licensed practical nurse (LPN)-A indicated she would administer 4 tsp. of Maalox as R42 usually wanted the maximum amount of Maalox available. LPN-A verified the physician order contained a range without parameters; indicating the order should be clearer. During interview on 8/23/17, at 1:45 p.m. RN-B stated the lack of parameters "leaves leeway" and should be more specific and staff need to document the amount administered to appropriately monitor resident response to the medication. During interview on 8/23/17, at 3:36 p.m. the director of nursing (DON) indicated she would expect staff to clarify the order and/or the consulting pharmacist. She further indicated that concise/clear orders were a standard of practice. She confirmed nursing staff should document the actual amount administered to R42. Facility consultant pharmacist was unavailable for interview due to family emergency.	F 428		
F 441 SS=F	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals	F 441		10/3/17

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F 441	Continued From page 38	F 441		

providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);

(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and

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F 441	Continued From page 39 (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility 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), that dirty items were not intermingled with clean items located in the clean utility room and/or medication cart and failed to implement a program to prevent an outbreak of Legionnaires' Disease (a type of pneumonia caused by legionella bacteria) in the facility which had the potential to effect all 56 residents residing in the facility, visitors, and staff. 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	F 441	Legionnaires' Disease Prevention: A multidisciplinary team has been established to include Infection Control practitioners, Maintenance Manager, Environmental Services Manager and Director. The NH Medical Director informed of plan of action. OSHA and CDC standards of practice were reviewed relevant to Legionnaires' and establishment of a Water Management Program. The CDC toolkit for "Developing a Water Management Program to Reduce Legionella Growth and Spread in Buildings" has been implemented. The facility risk assessment was initiated on 8/31/2017 and completed 9/22/2017 to identify where opportunistic waterborne pathogens could grow. The assessment is inclusive of the resident living environment as well as the Dietary and Laundry departments with expansion to the	

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F 441	Continued From page 40 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. During the initial walk through of the facility on 8/21/17, at 3:04 p.m. it was noted that R56 utilized had a humidifier in his room. Interview with R56 and his family member at this time, confirmed the humidifier had been purchased from a local store a few months ago. It was noted that nursing staff filled the humidifier with tap water from the sink and no routine filter replacement and/or equipment cleaning occurred. Further observations on 8/21/17, at 3:04 p.m. indicated resident care items were stored under the sink next to bare pipes. The central hall clean utility room had plumbing pipes which were corroded. The resident care items stored under the sinks in all 3 clean utility rooms included: graduated containers (used to measure urine from Foley catheter bags when emptied), bedpans and wash basins. Also stored in the central hall clean utility room were visibly soiled staff walkie-talkies. Personal staff drinks and purses were stored on the counter in the clean utility room. In the whirlpool tub room located in the central hall, a dirty, soiled electric shaver with visible hair and skin particles in the removable head was stored. It was noted the whirlpool tub room had portable oxygen tanks stored which were visibly dirty on the lower half of the tank and gravel was noted on the floor beneath the tanks. In addition, clean and/or sterile respiratory and intravenous supplies were stored in this room. At	F 441	adjacent hospital environment and ancillary departments on HCHA campus. The facility's water system description and diagram of water flow throughout the building has been completed. A facility checklist has been developed based on findings from environmental rounding. Reorganization of the utility rooms is being done to prevent supply and/or equipment contamination with bacteria. Plumbing fixtures and pipes have been evaluated. Replacement of faucet aerators and shower heads is being done. Procedure updates relevant to Infection Control cleaning of equipment and devices is being done. A work checklist for cleaning and maintenance of identified areas including management of equipment devices has been developed. The HCHA Legionnaires' Disease: Water Management Program policy was approved by Medical Staff 9/12/2017. This included discussion of disease diagnosis. Staff education on Legionnaires' as well as the water management program relevant to employee position is being done. All Staff Annual Education content will be updated to include Legionnaires' and our water management program. A quality assurance monitor is established to assure quarterly environmental rounding is completed. This will include measurement of timeliness in addressing environment conditions requiring attention	

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F 441	Continued From page 41 3:15 p.m., while in the central hallway whirlpool tub, a large hole was noted in the wall, approximately 3 feet high by 2 feet wide. This hole had exposed pipes, wood beams and electrical boxes in the wall. It appeared visibly dirty with dust and debris and was not a cleanable surface area. A staff purse was stored on a chair located inside the whirlpool tub room. On 8/21/17, at 3:25 p.m. it was noted that dirty toe nail trimmers were stored on the counter in the whirlpool tub room in the east hall. These trimmers appeared severely rusted and contained skin and nail debris. The clean utility in the east hall had staff personal drinks and purses located on the clean counter. On 8/21/17, at 3:35 p.m. the whirlpool tub room located on the west hall also had nail clippers with visible nail trimmings evident when stored on the counter. On 8/21/17, at 6:24: p.m. during observation of the evening meal nursing assistant (NA)-B was seated at a table in the dining room where she attempted to feed an unidentified resident. After the resident declined to eat, NA-B proceeded to stand up and moved away from the table without sanitizing her hands. NA-B proceeded to touch another unidentified resident's shoulder while speaking to her and returned to the first resident to assist with feeding. NA-B then stood up from the table and proceeded to assist with removal of a bib apron from a third unidentified resident. NA-B failed to implement handwashing and/or hand sanitization between resident contacts. It was noted that NA-B wiped her nose with bare hands and then touched another resident's arm. NA-B transported the resident from the dining	F 441	inclusive of device and equipment utilization. The Director and Infection Control practitioners will oversee monitoring compliance. Infection Control with Dressing Changes: Policy reviewed. Procedure reference for changing dressings placed in the skin book in each of the two nurse work stations. Aseptic technique relevant to dressing care reviewed at Nurse Staff meeting 9/20/2017. RN-A re-education on dressing change protocol utilizing aseptic technique, hand hygiene, device cleaning and medication cart management. Quality monitor established to assure compliance with dressing change protocol: ADONs and/or Care Clinicians will oversee staff technique with dressing changes on a weekly basis. Goal: staff demonstration of aseptic technique when changing dressings @ 100%; target 95%. Staff education relevant to standard of care will be provided individually as indicated. Cleaning of multi-used resident equipment: Policy reviewed. Rusty clippers replaced. Cleaning procedure information posted for staff as well as provision of individualized education. Management of humidifiers and like equipment allowed in the facility reviewed. Resident notification of personal equipment allowance, process for approval for use, maintenance responsibility of said equipment being updated as to facility policy. Standards of	

