DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 13, 2022

Administrator
Evansville Care Center
649 State Street Northwest
Evansville, MN 56326

RE: CCN: 245510
Cycle Start Date: May 4, 2022

Dear Administrator:

On May 4, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Rd., Suite 300
Fergus Falls, Mn. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by August 4, 2022 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by November 4, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
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
	245510	A. BUILDING _____ B. WING _____	05/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVANSVILLE CARE CENTER	649 STATE STREET NORTHWEST EVANSVILLE, MN 56326

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E 000	Initial Comments On 5/2/22, to 5/4/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 5/2/22, to 5/4/22, a standard recertification 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, Requirements for Long Term Care Facilities. Your facility was found to be NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights.	F 550		6/1/22

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

Electronically Signed | 05/18/2022

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F 550	Continued From page 1 The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.	F 550		

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F 550	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure dignity was maintained for 1 of 1 resident (R13) who utilized an incontinent pad. Findings include: R13's quarterly Minimum Data Set (MDS), dated 3/10/22, identified R13 was cognitively intact and had diagnoses which included hemiplegia, seizure disorder, anxiety. The MDS indicated R13 required staff supervision with bed mobility, eating, limited assistance with transfers and extensive assistance of one staff for dressing, toileting, personal hygiene and bathing. The MDS identified R13 was occasionally incontinent of urine and continent of bowel and was not on a toileting program. R13's care plan revised on 5/3/22, indicated R13 required staff assistance with toileting tasks due to occasional incontinence of bladder and wore a brief. The care plan identified R13 was independent with mobility once up in her motorized scooter. During observations on 5/2/22, at 3:22 p.m. R13 was observed outside seated in her scooter smoking. A white incontinent pad was draped over R13's entire seat and hung down the sides of her scooter. The white incontinent pad was visible to other residents and visitors. - at 3:35 p.m. R13 re-entered the building independently and went to the commons area to sit where other residents were present. R13's white incontinent pad remained the same and was visible to other residents.	F 550	F550 The resident was interviewed. She expressed that she would like to continue to use an incontinent pad over her seat of her motorized scooter. A patterned pad was provided. Her plan of care was updated to reflect the preference. Staff educated. All incontinence management plans were reviewed for all residents. All residents who require an incontinent pad is utilizing this product in a discreate way. No further complaints noted from residents. Care plans were updated to reflect current use. Dignity with the use of incontinence products will be audited by the MDS Coordinator on a weekly basis for four weeks and then on a quarterly basis thereafter during the resident assessment period. The incontinence products will be audited with the review of bowel and bladder program. Audits will be monitored by the QAPI team on a quarterly basis. Education will be provided to all staff on resident rights with a specific focus on maintaining resident dignity. The Director of Nursing will be responsible. The date compliance will be certain will be 06/01/2022.	

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F 550	Continued From page 3 - at 4:18 p.m. R13 was observed outside smoking seated in her electric scooter and the white incontinent pad remained the same. - at 4:20 p.m. R13 re-entered the facility and went to the commons area to sit where other residents were present. R13's white incontinent pad remained the same. - at 4:46 p.m. R13 was observed outside smoking and continued to have a white incontinent pad on the seat of her scooter visible to other residents and visitors. - at 4:51 p.m. R13 remained the same. During observations on 5/3/22, at 10:45 a.m. R13 was observed outside seated in her scooter smoking. A white incontinent pad was draped over R13's entire seat and hung down the sides of her scooter. The white incontinent pad was visible to other residents and visitors. - at 12:30 p.m. R13 was observed seated on her electric scooter out in the commons area with other residents present. R13's white incontinent pad remained the same. - at 1:43 p.m. R13 was observed seated on her electric scooter out in the dining room area with other residents while she looked at her cell phone. R13's white incontinent pad remained the same. - at 3:24 p.m. R13 was observed outside smoking and her white incontinent pad remained the same. During observations on 5/4/22, at 7:17 a.m. R13 exited her room in her electric scooter. R13's seat of her scooter had a white incontinent pad draped over the entire seat of her electric scooter and was visibly hanging down the sides of her scooter exposed for other residents and visitors to see. R13 wheeled down the hallway and went out side	F 550		

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F 550	Continued From page 4	F 550		

to smoke.
- at 7:40 a.m. R13 was seated in the commons area on her electric scooter with other residents present. R13's white incontinent pad remained the same.
- at 8:05 a.m. R13 was seated in the commons area on her electric scooter eating her breakfast independently with other residents present. R13's white incontinent pad remained the same.

