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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: XFI5

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 **09/05/2013** (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):

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Kathy Serie, Unit Supervisor — 08/23/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 09/16/2013 (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
09/20/2013
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN: 24-5467

On September 5, 2013, the Minnesota Department of Health completed a PCR by review of your plan of correction and on October 24, 2013, 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 standard survey completed on July 18, 2013 and an FMS completed on August 27, 2013.

As a result of the revisit findings, the Department is recommended to the CMS Region V Office the following actions related to the remedies outlined in their letter of September 10, 2013. The CMS RO concurred.

Mandatory denial of payment for new Medicare and Medicaid admissions, effective October 18, 2013, be rescinded. (42 CFR 488.417 (b))

Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey completed on July 18, 2013 and FMS completed on August 27, 2013, as of October 7, 2013.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245467

January 21, 2014

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

Dear Mr. Gollaher:

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

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

Effective August 27 2013, the above facility is certified for:

58 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Kate Johnston

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

January 6, 2014

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

RE: Project Number S5467023, F5467021 and F5467023

Dear Mr. Gollaher:

On August 6, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey completed on July 18, 2013. The 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 August 27, 2013, surveyors from the Centers for Medicare and Medicaid Services (CMS) completed a Federal Monitoring Survey (FMS) of your facility. As the surveyor informed you during the exit conference, the FMS revealed that your facility continues to not be in substantial compliance. The FMS 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). As a result of the FMS, CMS imposed the following remedy:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective October 18, 2013. (42 CFR 488.417 (b))

Also, the CMS Region V Office notified you in their letter of September 10, 2013, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 18, 2013.

On September 5, 2013, the Minnesota Department of Health completed a PCR by review of your plan of correction and on October 24, 2013, 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 standard survey completed on July 18, 2013 and an FMS completed on August 27, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 7, 2013. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey completed on July 18, 2013 and FMS completed on August 27, 2013, as of October 7, 2013.

As a result of the revisit findings, the Department is recommended to the CMS Region V Office the following actions related to the remedies outlined in their letter of September 10, 2013. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective October 18, 2013, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective October 18, 2013, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective October 18, 2013, is to be rescinded.

In the CMS letter of September 10, 2013, CMS advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 18, 2013, due to denial of payment for new admissions. Since your facility attained substantial compliance on October 7, 2013, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition.

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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245467	A. Building B. Wing	9/5/2013

Name of Facility	Street Address, City, State, Zip Code
HENDRICKS COMMUNITY HOSPITAL	503 E LINCOLN STREET HENDRICKS, MN 56136

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **08/27/2013**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **08/27/2013**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **08/27/2013**
ID Prefix **F0411** Reg. # **483.55(a)** LSC	Correction Completed **08/27/2013**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **08/27/2013**	ID Prefix **F0463** Reg. # **483.70(f)** LSC	Correction Completed **08/27/2013**
ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **08/27/2013**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	MM/PS	01/06/2014	31767	09/05/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
7/18/2013			

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245467	A. Building B. Wing **01 - MAIN BUILDING 01**	10/24/2013

Name of Facility	Street Address, City, State, Zip Code
HENDRICKS COMMUNITY HOSPITAL	503 E LINCOLN STREET HENDRICKS, MN 56136

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **10/03/2013**	ID Prefix	Correction Completed **09/27/2013**	ID Prefix	Correction Completed **10/03/2013**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0021		LSC K0025		LSC K0061	
ID Prefix	Correction Completed **10/07/2013**	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # **NFPA 101**		Reg. #		Reg. #	
LSC K0062		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By _____ **State Agency**	**Reviewed By** MM/PS	**Date:** 01/06/2014	**Signature of Surveyor:** 19251	**Date:** 10/24/2013
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 8/27/2013	_____	**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?** **YES** **NO**

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245467	A. Building B. Wing 01 - MAIN BUILDING 01	10/24/2013

Name of Facility	Street Address, City, State, Zip Code
HENDRICKS COMMUNITY HOSPITAL	503 E LINCOLN STREET HENDRICKS, MN 56136

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0025	08/21/2013	ID Prefix Reg. # NFPA 101 LSC K0147	07/20/2013	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By MM/PS	Date: 01/06/2014	Signature of Surveyor: 19251	Date: 10/24/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 7/18/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: XFI5