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F 441	Continued From page 42 room via the resident's wheelchair. When observed on 8/23/17, at 7:46 a.m. registered nurse (RN)-A had a personal drink (coffee) located on top of the medication cart during morning medication administration. On the medication cart,a flashlight was stored on top of the dirty sharps container (where used needles and syringes are routinely stored). It was learned the flashlight was used for multiple residents when neurological checks (used to assess mental and brain activity) were conducted by licensed staff. During an observation of a dressing change on R48's foot on 8/23/17, at 8:00 a.m. RN-A laid down on the floor to complete visualization of a heel wound. After this was completed, RN-A discarded the soiled gloves and while sitting on the floor, removed R48's rolled gauze dressing from his left lower leg with her bare hands. She proceeded to touch her hair, brushing it from her face. After she tossed the soiled dressing into the garbage, RN-A returned to R48 and pushed him in his wheelchair out of his room. RN-A then donned clean gloves without washing and/or sanitizing her hands and proceeded to check R48's blood glucose. After completing the blood glucose check, RN-A removed the soiled gloves, picked up the glucometer (machine used to check blood glucose) with bare hands and wiped it clean with a disinfectant wipe. RN-A placed the glucometer on the medication cart next to her cup of coffee and transported R48 to the dining room. RN-A did not disinfect the top of the cart prior to placing the soiled glucometer onto the medication cart. When interviewed on 8/23/17, at 9:41 a.m. RN-A	F 441	cleaning multi-used resident equipment reviewed at 9/12/2017 CNA Staff meeting 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 room has been repaired. Tub cleaning procedure posted in the tub rooms. Staff education on procedure has been completed with primary staff assigned bath aide duties. Additional staff training in the event of being assigned bath aide duties is in process. Exposed wall in central tub room in process of repair. Utility Room Management: Reorganization of soiled and clean utility rooms being done. Staff walkie-talkies relocated to staff locker area. Alternative location secured for oxygen tank storage. Plumbing fixtures and pipes evaluated along with the Legionnaires' Water Management Program policy work. Ice Machine cleaning procedure updated. Ice Machine is slotted for relocation to the planned renovated kitchen site location in the Nursing Home. Nurses and TMAs informed to keep clean and dirty items separated on medication cart as well as compliance for disinfectant protocol of the medication carts. Hand hygiene standards reviewed at September CNA and Nurse staff	

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F 441	Continued From page 43 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. It was again noted on 8/23/17, at 10:00 a.m. that RN-C stored the flashlight used for neurological checked on top of the dirty sharps container located on the medication cart. In addition, it was noted a box of Inter-dry dressings were located next the container, available for staff use since it did not fit inside the medication cart according to RN-C. When interviewed on 8/23/17, at 10:08 a.m. the director of nursing (DON) agreed that cross-contamination was a concern with the noted observations; dressing change, storage of clean/soiled equipment and lack of proper handwashing. It was her expectation staff were to follow appropriate infection control technique during dressing changes. The DON further agreed she expected NA-B to implement handwashing and/or use of hand sanitizer between resident contact. When observed on 8/23/17, at 11:59 p.m. at the west nurses station, a box of Inter-dry dressings were now located on the nurses station counter. Adjacent to these dressings was a cup of coffee	F 441	meetings. Personal beverages, food items and/or personal items such as purses, phones, etc. are not allowed in proximity to resident care giving locations of medication distribution, supply/storage areas or other locations such as work stations where resident care giving supplies may be located. Information and directive reviewed at 9/12/2017 CNA meeting and 9/201/2017 Nurse meeting. Director will be responsible to oversee quality assurance monitoring of Infection Control standards relevant to the Legionnaires': Water Supply Management Program, Standards in Dressing Care, Equipment Disinfectant Procedure Compliance and Environment Maintenance. Monthly audit.	

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and under the counter a large 18 ounce opened bag of an unidentified staff member's cheese puffs stored on the floor next to the medication refrigerator.

During observation of the noted concerns and when interviewed on 8/23/17, at 1:00 p.m. the DON indicated she was unaware of the cross contamination of items in the clean utility rooms and confirmed that after viewing the resident care items stored beneath the sink with corroded pipes, she identified they had a higher number of urinary tract infections. The DON agreed it could be a source of contamination to these items. The DON stated that staff were to store personal drinks and/or purses in their breakroom and not in clean utility rooms where clean resident items are kept. The DON confirmed the use of a rusty toenail trimmer was unacceptable. There was also visible hair noted inside the tub and powder on the whirlpool tub chair seat in the central whirlpool tub room when toured at 1:00 p.m. The DON agreed staff had not properly cleaned nor disinfected the whirlpool tub and seat after resident use.

On 8/24/17, at 10:30 a.m. NA-C demonstrated cleaning and disinfection of the whirlpool tub located in the central hall whirlpool tub room. NA-C proceeded to grab a spray bottle of Cen-Kleen from the cupboard and explained she would spray the whirlpool tub down, use the scrub brush to clean the tub and then rinse the tub. NA-C explained that at the end of the day, she would gather all the combs and brushes and rinse them in the whirlpool tub. She acknowledged that was not according to manufacturer's guidelines or instructions, but the process had been changed by the previous DON at least one year ago.

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Review of the instructions for cleaning and disinfecting the whirlpool tub, located on the wall behind the tub indicated staff were to have the chemical flow through the jets, enabling the jets to be disinfected. It was noted that 31 of 56 residents routinely bathed in this whirlpool tub. NA-C also explained that nail clippers were routinely cleaned by wiping them off briefly with an alcohol pad. NA-C would clean the residents' combs and brushes by spraying them with Cen-Kleen and rinsing them off inside the whirlpool tub at the end of the day. Staff had no disinfectant available for use on the multi-use resident care items.

R6 was bathed in that whirlpool tub and her toenails were trimmed on bath days. Review of the Provider Visit Note dated 6/22/17, indicated R6 was examined in the clinic that day for an infected toenail. "Cleanse infected proximal nail cuticle to left third toe with wound cleanser, apply Silvadene [topical antibiotic] and cover with Band-aid daily until condition resolves. Cephalexin [oral antibiotic] 500 [milligrams] mg 1 capsule BID [twice daily] x 7 days. Probiotic daily while on oral antibiotic."

Interview on 8/24/17, at 10:46 a.m. with the DON revealed she agreed staff were not appropriately disinfecting the central hall whirlpool tub nor 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

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F 441	Continued From page 46 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 August 2015 Hand Hygiene facility policy indicated hand hygiene was to have been performed by staff before and after donning or removing gloves, when hands were visibly dirty or contaminated. A hand sanitizer was to be used to decontaminate hands between direct contact with residents, after contact with a resident's skin, and when staff members' hands came into contact with resident care equipment in the immediate vicinity of a resident.	F 441		
F 492 SS=D	483.70(b)(c) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD (b) Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.	F 492		9/22/17

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F 492	Continued From page 47 (c) Relationship to Other HHS Regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the supplemental nursing service agency (SNSA) utilized by the facility was registered with the Minnesota commissioner, as required. This had the potential to affect all 56 residents who resided in the facility and received services from the supplemental staff. Findings include: During the entrance conference on 8/21/17, at 2:59 p.m. director of nursing (DON) stated the facility utilized the Fortus Healthcare Resources staffing agency to provide nursing coverage. When interviewed on 8/22/17, at 3:40 p.m. the DON verified via the Minnesota Department of Health's Directory of Registered Supplemental	F 492	Supplemental Staff Nursing Service Agency registration of Fortus Group Travel INC has been confirmed by the Minnesota Department of Health as of 9/22/2017. Other agency utilization is confirmed as an authorized agency. ADON Staff Coordinator, ADON Care Coordinator and Director informed of regulation requirement for supplemental agency staff registration with the Minnesota Department of Health prior to engagement in staff utilization. ADON Staff Coordinator and ADON will be responsible to confirm SNSA registration on a semi-annual basis to assure compliance that agencies maintain appropriate SNSA registration authorization.	