On 5/2/22, at 6:29 p.m. R13 indicated she was incontinent of urine at times and utilized incontinent products to mange it. R13 stated she disliked having the incontinent pad placed on the seat of her electric scooter since it hung down and "looked awful". R13 stated she believed it did not look good at all to have the incontinent pad visible to others especially if people knew what the pads were used for. R13 expressed she especially felt that way when she was at a restaurant.

On 5/4/22, at 11:32 a.m. nursing assistant (NA)-D stated R13 was incontinent of bladder at times, wore a brief and required staff assistance with toileting and incontinent brief changes. NA-D indicated R13 had an incontinent pad on the seat of her scooter to protect the cushion from becoming soiled in case she had an incontinent episode. NA-D stated the facility had different colored incontinent pads which could have been used instead of the white ones or disposable pads and indicated they all provided the same level of absorbency.

On 5/4/22, at 10:06 a.m. registered nurse (RN)-B stated R13 was incontinent of urine and required staff assistance with personal hygiene and incontinent cares. RN-B indicated R13 used an

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F 550	Continued From page 5 incontinent pad on the seat of her scooter to prevent the seat of her scooter from becoming soiled. RN-B stated she was not certain if R13 had concerns about the white incontinent pad placed on the seat of her scooter being visible to other residents and visitors however indicated she had not asked R13 about it. RN-B confirmed the white incontinent pad was visible to other residents and visitors and verified it could have been a dignity issue for R13. On 5/4/22, at 11:59 a.m. the director of nursing (DON) stated R13 was incontinent of urine at times and wore a brief. The DON indicated R13 required staff assistance with toileting and pericares and was not aware R13 utilized an incontinent pad on the seat of her scooter. The DON stated the facility had different types of incontinent pads which had patterns on them and was not certain why staff chose to use the white pads. The DON confirmed use of an incontinent pad which was visible to other residents and visitors could be a dignity issue. The DON stated she would expect staff to use the right type of incontinent pad on the seat of R13's scooter to prevent it from being visible to other residents and visitors. Review of the facility policy titled, Resident Rights, Dignity and Privacy undated, indicated staff would promote care for residents in a manner and in an environment that maintained or enhanced each resident's dignity and respect in full recognition of his or her individuality.	F 550		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse,	F 609		6/1/22

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F 609	Continued From page 6 neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report to the administrator and no later than 2 hours, to the State Agency (SA) an allegation of staff to resident verbal abuse for 1 of 1 residents (R17) who was reviewed for allegations of abuse. Findings include: R17's admission Minimum Data Set (MDS) dated	F 609	F609 The initial investigation of the incident has been completed. Upon findings of the survey the resident involved was interviewed again. She reiterates that she did not have reservations of staff working with her and notes that there have not been any further incidents. The staff involved was educated on abuse and self-care. A review will be conducted in 30	