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00340

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

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

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

4. TYPE OF ACTION: **2** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/18/2013** (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:

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Shawn Soucek, HPS SWS 08/23/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
(L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 9/20/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24-5467

At the time of the July 18, 2013 standard survey the facility was not in substantial compliance with Federal participation requirements. Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 5087

August 6, 2013

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

RE: Project Number S5467023

Dear Mr. Gollaher:

On July 18, 2013, 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 attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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:

Kathyrn Serie
Minnesota Department of Health
Mankato Place
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001-7789

Telephone: (507) 537-7158
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 August 27, 2013, 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 August 27, 2013 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

If an acceptable PoC 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 PoC 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 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 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by October 18, 2013 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement

of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 18, 2014 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

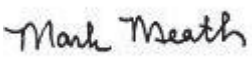
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions related to this letter.

Sincerely,



Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5467s13.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245467	A. BUILDING _____ B. WING _____	07/18/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. 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 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced	F 280	approved on 8/20/13 Kmt RECEIVED AUG 20 2013 Minnesota Dept of Health Mankato	9

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE CEO (X6) DATE 8-19-13

y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ier safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days owing 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 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued gram participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 280	Continued From page 1 by: Based on observation, interview and document review, the facility failed to ensure a resident's care plan was updated to reflect necessary care changes for skin and mobility for 1 of 3 residents (R18) reviewed for pressure ulcers. The findings include: Although R18 had a known history of pressure ulcers, the resident's plan of care was not revised to include interventions recommended by therapy, nor was the care plan revised to indicate the resident required assistance with repositioning and mobility when the resident experienced a decrease in her activity of daily living (ADL) abilities. During observations on 7/17/13 at 6:58 a.m., R18 was observed in her room seated in a wheelchair on two cushions. An egg crate cushion was also observed on the seat of the recliner located in R18's room. The resident's record was reviewed. According to documentation on the Big Stone Therapy Caregiver Education Sheet dated 6/24/13, an Occupational Therapist (OT) had recommended "use gel T-foam cushion in wheelchair and E-Z dish cushion in recliner to decrease pressure on [R18's] coccyx." The OT's recommendations were not added to the resident's care plan. During interview with nursing assistant (NA)-G on 7/17/13 at 2:21 p.m., NA-G verified R18 used to reposition herself but had declined in her ability to do so, and was no longer able to reposition herself as much as she used to.	F 280	F280 1. Corrective Action: a. The resident's cushions were corrected on 7/17/13. Her care plan was updated to reflect her changing needs. She was seen by the physician on 7/19/13 to review possible causes for decline. b. It is this facility's practice to provide a comprehensive care plan for each resident, meeting the requirements of the OBRA regulations. Resident R18 was re-evaluated by the RN and an assessment, CAA, and Care plan were updated with a significant change assessment with an ARD of 8/15. The resident is having a significant change assessment completed due in part to starting hospice care. 2. Corrective Action as it applies to other residents: a. All residents with skin integrity issues were reviewed and evaluated against their last comprehensive assessment to assure all care plans were up to date. b. The policy and procedure for skin integrity was reviewed and revised on 8/15/2013. c. Education was provided to all nursing staff on August 22nd & 26th on the skin policies, including notification, wound documentation, and standards for treatment and prevention of pressure ulcers 3. All Corrective Actions will be completed by: Aug 27th, 2013. 4. Reoccurrence will be prevented by: a. And RN will audit 100% of new pressure ulcers to determine that	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 280	Continued From page 2 During an observation on 7/17/13, at 1:41 p.m., registered nurse (RN)-E removed a Tegaderm hydrocolloid dressing from R18's buttocks. The skin on the left buttock was observed to have several sporadic red areas, dry in appearance, varying in size from 0.75 centimeters (cm) x (by) 0.2 cm. In addition there was a large, 10 cm x 4 cm, deep purple area observed extending from the resident's left buttock to the right buttock. The area was observed to be blanchable when the nurse pressed on the resident's skin with her fingers. A smaller non-blanchable red area measuring 2.0 cm x 3.0 cm, was observed on the resident's coccyx. The area appeared dry and irregularly shaped. Another dry reddened area was observed on the resident's right buttock measuring 4.0 cm x 5.0 cm. RN-E stated the resident's skin was, "worse since yesterday, probably from sitting too much." According to the record R18 had been admitted to the facility on 3/2/10, and had diagnoses that included: weight loss, diabetes and history of pressure ulcers, venous stasis ulcers and peripheral vascular disease. Documentation in the nurses' notes indicated R18 had experienced stage 2 pressure ulcers on both her right and left buttocks. The stage 2 pressure ulcers had been noted on 4/23/13, and had subsequently healed on 6/23/13 when there were no longer open areas present. A quarterly minimum data set (MDS) dated 6/22/13, indicated R18 was at risk for developing pressure ulcer and had three stage 2 ulcers. The MDS indicated there was no pressure ulcer reducing device for chair or bed, and no turning or repositioning program in place. In addition, the MDS indicated R18 was continent of bowel and bladder, required one person physical assist for transfers and toilet use, and was not	F 280	documentation follows the policy. Audits of the resident care will be done on 2 residents per week with skin issues to assure the care plan is being followed. The results of the reviews will be reported to the QA committee at its regular meetings. This will be audited for 90 days and the QA team will determine the need for further auditing. 5. The Correction will be monitored by: a. The Director of Nursing or designee.	