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F 492	Continued From page 48 Nursing Services Agency that Fortus Healthcare Resources was not one of the approved agencies listed. DON further verified that nursing assistant (NA)-B (hired through Fortus) had been working at the facility from 1/30/17 to the present providing direct patient care.	F 492		

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00340	A. BUILDING: _____ B. WING _____	08/24/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 8/21/17, 8/22/17, 8/23/17 and 8/24/17, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 005	MN Rule 4658.0015 COMPLIANCE WITH REGULATIONS AND STANDARDS A nursing home must operate and provide services in compliance with all applicable federal, state, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in a nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the supplemental nursing service agency (SNSA) utilized by the facility was registered with the Minnesota commissioner, as required. This had the potential to affect all 56 residents who resided in the facility and received services from the supplemental staff. Findings include: During the entrance conference on 8/21/17, at 2:59 p.m. director of nursing (DON) stated the facility utilized the Fortus Healthcare Resources staffing agency to provide nursing coverage. When interviewed on 8/22/17, at 3:40 p.m. the DON verified via the Minnesota Department of Health's Directory of Registered Supplemental	2 005	Corrected	9/22/17

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2 005	Continued From page 3 Nursing Services Agency that Fortus Healthcare Resources was not one of the approved agencies listed. DON further verified that nursing assistant (NA)-B (hired through Fortus) had been working at the facility from 1/30/17 to the present providing direct patient care. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review and revise policies and procedures to ensure staff utilized from SNSAs are from approved registered agencies with the State of Minnesota. The administrator could develop a system to educate staff and develop monitoring. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 005		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's	2 265		10/3/17

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2 265	Continued From page 4 physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. 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. Findings include: R48 was admitted on 6/15/17. Review of his electronic medical record (EMR) indicated his diagnoses at the time of admission were coronary artery disease, chronic kidney disease and diabetes. The Resident Assessment form dated 6/15/17, indicated that R48 had a reddened area on the left buttock. . Review of R48's Short Term Care Plan Skin Integrity form dated 7/8/17, indicated R48 had	2 265	Corrected	

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2 265	Continued From page 5	2 265		

decreased sensation and mobility. He had a pressure ulcer (PU) to the right heel. Interventions included: notify physician of wounds and treatments.

Review of the Short Term Care Plan Skin Integrity form dated 8/1/17, indicated R48 had PU to left buttock. Interventions noted included the physician was to be notified at that time.

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 physician notification documented.
(3) 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 activity in his chair and planned to order physical therapy (PT) to improve muscle function. WN-C made no mention of contacting the physician.
(4) On 7/8/17, (18 days later), WN-C re-assessed and documented a Stage II heel PU with slight purple bruising around edges 3.5 centimeters (cm) x 2 cm. WN-C painted the heel with Betadine and left open to air; added a heel protector for R48 to wear when in bed and/or to off-load pressure. WN-C also noted a podiatry appointment was being considered. There was a box check marked YES for follow-up requested.

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2 265	Continued From page 6 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-open 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. (9) On 8/18/17, (9 days later), the WN-C documented left buttock PU measured (#1) 0.5 cm x 0.5 cm and (#2)PU resolved. Right heel	2 265		

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2 265	Continued From page 7 PU-3.5 cm x 6 cm black scab and starting to peel on the edge. No physician notification documented. No other progress notes by any other nursing staff were made except by WN-C. Interview and document review on 8/24/17, at 12:24 p.m. with the assistance director of nursing (ADON) and WN-C confirmed physician notification at PU onset and/or at the time the wounds had changed had occurred. Review of the 2009 Skin Policy and Procedure indicated upon identification of a skin ulcer, the physician was to identify the type of ulcer and if not improved within 2 weeks, staff were to notify the provider and seek an order for a wound consult. Review of the Pressure Ulcer Prevention policy dated August 2013, indicated if the wound had not improved within 2 weeks, the provider was to be notified. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop systems for notification of change. The DON or designee could inservice staff regarding facility practices, policy and procedures for notifications of change. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 265		

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2 560	Continued From page 8	2 560		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a care plan was developed related to anticoagulant therapy for 1 of 1 resident (R42) reviewed for unnecessary medications. Findings include: R42's quarterly Minimum Data Set (MDS) assessment, dated 5/24/17, identified R42 was receiving an anticoagulant medication. R42's current physicians orders dated 7/27/17, included an order for warfarin sodium (blood thinner) 4 milligrams (mg) every Wednesday and Saturday and 5 mg every Monday, Tuesday, Thursday, Friday, and Sunday for diagnosis of atrial fibrillation (irregular heartbeat). 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	2 560	Corrected	10/3/17

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2 560	Continued From page 9 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 3:09 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 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 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. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to the development of the care plan. The DON or designee, could provide training for all nursing staff related to care plan development. The quality assessment and assurance committee could perform random audits to ensure compliance.	2 560		

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2 560	Continued From page 10 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. 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. Findings include: R48 was admitted to the facility on 6/15/17. Review of his electronic medical record (EMR) indicated his diagnoses at the time of admission were coronary artery disease, chronic kidney disease, and diabetes. R48's 6/15/17 Resident Assessment form indicated his left buttock had a reddened area. Review of the current EMR care plan, accessed only by licensed nurses, revealed on 6/22/17, the following interventions were to have been implemented for R48: (1) Administer treatments as ordered and monitor for effectiveness. (2) Assess/record/monitor wound healing weekly.	2 565	Corrected	10/3/17

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2 565	Continued From page 11	2 565		

Report improvements and declines to the doctor.
(3) "needs a pressure reduction cushion in his wheelchair (w/c)".
(4) "needs to turn/reposition at least every 2 hrs, more often as needed or requested."

Review of the Short Term Care Plan Skin Integrity form dated 7/8/17, revealed R48 had decreased sensation and mobility and a pressure ulcer (PU) to the right heel. Interventions included: (1) inspect the skin daily, cleanse the wound initially and at each dressing change (2) turn and reposition on a schedule; however, the frequency was left blank; (3) apply heel protector while in bed and in recliner; (4) Notify physician and family of wounds and treatments; and (5) weekly documentation by licensed nurse. On 8/18/17, an additional note was added to the form indicating staff were to continue to monitor as the area was firm, black with eschar.

Review of the Short Term Care Plan Skin Integrity form dated 8/1/17, indicated R48 has a PU his left buttock. Interventions included: (1) inspect the skin daily, cleanse the wound initially and at each dressing change; (2) apply a Mepilex dressing every 3-5 days and as needed (PRN) (3) turning and repositioning schedule was changed from every 2 hours to every 1.5 hours; (4) a pressure 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.

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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2 565	Continued From page 12	2 565		

interviewed at this time, R48 explained he was dependent upon staff for cares. It was noted there was no pressure relieving device/cushion evident in the recliner, wheelchair or bed. It was noted that R48 was wearing a heel protector boot on his right foot.

The following morning on 8/22/17, at 9:31 a.m. R48 was seated in his recliner consuming breakfast. R48 was clothed in a hospital gown. When interviewed R48 stated he was upset staff had not yet helped him dress as he was dependent for activities of daily living (ADL's) like getting dressed, toileting, transferring, and wheeling in his chair. R48 explained staff had awakened him at 7:00 a.m. for a blood sugar check and transferred him into the recliner. R48 verified he was able to make slight movements while in bed but not while in his chair. R48 confirmed he had not changed positions in his chair since staff had assisted him at 7:00 a.m. (2 1/2 hours earlier). Further observation on 8/22/17, at 9:50 a.m. noted that R48 remained in the recliner, waiting for staff assistance with dressing and repositioning.