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F 609	Continued From page 7 3/30/22, indicated R17 was cognitively intact and had diagnoses which included renal insufficiency, diabetes and cerebrovascular accident. The MDS identified R17 required staff supervision for bed mobility, limited assistance of one staff for transfers, ambulation, dressing, toileting, personal hygiene, bathing and was independent with eating. Review of R17's Record of Grievance/Complaint form dated 4/2/22, revealed the following: -R17 wrote a complaint about nursing assistant (NA)-C stating she had her call light on because she required assistance with wiping. NA-C entered R17's room and asked R17 what she wanted, R17 said she told NA-C and NA-C replied "what are you going to do when you go home, drag your butt across the floor?" R17 indicated NA-C was often snarly with her. - The grievance form indicated the director of nursing (DON) investigated the complaint and R17 was interviewed and confirmed the complaint. The DON interviewed NA-C and NA-C admitted she asked R17 why she needed assistance and had encouraged R17 to participate in her cares. NA-C could not recall saying anything derogatory or sarcastic to R17. - The form identified NA-C would apologize to R17 for offending her and would proceed in assisting R17 when ever she called without question. Review of R17's medical record lacked any documentation of the SA being notified of the allegation of verbal abuse. On 5/2/22, at 4:05 p.m. R17 stated there had been an incident with NA-C who had not been very nice to her about three weeks ago. R17	F 609	days with staff A facility wide investigation was also conducted and revealed no further incidents or concern with staff. The abuse prevention plan was reviewed to reflect current standards of practice. The facility incident reporting procedure was also reviewed. The grievance procedure was reviewed and revised. The charge nurse will review incidents potentially requiring reporting to MDH once the complaint or incident occurs. This will be accomplished by calling the administrator or designee at the time of the complaint / incident. Staff will review incidents potentially requiring reporting to MDH daily. The IDT will review M-F and the licensed nurses will review over the weekend and report any discrepancies to the Administrator immediately. This will ensure reporting has taken place if deemed appropriate by Administrator to ensure compliance and timeliness. An audit will be completed of each incident to ensure compliance. The IDT will review incidents at daily meetings to ensure reporting has taken place and it was within two hours to ensure compliance and timely reporting. This process will be indefinite. QAPI will review the policy and reporting procedure along with incidents on a quarterly basis and will be updated as needed to sustain compliance. Education will be provided to all staff with the changes and to reiterate the proper reporting requirements and that incidents have to be reported within two hours.	

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F 609	Continued From page 8 indicated NA-C came into her room to assist R17 in the bathroom when NA-C stated "what are you going to do when you get home,drag you butt across the floor?" R17 confirmed NA-C's statement made her feel about an inch high and it hurt her feelings. R17 indicated the DON spoke with her, stated NA-C was having an off day and advised R17 not to take the statement personally. R17 stated the DON said she would speak with NA-C about the incident to obtain her view of the incident. In a follow up interview on 5/4/22, at 7:07 a.m. R17 indicated the incident made her feel like she was putting NA-C out when R17 asked her for assistance. R17 stated the incident had made her very upset and it made her "heart hurt". R17 indicated NA-C was not nice and just did her job. R17 stated she felt she had been mentally abused by NA-C when she made that comment to her. R17 indicated she had informed registered nurse (RN)-B about the incident and was provided a grievance form to complete. On 5/4/21, at 10:15 a.m. RN-B indicated R17 wanted to file a grievance about a month ago regarding a statement NA-C made related to how R17 was going to manage independently when she went home. RN-B stated she was not able to remember the details however it had something to do with R17 requiring assistance in the bathroom. RN-B indicated R17 completed the grievance form and the form was turned in after RN-B had left for the day. On 5/4/22, at 10:37 a.m. NA-C stated she had entered R17's bathroom to assist R17 with toileting tasks. NA-C indicated a plan had been in place for R17 to return home soon and NA-C had	F 609	Annual training will also be reviewed with all staff. Each incident will be reviewed individually for compliance of the abuse prevention plan. The facility administrator will be responsible. The date compliance will be certain will be 06/01/2022.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 9	F 609		

asked R17 how she was going to manage those tasks when she returned home. NA-C stated the DON had asked her what had happened and she told her the same thing. NA-C indicated she had expressed a desire to go speak with R17 about the incident to the DON and the DON granted her permission to do so. NA-C stated she apologized to R17 the next day by herself and R17 informed her it was not what she said but how she had said it. NA-C confirmed she continued to work with R17 and other residents after the incident occurred and was not provided any education regarding the incident.

On 5/4/22, at 1:59 p.m. the DON confirmed the above findings and indicated R17 had reported to her after she had placed her call light on, NA-C answered the call and asked R17 what she wanted. The DON indicated NA-C asked R17 what her plans were when she returned home as she would not have assistance at home. The DON stated R17 expressed she had "an uneasy feeling" related to the incident. The DON indicated she had spoke to NA-C the next day and NA-C stated she would apologize to R17. When reviewing the grievance form with the DON, the DON verified R17 was angry about the incident. The DON stated NA-C had worked at the facility for a significant amount of time so she had not considered the incident to be an allegation of verbal abuse. The DON indicated R17 completed a grievance form which described the incident. The DON confirmed the facility had not reported the incident to the SA.