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	246467	A. BUILDING _____ B. WING _____	07/18/2013

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F 280	Continued From page 3 walking. The care plan included a problem initiated 3/6/13, which indicated R18 had three small stage 2 pressure ulcers on her right buttock related to immobility and peripheral vascular disease. The care plan goal was for the stage 2 pressure ulcers to show signs of healing, and remain free from breakdown and infection. In addition, the care plan indicated problems initiated 3/17/11, that the resident had a problem of being at risk for falls and had a decline in ADL function due to dementia. The care plan interventions continued to indicate the resident transferred herself to the bathroom independently, was independent with bed and chair mobility, propelled her wheelchair independently using her feet, and could reposition herself. The resident's care plan had not be revised to reflect the resident's current need for assistance with repositioning and transfers. A nurse's note dated 7/16/13, indicated R18 continued to be tired and weak. During interview with NA-E on 7/18/13, at 8:54 a.m., NA-E stated R18 had been independent with repositioning, cares and toileting, up until last week when R18 experienced a decline. During interview on 7/18/13, at 9:08 a.m., NA-F verified R18's decline and physical weakness since last week.	F 280		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245487	A. BUILDING _____ B. WING _____	07/18/2013

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

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F 314	Continued From page 4 who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 3 residents (R18) reviewed with pressure ulcers was provided with the necessary interventions to promote healing and prevent reoccurrence of pressure ulcers. Findings include: During observations on 7/17/13 at 6:58 a.m., R18 was observed in her room seated in a wheelchair on two cushions. An egg crate cushion was also observed on the seat of the recliner located in R18's room. The resident's record was reviewed. According to documentation on the Big Stone Therapy Caregiver Education Sheet dated 6/24/13, the recommendation by the therapist included "use gel T-foam cushion in wheelchair and E-Z dish cushion in recliner to decrease pressure on [R18's] coccyx." Nursing assistant (NA)-G was interviewed on 7/17/13, at 7:03 a.m.. NA-G verified R18 was sitting on two cushions in her wheelchair and that the recliner had an egg crate cushion in place on the cushion.	F 314	F314 1. Corrective Action: a. The resident's cushions were corrected on 7/17/13. Her care plan was updated to reflect her changing needs. She was seen by the physician on 7/19/13 to review possible causes for decline. b. It is this facility's practice to provide a comprehensive care plan for each resident, meeting the requirements of the OBRA regulations. Resident R18 was re-evaluated by the RN and an assessment, CAA, and Care plan were updated with a significant change assessment with an ARD of 8/15. The resident is having a significant change assessment completed due in part to starting hospice care. 2. Corrective Action as it applies to other residents: a. All residents with skin integrity issues were reviewed and evaluated against their last comprehensive assessment to assure all care plans were up to date. b. The policy and procedure for skin integrity was reviewed and revised on 8/15/2013. c. Education was provided to all nursing staff on August 22nd & 26th on the skin policies, including notification, wound documentation, and standards for treatment and prevention of pressure ulcers 3. All Corrective Actions will be completed by: Aug 27th, 2013. 4. Reoccurrence will be prevented by:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 314	Continued From page 6 During continuous observations on 7/17/13 from 7:10 a.m. until 8:57 a.m., R18 was observed to remain seated in her wheelchair in the dining room for breakfast. After breakfast was completed, the health unit coordinator (HUC) transported R18 to an audiology appointment located in the adjoining hospital. Upon return from the appointment on 7/17/13 at 10:05 a.m., the HUC stated she'd stayed with R18 throughout the audiology appointment. The HUC also verified that R18 had remained seated in the wheelchair during the entire appointment. Following the appointment, R18 was observed to remain seated in her wheelchair and to participate in a resident group activity. NA-G was interviewed at 11:30 a.m. on 7/17/13. NA-G stated R18 had been repositioned at 10:30 a.m. (three hours and twenty minutes without repositioning). During additional interview on 7/17/13 at 2:21 p.m., NA-G verified R18 used to reposition herself but had declined in her ability to do so, and was no longer able to reposition herself as much as she used to. During an observation on 7/17/13, at 1:41 p.m., registered nurse (RN)-E removed a Tegaderm hydrocolloid dressing from R18's buttocks. The skin on the left buttock was observed to have several sporadic red areas, dry in appearance, varying in size from 0.75 centimeters (cm) x (by) 0.2 cm. In addition there was a large, 10 cm x 4 cm, deep purple area observed extending from the resident's left buttock to the right buttock. The area was observed to be blanchable when the nurse pressed on the resident's skin with her fingers. A smaller non-blanchable red area	F 314	a. A RN will audit 100% of new pressure ulcers to determine that documentation and care follows the policy and care plan. Audits of the resident care will be done on 2 residents per week with skin issues to assure the care plan is being followed. The results of the reviews will be reported to the QA committee at its regular meetings. This will be audited for 90 days and the QA team will determine the need for further auditing. 5. The Correction will be monitored by: a. The Director of Nursing or designee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	246467	A. BUILDING _____ B. WING _____	07/18/2013