On 8/22/17, at 11:40 a.m. registered nurse (RN)-A was observed during a dressing change of R48's buttock and right heel. It was noted that R48 was seated in his wheelchair without a pressure-relieving cushion nor was a pressure relieving air mattress noted on the bed. When interviewed on 8/22/17, at 11:40 a.m. RN-A explained that wound nurse (WN)-C would typically measure and provide all wound care. R48's wound documentation identified the following from the 8/22/17, dressing change observation of RN-A: (1) right (R) foot wound-unstageable; measured 3.5 cm x 6 cm, black scab, starting to peel on the edge; no

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2 565	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 nursing progress notes and physician communication indicated the following documentation:
(1) On 6/15/17, a reddened area noted on left buttock;
(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.
(3) Review of the physician progress note dated 6/29/17, indicated R48 had been seen by his

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2 565	Continued From page 14 primary care physician (PCP) and the PCP noted R48 had prolonged activity in his chair and planned to order physical therapy (PT) to improve muscle function. (4) On 7/8/17, (18 days later), WN-C re-assessed and documented a Stage II heel PU with slight purple bruising around edges 3.5 centimeters (cm) x 2 cm. WN-C painted the heel with Betadine and left open to air; added a heel protector for R48 to wear when in bed and/or to off-load pressure. (5) On 7/21/17, it was noted there was a physician order for Mepilex to the left buttock every 3 days and as needed. PT/OT/ST were to be evaluated on 6/15/17. There was no documentation indicating that therapies had been involved. (6) 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. (7) 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-open 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. (8) Review of faxed records revealed on 8/16/17, a telephone order for occupational therapy (OT) to evaluate and treat on 8/16/17, for a pressure reduction system for R48's bed, chair, and w/c was signed by the PCP on 8/17/17. (9) On 8/18/17, (9 days later), the WN-C documented left buttock PU measured (#1) 0.5 cm x 0.5 cm and (#2)PU resolved. Right heel PU-3.5 cm x 6 cm black scab and starting to peel on the edge. No physician notification had been documented nor had the pressure reduction	2 565		

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2 565	Continued From page 15 system been implemented. No weekly nursing progress notes (by any nursing staff) related to PU monitoring were documented except by the wound nurse (WN-C), which had not been implemented weekly as identified in the plan of care. When interviewed on 8/24/17, at 12:24 p.m. the assistant director of nursing (ADON) and WN-C confirmed there was no Standing Order to administer treatment for skin issues and PU's. Treatment was based upon WN-C judgment. The WN-C acknowledged she had not always evaluated the wound at least weekly and the Pressure Ulcer (PU) team consisted of only herself, as there was no interdisciplinary team involvement in the management of R48's 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	2 565		

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2 565	Continued From page 16 never seen a pressure relieving cushion in the wheelchair nor recliner since admission of R48. NA-A verified there was no repositioning schedule for R48. NA-A stated she knew R48's cares well as she was his regular NA. She explained that NA staff would assist R48 to the bathroom and then assist him into the recliner from the wheelchair. NA-A stated that staff had not attempted to offload pressure while he remained seated in any chair and indicated she had not been instructed to reposition R48 as identified in the EMR plan of care. Review of the 2009 Skin Policy and Procedure Hendricks Nursing Home policy included: direct care staff shall be instructed on all interventions for each resident and monitoring results will be brought to the interdisciplinary team (Pressure ulcer team). SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. The results could be discussed at the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and	2 830		10/3/17

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2 830	Continued From page 17 plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in 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. Findings include: Observation on 8/21/17, at 5:04 p.m. in R6's room indicated that two half side rails were attached to the bed frame. Each rail was divided into two halves, top and bottom. Within the bedrail is Zone 1. The top of the area measured 3.75 inches (in) x 29 in. and the bottom measured 4 in. x 33 in. Review of R6's 6/18/15, Side Rail assessment indicated it had not been re-assessed/re-evaluated for appropriateness since 12/18/15. There was no physician's order documented and R6 was noted to have intermittent confusion with diagnosis of Alzheimer's. Observation on 8/21/17, at 7:04 p.m. in R22's room indicated that two bilateral grab bars were attached to the bed frame. Review of R22's Side Rail assessment dated 6/16/17, lacked indication it had been evaluated for safety nor appropriate	2 830	Corrected	

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2 830	Continued From page 18	2 830		

use. R22 had not requested the use of any grab rails and it was observed she was unable to utilize the rails at this time, but indicated she was "ok with leaving them on when offered to remove." There was no physician's order documented on the assessment nor evident in the record.

Observation on 8/21/17, at 7:17 p.m. in R31's room indicated that two bilateral side rails were attached to the bed. Each side rail had a top and bottom section within Zone 1. The top section measured 4 in. x 12.75 in. and the bottom measured 4.5 in. x 12.75 in. Review of R31's 2/11/13, Side Rail assessment indicated it had not been re-assessed since 8/12/14. There was no physician's order documented on the assessment. R31 was noted to be cognitively impaired.

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 room indicated there was one grab bar located on the left side of the bed. Review of R48's 6/15/17, Side Rail assessment indicated R48 had not requested the use of any rails. There was no assessment conducted for use or safety of bed rails or physician's order for R48.

Interview with the assistant director of nursing on 8/24/17, at 10:30 a.m. indicated she was unaware staff needed to have a physician's orders in place for side rail usage and stated bedrails should be

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2 830	Continued From page 19 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 CORRECTION: Twenty-one (21) days.	2 830		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores	2 900		10/3/17

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2 900	Continued From page 20 receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and implement the necessary services for 1 of 1 resident (R48) reviewed with two Stage II pressure ulcers located on the buttock and one unstageable heel PU. Findings include: R48's electronic medical record (EMR) face sheet indicated he'd been admitted on 6/15/17 with diagnoses including: coronary artery disease, chronic kidney disease and diabetes. The Brief Interview of Mental Status (BIMS) assessment identified on the admission Minimum Data Set (MDS) dated 6/21/17, identified a score of 11/15, indicating intact cognition. A Resident Assessment form dated 6/15/17, indicated R48 had a reddened area on the left buttock. On 8/21/17, at 5:26 p.m. R48 was observed seated in a chair in his room waiting for staff to transfer him into a wheelchair for transport to the evening meal. When interviewed at that time, R48 stated he was dependent on staff for cares. During the observation, R48 was wearing a heel protector boot on his right foot. Additionally, observation revealed no pressure relieving device/cushion was evident in the recliner, in the wheelchair or on the bed. On 8/22/17, at 9:31 a.m. R48 was observed seated in a recliner in his room eating breakfast.	2 900	Corrected	

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2 900	Continued From page 21 R48 was dressed in a hospital gown. When interviewed R48 stated he was upset staff had not yet helped him get dressed for the day, and verified he was dependent on staff for activities of daily living (ADL's) like getting dressed, toileted, transferring, and wheeling in his wheel chair. R48 explained staff had awakened him at 7:00 a.m. that morning for a blood sugar check and had transferred him into the recliner. R48 stated while he was able to move himself slightly while in bed, he was not able to move himself while in his chair. R48 confirmed he had not changed positions since staff had assisted him at 7:00 a.m. (2 1/2 hours earlier). During further observation at 9:50 a.m. on 8/22/17, R48 remained in the recliner and verified he was still waiting for staff assistance with dressing and repositioning. On 8/22/17, at 11:40 a.m. registered nurse (RN)-A was observed to conduct dressing changes for a PU located on R48's right heel. It was noted that R48 was seated in his wheelchair without a pressure-relieving cushion nor was a pressure relieving air mattress noted on the bed. When interviewed on 8/22/17, at 11:40 a.m. RN-A explained that wound nurse (WN)-C would typically measure and provide all wound care. R48's wound documentation identified the following from the 8/22/17, dressing change observation of RN-A: (1) right (R) foot wound-unstageable; measured 3.5 cm x 6 cm, black scab, starting to peel on the edge; no 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.	2 900		