On 5/4/22, at 2:31 p.m. the administrator confirmed the above findings and indicated he could not recall if he had been notified of the allegation involving NA-C. The administrator

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	245510	A. BUILDING _____ B. WING _____	05/04/2022

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F 609	Continued From page 10 stated the facility's abuse process consisted of the resident completing a grievance form and staff were expected to report the incident immediately. The administrator indicated if the allegation involved a staff member they would be taken off the schedule until the investigation was completed. The administrator indicated they review their grievances in the morning at the managers meeting everyday. Review of the facility policy titled, Abuse Prevention Plan revised on 1/28/21, indicated the facility would report all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property immediately to the administrator of the facility and to other officials in accordance with State laws. The policy indicated the allegations would be reported immediately, but not later than two hours after the allegation had been made, if the events that caused the allegation involved or resulted in serious bodily injury, or not later than 24 hours after the events that caused the allegation do not involve abuse and do not result in serious bodily injury, to the Administrator and to other officials in accordance with state law.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.	F 610		6/1/22

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F 610	Continued From page 11 §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to thoroughly investigate an allegation of staff to resident abuse for 1 of 1 residents (R17) reviewed for allegations of abuse. In addition, the facility failed to protect the resident and report to the State Agency (SA) the results of the investigation within 5 working days for 1 of 1 allegations of abuse reviewed. Findings include: R17's admission Minimum Data Set (MDS) dated 3/30/22, indicated R17 was cognitively intact and had diagnoses which included renal insufficiency, diabetes and cerebrovascular accident. The MDS identified R17 required staff supervision for bed mobility, limited assistance of one staff for transfers, ambulation, dressing, toileting, personal hygiene, bathing and was independent with eating. Review of R17's Record of Grievance/Complaint form dated 4/2/22, revealed the following: -R17 wrote a complaint about nursing assistant (NA)-C stating she had her call light on because she required assistance with wiping. NA-C	F 610	F610: Investigate/Prevent/Correct Alleged Violation A follow up investigation for resident R17 was completed on 5/5/22. An investigation was completed, and it was determined this was an isolated incident. Individual education was provided to CNA involved in grievance. An interview of all residents in facility was conducted to identify if any other residents were affected. No additional findings. The grievance form will be updated with specific direction on what to immediately do with the form once it is received by staff. The grievance policy will be updated to reflect the new process. Education will be provided to all staff on changes made. Annual training will be reviewed with all staff. To ensure system success with investigations, a form will be created to make certain the facility has a thorough template for each and every investigation and to include timely reporting requirements. An initial assessment will	

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F 610	Continued From page 12 entered R17's room and asked R17 what she wanted, R17 said she told NA-C and NA-C replied "what are you going to do when you go home, drag your butt across the floor?" R17 indicated NA-C was often snarly with her. - The grievance form indicated the director of nursing (DON) investigated the complaint and R17 was interviewed and confirmed the complaint. The DON interviewed NA-C and NA-C admitted she asked R17 why she needed assistance and had encouraged R17 to participate in her cares. NA-C could not recall saying anything derogatory or sarcastic to R17. - The form identified NA-C would apologize to R17 for offending her and would proceed in assisting R17 when ever she called without question. Review of R17's medical record lacked any documentation of the SA being notified of the allegation of verbal abuse. On 5/4/22, at 1:59 p.m. the DON confirmed the above findings and indicated she had not considered the incident to be an allegation of abuse. The DON stated she had interviewed R17 and NA-C and confirmed she not spoke to other staff or residents to determine if there had been other allegations. The DON indicated the facility's usual practice was to ensure the resident was safe, remove the staff member from the floor, report the allegation to the SA and begin the investigation. The DON stated part of the investigation would be to interview other residents and staff and to submit the results of the investigation to the SA within 5 days. The DON confirmed NA-C had never been removed from the schedule during the investigation nor was there an investigation sent to the SA.	F 610	determine resident safety and need for an investigation. After initial assessment, the level of risk of staff will be determined and may be removed from floor. Upon completion of investigation, it will be determined when staff can return to the floor, or other steps that need to be taken such as education or disciplinary action. Tracking of the five-day reporting window will be completed on the investigation form to ensure compliance. The IDT will audit each investigation at daily meetings to ensure reporting has taken place and it was within five working days to ensure compliance and timely reporting. This process will be indefinite. QAPI will review the policy and investigation procedure on a quarterly basis and will be updated as needed to sustain compliance. The facility Administrator will be responsible. The date compliance will be certain is 6/1/22.	