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F 314	Continued From page 6 measuring 2.0 cm x 3.0 cm, was observed on the resident's coccyx. The area appeared dry and irregularly shaped. Another dry reddened area was observed on the resident's right buttock measuring 4.0 cm x 6.0 cm. RN-E stated the resident's skin was, "worse since yesterday, probably from sitting too much." During an observation on 7/17/13, at 2:46 p.m., R18 was observed to be layed on her right side in bed. The large purple area observed extending from the left buttock to the right buttock was less purple in color. A small purple area was observed to remain on R18's right buttock however, other areas that had been previously purple were now red and blanchable. According to the record R18 was admitted on 3/2/10, and had diagnoses that included: weight loss, diabetes and history of pressure ulcers, venous stasis ulcers and peripheral vascular disease. Documentation in the nurses' notes indicated R18 had experienced stage 2 pressure ulcers on both her right and left buttocks. The stage 2 pressure ulcers had been noted on 4/23/13, and had subsequently healed on 6/23/13 when there were no longer open areas present. A quarterly minimum data set (MDS) dated 5/22/13, indicated R18 was at risk for developing pressure ulcer and had three stage 2 ulcers. The MDS indicated there was no pressure ulcer reducing device for chair or bed, and no turning or repositioning program in place. In addition, the MDS indicated R18 was continent of bowel and bladder, required one person physical assist for transfers and toilet use, and was not walking. The care plan included a problem initiated 3/6/13, which indicated R18 had three small stage 2	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 314	Continued From page 7 pressure ulcers on her right buttock related to immobility and peripheral vascular disease. The care plan goal was for the stage 2 pressure ulcers to show signs of healing, and remain free from breakdown and infection. A nurse's note dated 7/16/13, indicated R18 continued to be tired and weak and that there were "some shears to loose skin, but negative for pressure ulcers." During interview on 7/17/13, at 2:27 p.m., the director of nursing (DON) verified she had not been aware that staff were utilizing two cushions in R18's wheelchair as opposed to the therapists' gel cushion recommendation. During interview on 7/18/13, at 8:54 a.m., NA-E stated R18 had been independent with repositioning, cares and toileting, up until last week when R18 experienced a decline. During interview on 7/18/13, at 9:08 a.m., NA-F verified R18's decline and physical weakness since last week. The facility's Skin Policy Procedure dated October 2012 included: " Policy: To ensure a resident who enters the facility without pressure ulcers does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable. To provide care and services to prevent pressure ulcer development, to promote the healing of pressure ulcers/wounds that are present, and prevent development of additional pressure ulcers/wounds."	F 314		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	246487	A. BUILDING _____ B. WING _____	07/18/2013