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2 900	Continued From page 22 After the dressing change was completed, R48 was transferred back into a seated position in the wheelchair. A pressure relieving cushion was not evident in the chair. Later, it was noted on 8/22/17, at 12:20 p.m. that R48 was dressed and seated in his wheelchair, still without a cushion and/or pressure relieving device in place. During random observations on 8/23/17 and 8/24/17, R48 remained in a seated position, a cushion was not located in the wheelchair and/or recliner. The Comprehensive Pressure Ulcer Risk Assessment dated 6/15/17, indicated R48's reddened area on his left buttock continued after a pressure points assessment after 2.5 hours. The sections labeled History of Pressure Ulcers and Skin Conditions and Summary of Comprehensive Skin Assessment were left blank. Risk factors and Interventions were also left blank and not completed by nursing staff. The Admission Care Plan dated 6/15/17, indicated R48 was incontinent of bowel, required 1-2 staff assistance with the wheelchair and transfer between surfaces and 1 staff to walk short distances. The Braden Score (pressure ulcer risk) score dated 6/15/17, was identified as 20, indicating R48 was not at risk for pressure ulcers. However, the information documented on the Braden Score assessment was not consistent with the assessment completed on the Admission Care Plan form dated 6/15/17. The Braden assessment identified that R48 had no impairment related to sensory perception, was rarely moist, walked occasionally and did not	2 900		

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2 900	Continued From page 23 require staff assistance into chair and/or wheelchair (only slightly limited). The plan of care indicated R48 required 1-2 staff assistance with transfer. The Braden assessment identified that R48 did not have any problem or potential problem with friction or sheer, or skin concern that would have required repositioning. Review of a physician progress note dated 8/3/16, made by certified nurse practitioner (CNP)-D indicated R48 had a monofilament test (used to assist in the detection of peripheral neuropathy) performed on his feet. CNP-D was unable to elicit a response from R48's left foot, indicating loss of sensation in his left foot. This information was in conflict with the "no impairment related to sensory perception" noted on the Braden scale. Review of laboratory data dated 6/14/17, indicated R48's albumin level was low at 2.9, which may affect wound healing. 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 current EMR care plan, accessible only by licensed nurses, revealed on 6/22/17, the following interventions were to have been implemented for R48: (1) Administer treatments as ordered and monitor for effectiveness. (2) Assess/record/monitor wound healing weekly. Report improvements and declines to the doctor. (3) Inform the resident, family and caregivers of any new area of skin breakdown. (4) Cavilon (a barrier cream) to left buttock twice daily. (5) "needs a pressure reduction cushion in his	2 900		

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2 900	Continued From page 24 wheelchair (w/c)". (6) "needs to turn/reposition at least every 2 hrs, more often as needed or requested." (7) needs 1-2 staff assistance to help with repositioning, turning, and lying down or sitting up in bed. (8) needs the assistance of 1-2 staff to walk short distances in his room. "Per [R48] and his family, he was utilizing his walker or wheelchair to get around his house." The care plan was updated on 7/8/17, to reflect [R48] had a Stage II PU to the right heel and was also to wear a heel protector/boot to area as a daily treatment. No further updates were made to R48's care plan. Review of the Short Term Care Plan Skin Integrity form dated 7/8/17, revealed R48 had decreased sensation and mobility and a pressure ulcer (PU) to the right heel. Interventions included: (1) inspect the skin daily, cleanse the wound initially and at each dressing change (2) turn and reposition on a schedule; however, the frequency was left blank; (3) apply heel protector while in bed and in recliner; (4) Notify physician and family of wounds and treatments; and (5) documentation weekly by licensed nurse. On 8/18/17, an additional note was added to the form indicating staff were to continue to monitor as the area was firm, black with eschar. Review of the Short Term Care Plan Skin Integrity form dated 8/1/17, indicated R48 has a PU his left buttock. Interventions included: (1) inspect the skin daily, cleanse the wound initially and at each dressing change; (2) apply a Mepilex dressing every 3-5 days and as needed (PRN) (3) turning and repositioning schedule was changed from every 2 hours to every 1.5 hours; (4) a pressure	2 900		

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2 900	Continued From page 25	2 900		

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 cm. -staff 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 minor 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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2 900	Continued From page 26 activity in his chair and planned to order physical therapy (PT) to improve muscle function. (5) On 7/8/17, (18 days later), WN-C re-assessed and documented a Stage II heel PU with slight purple bruising around edges 3.5 centimeters (cm) x 2 cm. WN-C painted the heel with Betadine and left open to air; added a heel protector for R48 to wear when in bed and/or to off-load pressure. (6) Review of R48's EMR physician's orders lacked any related to PU's until 7/8/17. At that time, there was an order for Betadine to the right heel and application of the heel protector. On 7/8/17, WN-C faxed information to the PCP's office, indicating R48 complained of heel pain and staff discovered a blister measuring 3.5 cm x 2 cm. WN-C further noted she had painted it with Betadine and placed a heel protector in R48's room, encouraging him not to use his right foot for repositioning in bed. WN-C also noted a podiatry appointment was being considered. There was a box check marked YES for follow-up requested. Documentation was also lacking to indicate podiatry services had been offered and/or follow-up occurred. (7) 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. (8) 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	2 900		

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2 900	Continued From page 27 boggy measuring 1 cm x 3 cm. No physician notification was documented by the WN-C. (9) On 7/21/17, it was noted there was a physician order for Mepilex to the left buttock every 3 days and as needed. PT/OT/ST were to be evaluated on 6/15/17. There was no documentation indicating therapies had completed the evaluations. (10) 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. After R48 was given a tub bath, skin prep applied and Mepilex covered both areas. 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. (11) Review of R48's faxed and/or verbal communication records revealed on 7/31/17, a fax was sent to the PCP, with notification that R48 had a "Second open area to left buttock measuring 2 cm x 0.3 cm. Mepilex covering both areas. Will monitor till healed." However, the status of the heel PU was not mentioned. No follow-up requested nor was there documentation indicating the physician had responded to the treatment orders. (12) 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-open 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. (13) Review of faxed records revealed on 8/16/17, a telephone order for occupational therapy (OT) to evaluate and treat on 8/16/17, for	2 900		

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2 900	Continued From page 28 a pressure reduction system for R48's bed, chair, and w/c was signed by the PCP on 8/17/17. There were no other signed faxed or telephone orders related to the identified PU's documented by the wound nurse. (14) On 8/18/17, (9 days later), the WN-C documented left buttock PU measured (#1) 0.5 cm x 0.5 cm and (#2)PU resolved. Right heel PU-3.5 cm x 6 cm black scab and starting to peel on the edge. No other weekly nursing progress notes (by any nursing staff) were documented except by the wound nurse (WN-C). The plan of care had not been implemented as indicated. Review of the April, 2016 National Pressure Injury Advisory Panel's pressure ulcer/injury stages, http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/, indicated a Stage I pressure ulcer is a reddened area of intact skin. A Stage II pressure ulcer is a partial-thickness loss of skin with exposed dermis. An unstageable pressure ulcer/injury is defined as an obscured by slough or eschar (black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges and may be either firmer or softer than surrounding skin). A deep tissue pressure ulcer/injury is a persistent non-blanchable deep red, maroon or purple discoloration of intact or non-intact skin. Pain and temperature change often precede skin color changes. When interviewed on 8/24/17, at 12:24 p.m. the assistant director of nursing (ADON) and WN-C agreed the comprehensive skin assessment performed upon admission was not completed accurately. It was also confirmed the physician had not ordered the treatments for wound care.	2 900		