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F 610	Continued From page 13 On 5/4/22, at 2:31 p.m. the administrator confirmed the above findings and indicated he could not recall if he had been notified of the allegation involving NA-C. The administrator stated the facility's abuse process was to complete a grievance, report it immediately to the SA, investigate the allegation and submit the results of the investigation to the SA. The administrator indicated if the allegation involved a staff member they were to be removed from the schedule until the investigation was completed. Review of the facility policy titled, Abuse Prevention Plan revised on 1/28/21, Review of the facility policy titled, Abuse Prevention Plan revised on 1/28/21, indicated the facility would report all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property immediately to the administrator of the facility and to other officials in accordance with State laws. The policy indicated the allegations would be reported immediately, but not later than two hours after the allegation had been made, if the events that caused the allegation involved or resulted in serious bodily injury, or not later than 24 hours after the events that caused the allegation do not involve abuse and do not result in serious bodily injury, to the Administrator and to other officials in accordance with state law. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including the State survey and certification agency) within 5 working days of the incident, and if the alleged violation was verified appropriate action would be taken."	F 610		

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F 886	Continued From page 14	F 886		
F 886 SS=F	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the	F 886		6/1/22

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F 886	Continued From page 15 results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure routine COVID-19 testing occurred for unvaccinated staff according to the community positivity rates identified in CMS (Centers for Medicare and Medicaid Services) guidelines. In addition, the facility failed to identify if any individuals providing services under arrangement or volunteers who were not up to date with COVID vaccinations were also routinely tested per CMS guidelines. This deficient practice had the potential to affect all 24 residents residing in the facility.	F 886	F886: COVID-19 Testing – Residents & Staff All staff that are not fully vaccinated or up to date have been identified and tested. The testing policy has been reviewed and updated to reflect alternate test reporting at the frequency of the county rate. The testing spreadsheet log was updated to reflect the dates of testing. The manager will be responsible to ensure the staff does not work until testing is completed. Staff education will be provided to all staff on updated policy and procedures. An	

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F 886	Continued From page 16 Findings Include: CMS's Quality, Safety and Oversite Group (QSO) memo 20-38 for nursing homes dated 3/10/22, identified the long term care (LTC) facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. The memo indicated the facility must have procedures for addressing staff, including individuals providing services under arrangement and volunteers, who refuse testing or were unable to be tested. The QSO memo identified "Facility staff" included employees, consultants, contractors, volunteers, and caregivers who provided care and services to residents on behalf of the facility, and students in the facility's nurse aide training programs or from affiliated academic institutions. For the purpose of testing "individuals providing services under arrangement and volunteers," facilities should prioritize those individuals who were regularly in the facility (e.g., weekly) and had contact with residents. The memo instructed facilities to use their community transmission level as the trigger for staff testing frequency. The facility was expected to test all staff, who were not up-to-date, at the frequency prescribed in the Routine Testing table based on the level of community transmission. The Center for Disease Control and Prevention (CDC) identified the Douglas county community transmission rate was substantial from 4/19/22, to 4/25/22. Review of the employee COVID-19 vaccination log, untitled, undated, identified the facility had a total of 41 staff. Nine of the 41 staff were not up to date and eight staff had religious exemptions.	F 886	audit of the testing log will be performed weekly for four weeks and then monthly for six months to ensure each employee is testing according to CMS requirements and county rates. QAPI will review audits on a quarterly basis and will be updated as needed to sustain compliance. Social Services Designee will be responsible. The date compliance will be certain is 6/1/22. Orientation process will be updated to capture vaccination dates/brand. A copy of the staff's vaccination card or a printout from their clinical records will be obtained. This will be done at orientation before staff work with residents. An audit of vaccination/exemption tracking will be performed weekly for four weeks and then monthly for six months to ensure each employee is has vaccination information in place according to CMS requirements. QAPI will review audits on a quarterly basis and will be updated as needed to sustain compliance. Education provided to Human Resources Director with new process to ensure compliance. Education provided to all staff. Infection Control Nurse will be responsible. The date compliance will be certain is 6/1/22. A list of contracted staff providing services was made and vaccination records/exemption forms will be obtained for those individuals. Facility will obtain records for any new contracted staff going forward upon first entrance into facility. Policy was updated to include contracted and volunteer staff. Manager education	