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F 371	Continued From page 8 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure food and ice were served in a sanitary manner which had the potential to affect 49 of 49 residents currently residing in the facility. Findings include: During observations of the evening meal on 7/15/13 at 5:03 p.m., in the main dining room, dietary aide (DA)-A was dishing up meals from behind a steam table, then handing off the plates to other dietary staff who then distributed the plates to residents in the dining room. Among the menu items served during the evening meal were cheese sandwiches, which were pre-prepared, stacked, and unwrapped, in a serving tray along with other foods on the steam table. Residents in the dining room were asked to indicate their menu choices on slips of paper, which the serving staff then collected and gave to the dietary worker who dished up the individual food choices. At 5:11 p.m., DA-A was observed to handle a resident's menu choice paper with her gloved left	F 371	F371 1. Corrective Action: a. Nursing and Dietary were re-educated on the need to use utensils when serving all items and the need to maintain sanitary food handling conditions b. The ice machine surfaces were cleaned on July 17, 2013 and the external fan areas on Aug. 13, 2013. 2. Corrective action as it applies to others: a. The Policy and Procedure for Food Handling was reviewed on 8/16/13 and is current. b. The Policy and Procedure for the cleaning of the ice machines was reviewed and revised on 8/19/2013. c. The ice machine surfaces are cleaned weekly with an anti-lime cleanser by the environmental services staff. The maintenance staff cleans the inside of the machine with a specialty cleanser every 3 months according to the manufacturer's instructions. As well maintenance will clean the fan areas of the ice machine by removing the metal covers every 3 months and as needed. The current ice machine tray and spout covers have replacements purchased. d. Education was provided to Dietary on Aug. 22nd, Environmental Services and Maintenance on Aug. 20, and Nursing on Aug. 22nd and 26th. 3. All Corrective Actions will be completed by: Aug 27th, 2013. 4. Reoccurrence will be prevented by:	

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HENDRICKS COMMUNITY HOSPITAL	503 E LINCOLN STREET HENDRICKS, MN 56136

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F 371	Continued From page 9 hand, read the slip, ladled soup into a bowl, and placed the bowl on top of a serving plate. Then, with the gloved left hand, DA-A grabbed an unwrapped cheese sandwich from the pan containing the sandwiches, and placed the sandwich on the plate, next to the bowl of soup. DA-A then handed the plate to another dietary worker, who transported the meal to a resident. At 5:12 p.m., DA-A lifted a tray of clean soup bowls from below the steam table, placing the tray at waist-high level for service. With the same gloved-left hand, DA-A grasped and looked at another resident's menu choice slip, read the paper, placed a filled soup bowl on plate. Again, DA-A touched an unwrapped cheese sandwich off the tray-line sandwich pan, and placed the sandwich on this plate. DA-A then passed the plate to another aide for distribution to a resident. During an interview with DA-A on 7/16/13 at 5:26 p.m., DA-A acknowledged having touched resident menu choice paper slips with a gloved left hand, and without changing gloves, also having touched unwrapped cheese sandwiches to served to residents. DA-A could not recall having received specific training on how to properly handle unwrapped sandwiches, but knew the sandwiches should not be touched "with my dirty gloves or bare hands." On 7/17/13 at 7:21 a.m., nursing assistant (NA)-A was observed using a portable food cart to serve breakfast to residents right outside their rooms at the far end of the 200 unit wing hallway of the facility. The cart, approximately 3 feet by 5 feet, had storage drawers accessible on the long end side, which held containers of cereal, plastic utensils, covered juice bottles, and breakfast	F 371	a. Audits will be conducted at 4 meals a week, randomly rotated to include breakfast, dinner and supper to monitor food handling. b. Audits of the ice machine and fans will be conducted by the environmental services director or designee on an every 2 week basis to check the logs and the equipment. c. Auditing will continue for a minimum of 90 days. Results of the audits will be brought to the QA team meeting and the team will determine the need for further audits. 5. The Correction will be monitored by: a. The Director of Nursing and the Dietary Manager or designees. RECEIVED AUG 2 0 2013 Minnesota Dept of Health Mankato	