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2 900	Continued From page 29 WN-C stated would administer treatment for skin issues and PU's based upon her judgment. WN-C added, "If the physician's doesn't like what I'm using, they will tell me to use something different." There was no Standing Orders for her to follow related to wound care signed by the physician. WN-C was unable to verify communication with the physician at the onset of the PU nor that it occurred regularly as the wound progressed as the physicians relied upon her judgement regarding the proper treatments. The WN-C acknowledged she had not always evaluated the wound at least weekly and the Pressure Ulcer (PU) team consisted of only herself, as there was no interdisciplinary team involvement in the management of R48's 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 staff 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 NA staff lacked access to the EMR care plan and utilized their own NA care plan. After review of the NA care plan, the ADON agreed this care plan 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 never seen a pressure relieving cushion in the wheelchair nor recliner since admission of R48.	2 900		

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2 900	Continued From page 30 NA-A verified there was no repositioning schedule for R48. NA-A stated she knew R48's cares well as she was his regular NA. She explained that NA staff would assist R48 to the bathroom and then assist him into the recliner from the wheelchair. NA-A stated that staff had not attempted to offload any pressure on his buttocks while he remained seated. NA-A stated she felt toileting was repositioning R48 since he was assisted to the bathroom 3-4 times/ day. NA staff only repositioned the resident upon his request for toileting needs and indicated she had not been instructed to reposition R48 in any other way. No additional information was available to NA staff related to pressure ulcer care or interventions on the NA's care plan. 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 mobility, pressure relief, nutritional status and	2 900		

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2 900	Continued From page 31 interventions, incontinence, skin condition checks, treatment, pain, infection, and education of resident and family. Nursing personnel who provide care were to have pressure ulcer training. Direct care staff were to be instructed on all interventions for each resident. Monitoring results were to be brought to the interdisciplinary team (Pressure ulcer team). Review of the Pressure Ulcer Prevention policy dated August 2013, indicated the Braden scale will be completed weekly after admission for 4 weeks, then quarterly and with comprehensive assessments. The Pressure Ulcer Root Cause Analysis Tool was to have been utilized to determine potential factors that caused the pressure ulcer(s). If the wound had not improved within 2 weeks, the provider was to have been notified. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) could review and revise the pressure ulcer protocol. In addition, the DON could provide education to the nursing staff on the importance of assessing pressure ulcers and implementing pressure reducing interventions. The DON could develop a system for the nursing staff to monitor that interventions are implemented. The quality assessment and assurance committee could do random audits of pressure ulcers to ensure residents are receiving the appropriate care and treatment. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program	21375		10/3/17

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21375	Continued From page 32 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. Findings include: During the initial walk through of the facility on 8/21/17, at 3:04 p.m. it was noted that R56 utilized had a humidifier in his room. Interview with R56 and his family member at this time, confirmed the humidifier had been purchased from a local store a few months ago. It was noted that nursing staff filled the humidifier with tap water from the sink and no routine filter replacement and/or equipment cleaning occurred. Further observations on 8/21/17, at 3:04 p.m. indicated resident care items were stored under the sink next to bare pipes. The central hall clean utility room had plumbing pipes which were corroded. The resident care items stored under the sinks in all 3 clean utility rooms included: graduated containers (used to measure urine from Foley catheter bags when emptied),	21375	Corrected	

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bedpans and wash basins. Also stored in the central hall clean utility room were visibly soiled staff walkie-talkies. Personal staff drinks and purses were stored on the counter in the clean utility room. In the whirlpool tub room located in the central hall, a dirty, soiled electric shaver with visible hair and skin particles in the removable head was stored. It was noted the whirlpool tub room had portable oxygen tanks stored which were visibly dirty on the lower half of the tank and gravel was noted on the floor beneath the tanks. In addition, clean and/or sterile respiratory and intravenous supplies were stored in this room. At 3:15 p.m., while in the central hallway whirlpool tub, a large hole was noted in the wall, approximately 3 feet high by 2 feet wide. This hole had exposed pipes, wood beams and electrical boxes in the wall. It appeared visibly dirty with dust and debris and was not a cleanable surface area. A staff purse was stored on a chair located inside the whirlpool tub room.

On 8/21/17, at 3:25 p.m. it was noted that dirty toe nail trimmers were stored on the counter in the whirlpool tub room in the east hall. These trimmers appeared severely rusted and contained skin and nail debris. The clean utility in the east hall had staff personal drinks and purses located on the clean counter.

On 8/21/17, at 3:35 p.m. the whirlpool tub room located on the west hall also had nail clippers with visible nail trimmings evident when stored on the counter.

On 8/21/17, at 6:24: p.m. during observation of the evening meal nursing assistant (NA)-B was seated at a table in the dining room where she attempted to feed an unidentified resident. After the resident declined to eat, NA-B proceeded to

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stand up and moved away from the table without sanitizing her hands. NA-B proceeded to touch another unidentified resident's shoulder while speaking to her and returned to the first resident to assist with feeding. NA-B then stood up from the table and proceeded to assist with removal of a bib apron from a third unidentified resident. NA-B failed to implement handwashing and/or hand sanitization between resident contacts. It was noted that NA-B wiped her nose with bare hands and then touched another resident's arm. NA-B transported the resident from the dining room via the resident's wheelchair.

When observed on 8/23/17, at 7:46 a.m. registered nurse (RN)-A had a personal drink (coffee) located on top of the medication cart during morning medication administration. On the medication cart,a flashlight was stored on top of the dirty sharps container (where used needles and syringes are routinely stored). It was learned the flashlight was used for multiple residents when neurological checks (used to assess mental and brain activity) were conducted by licensed staff.

During an observation of a dressing change on R48's foot on 8/23/17, at 8:00 a.m. RN-A laid down on the floor to complete visualization of a heel wound. After this was completed, RN-A discarded the soiled gloves and while sitting on the floor, removed R48's rolled gauze dressing from his left lower leg with her bare hands. She proceeded to touch her hair, brushing it from her face. After she tossed the soiled dressing into the garbage, RN-A returned to R48 and pushed him in his wheelchair out of his room. RN-A then donned clean gloves without washing and/or sanitizing her hands and proceeded to check R48's blood glucose. After completing the blood

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glucose check, RN-A removed the soiled gloves, picked up the glucometer (machine used to check blood glucose) with bare hands and wiped it clean with a disinfectant wipe. RN-A placed the glucometer on the medication cart next to her cup of coffee and transported R48 to the dining room. RN-A did not disinfect the top of the cart prior to placing the soiled glucometer onto the medication cart.

When interviewed 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.

It was again noted on 8/23/17, at 10:00 a.m. that RN-C stored the flashlight used for neurological checked on top of the dirty sharps container located on the medication cart. In addition, it was noted a box of Inter-dry dressings were located next the container, available for staff use since it did not fit inside the medication cart according to RN-C.

When interviewed on 8/23/17, at 10:08 a.m. the director of nursing (DON) agreed that cross-contamination was a concern with the noted observations; dressing change, storage of clean/soiled equipment and lack of proper handwashing. It was her expectation staff were

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to follow appropriate infection control technique during dressing changes. The DON further agreed she expected NA-B to implement handwashing and/or use of hand sanitizer between resident contact.

When observed on 8/23/17, at 11:59 p.m. at the west nurses station, a box of Inter-dry dressings were now located on the nurses station counter. Adjacent to these dressings was a cup of coffee and under the counter a large 18 ounce opened bag of an unidentified staff member's cheese puffs stored on the floor next to the medication refrigerator.