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F 886	Continued From page 17 Review of the facility Staff Testing log from 2/3/22, to 5/2/22, identified the following: -nursing assistant (NA)-A was marked as "no show" for testing scheduled 2/7/22. -NA-B was marked as "no show" for testing scheduled 2/24/22. -licensed practical nurse (LPN)-A was marked as "no show" for testing scheduled 4/21/22. -NA-C was marked as "no show" for testing scheduled 4/18/22. The testing log lacked identification if facility staff were tested prior to working when they were marked "no show" for the scheduled dates for routing testing. In addition, the facility lacked documentation which identified any individuals providing services under arrangement in the facility who were not up to date for COVID vaccinations were routinely tested based on the community transmission level. Review of the facility Daily Assignment Sheets from 2/3/22, to 5/2/22, identified the following: -NA-A worked 2/10/22, three days after marked "no show" for testing scheduled 2/7/22. -NA-B worked 2/25/22, one day after marked "no show" for testing scheduled 2/24/22. -LPN-A worked 4/21/22, after marked "no show" for testing scheduled 4/21/22. -NA-C worked 4/20/22, two days after marked "no show" for testing scheduled 4/18/22. NA-A's COVID-19 vaccination records identified Pfizer vaccination was administered 6/4/21, and 6/25/21. NA-A's form titled Employee Declination Of COVID Booster Vaccination identified NA-A declined the COVID-19 booster vaccination on 11/3/21.	F 886	will be provided on new procedure to ensure compliance. Contracted companies will be contacted and educated on our new process. An audit of the entrance screening questionnaire will be performed weekly for six weeks to ensure compliance. QAPI will review audits on a quarterly basis and will be updated as needed to sustain compliance. Social Services will be responsible. The date compliance will be certain is 6/1/22.	

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F 886	Continued From page 18 NA-B's COVID-19 vaccination records identified Pfizer vaccination was administered 1/13/22. No second vaccination or booster vaccination records were received. On 5/5/22, Administrator confirmed by email NA-B had not received her second vaccination or the booster. LPN-A's Religious Accommodation Request Form dated 11/21/22, identified NA-B's request for exemption was signed 11/18/21, no approval signature or date identified. NA-C's COVID-19 vaccination records identified Moderna vaccination was administered 1/7/21, and 2/4/21. NA-C's form titled Employee Declination Of COVID Booster Vaccination identified NA-C declined the COVID-19 booster vaccination on 2/15/22. During an interview on 5/4/22, at 11:36 a.m. social service designee (SSD)-A stated she completed the staff testing logs. SSD-A confirmed she recorded staff testing performed on the scheduled testing days and verified when staff were tested by placing an X on the log. SSD-A indicated she did not keep track if staff worked after they missed the scheduled testing date. SSD-D stated she was not aware if staff were tested prior to working their next shift if they missed a testing date. During a follow-up interview on 5/4/22, at 12:57 p.m. SSD-A confirmed the facility only tracked testing for facility employees and therapists. SSD-A verified the facility did not track vaccination status or testing of any other contracted staff who were in the facility providing services.	F 886		