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	246467	A. BUILDING _____ B. WING _____	07/18/2013

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F 371	Continued From page 10 condiments. On top of the cart were a toaster, a bread cutting board, a small container with butter and butter knife, loaves of sliced bread in plastic bags, a stainless steel container with a ladle for hot oatmeal, a container filled with fruit, a coffee carafe, and hand sanitizer. At 7:34 a.m., NA-A used sanitizer to cleanse hands prior to entering R1 room to take a breakfast order. While standing in R1's room talking to the resident, NA-A placed hands on her hips, and also placed both hands into the pockets of her scrub top. NA-A then exited R1's room, went to the cart, sanitized hands, and began gathering the requested breakfast order items from the portable food cart. NA-A reached into the bread bag with an ungloved hand and retrieved a slice of bread, and placed it in the toaster. NA-A then opened a drawer on the cart, and pulled out a closed plastic container and poured dry cereal into a bowl. After putting the container away, NA-A pulled plastic utensils and a single-serving container of jam from another drawer. NA-A filled a small bowl with fruit from a larger container atop the cart. After the slice of bread popped up in the toaster, NA-A touched the toasted bread, bare handed, placed it on the cutting board, and buttered the toast. NA-A then placed the buttered toast onto a disposable plate and carried the plate to R1's room. During an interview on 7/17/13 at 7:42 a.m., NA-A verified having placed her hands on her hips and having tucked her hands inside the pockets of her scrub top while talking taking the breakfast order in R-1's room. NA-A also confirmed that she touched R1's bread with bare hands before and after toasting. NA-A felt this was not a problem and didn't think about it "because I used hand	F 371		

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F 371	Continued From page 11 sanitizer before I touched the bread." During in interview on 7/17/13 at 2:35 p.m., the dietary manager (DM)-A stated that unwrapped menu items, such as the cheese sandwiches, should be served using tongs, or by using a gloved hand. DM-A stated that a glove is no longer clean after it comes in contact with paper or other dirty and contaminated surfaces. The director of nursing (DON) said in an interview on 7/17/2013 at 3:02 p.m., that unwrapped food, such as a slice of bread, or breadstick, was to be served with "a tongs or gloved hand," even if a worker used hand sanitizer. The DON said that gloves were not "magic" when used during a food service, and also needed be free of any contamination, and "mindful use of gloves" by the staff was required. On 7/17/2013 at 9:36 a.m. it was observed that water was dripping from a white-colored ice maker, located in the ice machine room on the 200 wing of the facility. It was noted that a lime build up was present on the water dispenser and tray. The environmental service manager, (ESM)-A verified during an interview on 7/17/13 at 10:35 a.m., that there are "issues" with the ice machine as evidenced by the calcium build up present on the dispenser and tray, and stated "I'd like to get rid of it." ESM-A stated the facility had several people looking at the problem, but had been aware that the machine was still in use and remained unclean. In an interview on 7/18/13 at 12:10 p.m., maintenance technician (MT)-A verified the ice	F 371		

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F 371	Continued From page 12 machine had lime build up, including the ice dispenser dripped water. MT-A stated the maintenance department had been responsible for the cleaning of the ice machine, which was completed "about every six months." MT-A said the facility did not have a policy related to routine cleaning of the ice machine. A facility policy entitled, Meals & Menus General Information revised 1/2006, directed that tongs or other utensils are used in handling food, whenever possible, and if necessary to use hands, they are thoroughly washed with hot water and soap, and plastic gloves (single service) are worn. The policy did not address the covering of food. A review of the facility's "Ice machine check sheet" document revealed the ice machine was checked on 7/6/12 and 1/7/13. The check list did not identify what type of cleaning was performed.	F 371		
F 411 SS=D	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist.	F 411		