During observation of the noted concerns and when interviewed on 8/23/17, at 1:00 p.m. the DON indicated she was unaware of the cross contamination of items in the clean utility rooms and confirmed that after viewing the resident care items stored beneath the sink with corroded pipes, she identified they had a higher number of urinary tract infections. The DON agreed it could be a source of contamination to these items. The DON stated that staff were to store personal drinks and/or purses in their breakroom and not in clean utility rooms where clean resident items are kept. The DON confirmed the use of a rusty toenail trimmer was unacceptable. There was also visible hair noted inside the tub and powder on the whirlpool tub chair seat in the central whirlpool tub room when toured at 1:00 p.m. The DON agreed staff had not properly cleaned nor disinfected the whirlpool tub and seat after resident use.

On 8/24/17, at 10:30 a.m. NA-C demonstrated cleaning and disinfection of the whirlpool tub located in the central hall whirlpool tub room. NA-C proceeded to grab a spray bottle of

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Cen-Kleen from the cupboard and explained she would spray the whirlpool tub down, use the scrub brush to clean the tub and then rinse the tub. NA-C explained that at the end of the day, she would gather all the combs and brushes and rinse them in the whirlpool tub. She acknowledged that was not according to manufacturer's guidelines or instructions, but the process had been changed by the previous DON at least one year ago.

Review of the instructions for cleaning and disinfecting the whirlpool tub, located on the wall behind the tub indicated staff were to have the chemical flow through the jets, enabling the jets to be disinfected. It was noted that 31 of 56 residents routinely bathed in this whirlpool tub. NA-C also explained that nail clippers were routinely cleaned by wiping them off briefly with an alcohol pad. NA-C would clean the residents' combs and brushes by spraying them with Cen-Kleen and rinsing them off inside the whirlpool tub at the end of the day. Staff had no disinfectant available for use on the multi-use resident care items.

R6 was bathed in that whirlpool tub and her toenails were trimmed on bath days. Review of the Provider Visit Note dated 6/22/17, indicated R6 was examined in the clinic that day for an infected toenail. "Cleanse infected proximal nail cuticle to left third toe with wound cleanser, apply Silvadene [topical antibiotic] and cover with Band-aid daily until condition resolves. Cephalexin [oral antibiotic] 500 [milligrams] mg 1 capsule BID [twice daily] x 7 days. Probiotic daily while on oral antibiotic."

Interview on 8/24/17, at 10:46 a.m. with the DON revealed she agreed staff were not appropriately disinfecting the central hall whirlpool tub nor

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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 August 2015 Hand Hygiene facility policy indicated hand hygiene was to have been performed by staff before and after donning or removing gloves, when hands were visibly dirty or contaminated. A hand sanitizer was to be used to decontaminate hands between direct contact with residents, after contact with a resident's skin, and when staff members' hands came into contact with resident care equipment in the immediate vicinity of a resident.

SUGGESTED METHOD OF CORRECTION:
The director of nursing could give education to all staff responsible for preventing infection. Also to monitor for ongoing compliance.

TIME PERIOD FOR CORRECTION: Twenty-one

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21375	Continued From page 39 (21) days.	21375		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility to implement a program to prevent an outbreak of Legionnaires' Disease (a	21390	Corrected	10/3/17

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21390	Continued From page 40 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. 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. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to Legionnaires' disease and ensure the facility risk assessment is completed and reviewed periodically. The DON or designee could educate staff on the policies and the quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy.	21530		10/3/17

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21530	Continued From page 41 This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review the	21530	Corrected	

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consulting pharmacist failed to identify that the Abnormal Involuntary Movement Scale (AIMS)-(an assessment used to assess involuntary movements associated with the use of anti-psychotic medication) had been conducted to monitor medication side effects and that parameters for antacid administration were identified and documented to monitor effectiveness for 2 of 5 resident (R51, R42) reviewed for unnecessary medications.

Findings include:

R51's quarterly Minimum Data Set (MDS) assessment dated 6/2/17, identified a Brief Interview for Mental Status (BIMS) score of 5 indicating severely impaired cognition. It identified the use of an anti-psychotic (AP) medication and diagnoses including Alzheimer's disease and depression.

The physician progress note dated 5/25/17, indicated R51 had exhibited aggressive behavior toward peers. R51 was prescribed Seroquel (an anti-psychotic medication) 25 milligrams (mg) twice a day (BID) with plan to follow up with Sioux Falls psychiatry on 6/6/17.

The physician psychiatry progress note dated 6/6/17 included an order to increase R51's Seroquel 25 mg BID to Seroquel 25 mg in the AM and Seroquel 50 mg at bedtime.

A review of R51's chart did not reveal a baseline AIMS assessment had been completed to monitor for tardive dyskinesia (abnormal involuntary movements) as a potential side effect related to the use of Seroquel.

Review of the consultant pharmacist's monthly

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reviews dated, 5/30/17, 6/29/17, and 7/16/17, did not identify the lack of an AIMS assessment.

When interviewed on 8/24/17, at 1:55 p.m. the assistant director of nursing (ADON) confirmed an AIMS assessment had never been completed for R51, though the resident was "On her list". The ADON stated a baseline screening is completed upon admission then every 6 months thereafter. If a new anti-psychotic medication is initiated, an AIMS screening is completed 30 days after initiation.

The policy titled Completion of Assessments, revised 2/10, included: Tardive Dyskinesia: Baseline upon admission and then every six months thereafter. Thirty days after initialization of new anti-psychotic and discontinuation.

R42's quarterly Minimum Data Set (MDS) assessment dated 5/24/17, identified that R42 had a (BIMS) of 5 indicating severe cognitive impairment.

R42's current physician orders dated 7/27/17, included Maalox Regular Strength (medication used for stomach upset) 200-200-20 milligrams (MG)/5 milliliter (ml) 2-4 teaspoons (tsp) everyday.

Review of the medication administration record (MAR) identified R42 was being administered the Maalox on a daily basis as ordered; however, it did not define the amount of Maalox being administered.

Review of the consultant pharmacist monthly recommendations/reviews from 6/16 through 7/17/17 failed to identify a recommendation related to the Maalox order including parameters

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21530	Continued From page 44 of dose and/or lack of staff documentation of dosage administered to monitor effectiveness. Review of the medication administration record (MAR) identified R42 was being administered the Maalox on a daily basis as ordered; however, it did not define the amount of Maalox being administered. When interviewed on 8/23/17, at 1:27 p.m. registered nurse (RN)-A stated she would ask R42 how much Maalox she wanted or how her stomach was feeling. RN-A indicated she would administer a dose according to R42's response or symptoms. RN-A confirmed that nursing staff are expected to document the amount of Maalox (tsp)administered. She verified this was lacking from documentation reviewed. When interviewed on 8/23/17, at 1:31 p.m. licensed practical nurse (LPN)-A indicated she would administer 4 tsp. of Maalox as R42 usually wanted the maximum amount of Maalox available. LPN-A verified the physician order contained a range without parameters; indicating the order should be clearer. During interview on 8/23/17, at 1:45 p.m. RN-B stated the lack of parameters "leaves leeway" and should be more specific and staff need to document the amount administered to appropriately monitor resident response to the medication. During interview on 8/23/17, at 3:36 p.m. the director of nursing (DON) indicated she would expect staff to clarify the order and/or the consulting pharmacist. She further indicated that concise/clear orders were a standard of practice. She confirmed nursing staff should document the	21530		