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F 886	Continued From page 19 On 5/4/22, at 1:52 p.m. director of nursing (DON) confirmed SSD-A was responsible for ensuring all staff were tested for COVID-19 as required. DON indicated the facility's routine COVID-19 testing was completed based on the level of community transmission and the facility had been performing routine testing twice a week for the past two weeks. DON stated she would expect staff who had not completed routine testing on the scheduled date to be tested prior to their next scheduled shift. DON indicated the infection preventionist (IP)-A collected vaccination records of contracted staff and worked with SSD-A on the process. DON stated she would expect IP-A and SSD-A would assure staff who required testing had it completed according to the guidelines. DON confirmed the facility had no testing records of the contracted staff other than the pool staff. DON indicated proper testing of staff was important to prevent transmission of COVID-19 in the facility. On 5/4/22, at 2:27 p.m. IP-A confirmed she did not have records of contracted staff's COVID-19 vaccination status and indicated DON and Administrator were responsible for that. IP-A stated she was not responsible to assure COVID-19 testing was completed. The facility policy titled COVID-19 Testing Policy, undated, identified testing would be performed to reduce the risk for serious illness and death related to the COVID-19 pandemic. The policy identified the facility's routine testing intervals were based on the county COVID-19 level of community transmission. The policy further identified any staff that refused testing would not be allowed to work.	F 886		

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F 886	Continued From page 20 The policy lacked identification of procedures to determine testing needs and results of individuals providing services under arrangement and volunteers. Additionally, the policy lacked identification of procedures for staff testing of individuals who did not complete testing on the facility scheduled testing dates as required.	F 886		

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	245510	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/04/2022**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted on 05/04/2022 by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Evansville Care Center 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 and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 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. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/18/2022

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
	245510	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/04/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVANSVILLE CARE CENTER	**649 STATE STREET NORTHWEST** **EVANSVILLE, MN 56326**

(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 HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Evansville Care Center is a 1-story building with a partial basement. The building was constructed at three different times. The original building was constructed in 1968 and was determined to be of Type I(332) construction. In 1988, additions were added to the south of the Main Lounge and to the west of the North Wing that were determined to be of Type V(111) construction. In 1998 an addition was added to the end of West Wing that was determined to be of Type V(111) construction. Because the original building and the additions meet the construction types allowed	K 000		

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K 000	Continued From page 2 for existing buildings, the facility was surveyed as one building. The facility is completely fire sprinkler protected. The facility has a fire alarm system with smoke detectors in the corridors and areas open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 37 beds and had a census of 24 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a) are NOT MET as evidenced by:	K 000		
K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are	K 222		5/19/22

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K 222	Continued From page 3 being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the	K 222	K222: Egress Doors	

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K 222	Continued From page 4 facility failed to maintain the operation of the exit door locking device system per NFPA 101 (2012 edition), Life Safety Code, section 7.2.1.6.1.1(3)(4). These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 05/04/2022, at 10:45 AM, it was revealed by observation that the delayed egress exit door in the west exit on the south wing did not have the proper signage stating, "Push until alarm sounds, door can be opened in 30 seconds." 2. On 05/04/2022, at 10:50 AM, it was revealed by observation that the delayed egress exit door at the Sunset exit did not have the proper signage stating, "Push until alarm sounds, door can be opened in 30 seconds." 3. On 05/04/2022, at 11:22 AM, it was revealed by observation that the delayed egress exit door by resident room 120 did not have the proper signage stating, "Push until alarm sounds, door can be opened in 30 seconds." An interview with Maintenance Director, Administrator, and Regional Maintenance Director verified these deficient findings at the time of discovery.	K 222	Three doors identified that have a delayed egress did not have proper signage stating, “Push until alarm sounds, door can be opened in 30 seconds” Proper signage is being obtained and will be placed on the three doors. Column was added to annual door inspection log to ensure signage is intact. Date certain will be 5/19/22.	
K 353 SS=C	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection,	K 353		5/16/22

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K 353	Continued From page 5 Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the automatic sprinkler system was not maintained per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), the Standard for the Inspection, Testing, and Maintenance of Water Based Fire Protection Systems, section 5.4.1.4, and 5.4.1.4.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/04/2022, at 11:35 AM, it was revealed by observation that there were two unsecured fire sprinkler heads that were not protected from being damaged, stored within the spare sprinkler headbox that was located at the main fire sprinkler riser. An interview with the Maintenance Supervisor verified this deficient finding at the time of discovery.	K 353	K353: Sprinkler System – Maintenance and Testing Two sprinkler heads were unsecured stored within the spare sprinkler headbox that is located at the main fire sprinkler riser. Sprinkler heads have been secured by maintenance. A spare sprinkler head audit was added to the monthly maintenance checklist. Date certain 5/16/22.	

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