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21530	Continued From page 45 actual amount administered 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. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21530		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services,	21535		10/3/17

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21535	Continued From page 46 Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure an Abnormal Involuntary Movement Scale (AIMS)-(an assessment used to assess involuntary movements associated with the use of anti-psychotic medication) was completed to monitor for side effects and to document the amount of liquid medication administered for 2 of 5 residents (R51, R42) reviewed for unnecessary medications. Findings include: R51's quarterly Minimum Data Set (MDS) assessment dated 6/2/17, identified a Brief Interview for Mental Status (BIMS) score of 5, indicating severely impaired cognition. It identified the use of an anti-psychotic (AP) medication and diagnoses including Alzheimer's disease and depression. The physician progress note dated 5/25/17, indicated R51 had exhibited aggressive behavior toward peers. R51 was prescribed Seroquel (an anti-psychotic medication) 25 milligrams (mg) twice a day (BID) with plan to follow up with Sioux Falls psychiatry on 6/6/17. The physician psychiatry progress note dated 6/6/17 included an order to increase R51's Seroquel 25 mg BID to Seroquel 25 mg in the AM and Seroquel 50 mg at bedtime.	21535	Corrected	

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21535	Continued From page 47 A review of R51's chart did not reveal a baseline AIMS assessment had been completed to monitor for tardive dyskinesia (abnormal involuntary movements) as a potential side effect related to the use of Seroquel. When interviewed on 8/24/17, at 1:55 p.m. the assistant director of nursing (ADON) confirmed an AIMS assessment had never been completed for R51. The ADON stated a baseline screening is completed upon admission and every 6 months thereafter; further explaining that if a new antipsychotic medication is initiated, an AIMS screening is completed 30 days after initiation. The policy titled Completion of Assessments, revised 2/10, included: Tardive Dyskinesia: Baseline upon admission and then every six months thereafter. Thirty days after initialization of new antipsychotic and discontinuation. R42's current physician orders dated 7/27/17, included Maalox Regular Strength (medication used for stomach upset) 200-200-20 milligrams (MG)/5 milliliter (ml) 2-4 teaspoons (tsp) everyday. Review of the medication administration record (MAR) identified R42 was being administered the Maalox on a daily basis as ordered; however, it did not define the amount of Maalox being administered. When interviewed on 8/23/17, at 1:27 p.m. registered nurse (RN)-A stated she would ask R42 how much Maalox she wanted or how her stomach was feeling. RN-A indicated she would administer a dose according to R42's response or symptoms. RN-A confirmed that nursing staff are	21535		

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21535	Continued From page 48 expected to document the amount of Maalox (tsp)administered. She verified this was lacking from documentation reviewed. When interviewed on 8/23/17, at 1:31 p.m. licensed practical nurse (LPN)-A indicated she would administer 4 tsp. of Maalox as R42 usually wanted the maximum amount of Maalox available. LPN-A verified the physician order contained a range without parameters; indicating the order should be clearer. During interview on 8/23/17, at 1:45 p.m. RN-B stated the lack of parameters "leaves leeway" and should be more specific and staff need to document the amount administered to appropriately monitor resident response to the medication. During interview on 8/23/17, at 3:36 p.m. director of nursing (DON) indicated she would expect staff to clarify the order and nursing staff document the actual amount administered to R42. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could develop policies and procedures for the use and monitoring of psychoactive medications. Education could be provided related to accurate documentation of medications administered. The facility could educate staff on these policies and procedures, and audit resident records for compliance. The facility could report findings to the quality assurance committee, for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		

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K 000	INITIAL COMMENTS FIRE SAFETY 01 Main Building THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Hendricks Community Hospital Nursing Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145	K 000	EPOC	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245467	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/23/2017**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 St. Paul, MN 55101 Or by e-mail to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Hendricks Community Hospital Nursing Home was constructed as follows: The original building was constructed in 1969, is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; The first addition was constructed in 1987, is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; The second addition was constructed in 1993, is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction. The facility was inspected as one building The nursing home is separated from a critical access hospital by a two-hour fire wall, and the	K 000		

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K 000	Continued From page 2 opening protective consisted of a labeled, self-closing, positive latching, 90-minute fire rated door assembly. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. Resident Rooms are protected with automatic smoke detectors which are interconnected to the building fire alarm control panel [FACP]. The facility has a capacity of 58 beds and had a census of 56 at the time of the survey. The requirement at 42 CR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 346 SS=D	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This STANDARD is not met as evidenced by: Based on documentation review and interview, the Facility failed to provide a current and accurate Fire Alarm Out of Service Policy. This deficient practice could effect 56 of the 56 residents. Fire Alarm - Out of Service Where required fire alarm system is out of	K 346	Out of Service policy for fire alarm system has been updated with the current Staff/Fire Marshall contact information. Maintenance will maintain policy and update as indicated.	9/26/17

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K 346	Continued From page 3 services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 FINDINGS INCLUDE: On facility tour between 11:00 AM and 1:00 PM on 08/23/2017, documentation review revealed that the Out of Service Policy for the Fire Alarm System does not have current Staff/Fire Marshal contact information. This deficient practice was verified by the Facility Maintenance Director.	K 346		
K 354 SS=D	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This STANDARD is not met as evidenced by: Based on documentation review and interview, the Facility failed to provide a current and	K 354	Automatic Sprinkler Operation Back-Up policy has been updated with the current	9/26/17

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K 354	Continued From page 4 accurate Fire Sprinkler Out of Service Policy. This deficient practice could effect 56 of the 56 residents. Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Findings include: On facility tour between 11:00 AM and 1:00 PM on 08/23/2017, documentation review revealed that the Out of Service Policy for the Fire Sprinkler System does not have current Staff/ Fire Marshal contact information and the 10 hour out of service time needs to be updated. This deficient practice was verified by the Facility Maintenance Director.	K 354	staff/Fire Marshal contact information. The 10-hour out of service time has been updated for purposes of initiation of Fire Watch protocol. Maintenance will maintain policy and update as indicated.	
K 711 SS=E	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept	K 711		9/26/17

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K 711	Continued From page 5 informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This STANDARD is not met as evidenced by: Based on documentation review and interview, the Facility failed to maintain a Evacuation and Relocation Plan according to the 2012 Life Safety Code.This deficient practice could affect 56 of the 56 residents Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 FINDINGS INCLUDE: On facility tour between 11:00 AM and 1:00 PM on 08/23/2017, documentation review revealed the Facility Fire Emergency Plan needs to be updated to include language that staff will call 911 in the event of smoke and/or fire.	K 711	The Facility Fire Emergency Plan has been updated to include responsibility of the employee who discovers smoke and/or fire to call 911. Staff education to departments has been communicated. Maintenance will maintain policy and update as indicated.	

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K 711	Continued From page 6 This deficient practice was verified by the Facility Maintenance Director.	K 711		
K 911 SS=E	NFPA 101 Electrical Systems - Other Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This STANDARD is not met as evidenced by: Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This deficient practice could effect 56 of the 56 residents. FINDINGS INCLUDE: On facility tour between 11:00 AM and 1:00 PM on 08/23/2017, items were observed being stored within 36 inches of electrical access panels and shut off switches in the West Pod Mechanical Room. This deficient practice was verified by the Facility Maintenance Director.	K 911	The west pod mechanical room has been cleaned to maintain minimum of 36 inch space access to electrical panels and shut off switches. Staff educated. Maintenance will monitor compliance per periodic environmental rounding.	9/26/17