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F 411	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dental services were provided for 1 of 2 residents (R7) reviewed for dental services. Findings include: During resident observation at 10:48 a.m. on 7/16/13, R7 was observed to have broken lower teeth. When questioned at that time, R7 stated, "they don't hurt and I can eat fine". The resident said her family helps her with dental appointments if she needs them, however she could not remember the last time she had received dental care. R7 could not recall whether staff at the facility had asked her if she would like dental services or to get her teeth fixed. R7's record was reviewed. R7 had been was admitted to the facility on 6/17/09. The quarterly minimum data set dated 6/10/13, identified the resident as needing assistance with activities of daily living (ADLs), with one person physical assist and set up with personal hygiene, which included dental. The oral and dental status of the MDS did not indicate the resident had any mouth, facial pain, discomfort or difficulty with chewing, but verified the resident has upper dentures and a lower partial. Document review titled Oral/Dental Status, included notes from the director of nursing (DON) dated 9/26/12 indicating, "tooth has chipped off and is sharp-family requested dental visit." The DON had also documented on the form, "scheduling dental visit per family". Additional review of the resident's record indicated there were no dental notes or treatment following this. A nutritional assessment dated 5/10/13, did not include any identification of broken teeth or	F 411	F411 1. Corrective Action: a. The resident R7 was accepted by the dental clinic and received treatment on 7/29/13 to the satisfaction of the resident. 2. Corrective action as it applies to others: a. The Policy and Procedure for Dental Services was reviewed on 8/10/2013 and is current. b. All resident's dental services were reviewed to determine if their dental needs are being met. Resident's who potentially need dental services but refuse will be given a risk-benefit statement. d. Education was provided to the Nursing staff on Aug 22nd and 26th regarding the dental services policy. 3. All Corrective Actions will be completed by: Aug 27th, 2013. 4. Reoccurrence will be prevented by: a. Audits will be conducted by a nursing staff member on all new residents within 7 days of admission to determine if their initial oral/dental status assessment was complete and if they have any dental service needs, that they have arrangements for those services. b. Audits by a nursing staff member of 2 current residents per week will be conducted to review if there is any change in their dental needs and if so, have they been able to receive the dental services needed. c. Auditing will continue for a minimum of 90 days. Results of the audits	

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F 411	Continued From page 14 eating problems. The care plan dated 11/23/2012 included: "oral/dental health problems; broken teeth." Interventions included, "administer medications as ordered, coordinate arrangements for dental care, transportation as needed, monitor oral cavity every quarter with MDS, monitor/document to physician as need signs and symptoms of oral/dental problems pain, bleeding, teeth missing, loose or broken. Provide mouth care as ADL personal hygiene and consult with dietitian if chewing/swallowing problems noted." During an interview with registered nurse (RN)-A at 11:00 a.m. on 7/18/13, she stated R7 not seen a dental provider in a long time, and stated she was unsure when the resident's last dental exam was done. RN-A said R7's daughter wanted to have her mom seen locally for her dental needs; however the local dentist was not accepting new patients. RN-A verified there was no documentation of attempts to contact the local dental provider. The director of nursing (DON) verified at 11:15 a.m. on 7/18/13, there was no documentation or follow up regarding the resident's dental needs. After having brought this information to the DON's attention, the DON herself placed a call into the dentist on 7/18/13. The facility's policy Dental Services, revised August 2009, indicated staff were to ensure routine and emergency dental services were available to meet the residents' needs. "2. Routine and emergency dental services are provided to our residents through: a. A contract agreement with a local dentist; b. Referral to the resident's personal dentist; c. Referral to community based dentists; or d. Referral to other health care organizations that provide dental services. 3. Nursing will work with Health Unit Coordinators and Social Services in making	F 411	will be brought to the QA team meeting and the team will determine the need for further audits. 5. The Correction will be monitored by: a. The Director of Nursing or designee.	

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F 411	Continued From page 15 dental appointments and transportation arrangements as necessary. 4. Dental services must be offered annually. If the resident/family declines, a Risk/Benefit must be given to the resident/family and placed and [sic] the Care Plan."	F 411	**F441** 1. Corrective Action: a. All infection monitoring from July 2013-present was reviewed and analyzed to include the required components.	
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441	2. Corrective action as it applies to others: a. The Policy and Procedure for Infection Control Surveillance and Investigation was developed on 8/20/2013. b. New Infection Control Reports were developed to include the required items. c. Monthly Reports were developed to summarize the information needed to show that the infections were comprehensively reviewed. d. Education was provided to the Nursing staff on Aug 22nd and 26th regarding the policy and their role in reporting infections for themselves or residents, treatments, and monitoring for effectiveness of treatments. 3. All Corrective Actions will be completed by: Aug 27th, 2013. 4. Reoccurrence will be prevented by: a. Audits will be conducted by the Hendricks Hospital Infection Control Practitioner (ICP) each month to review the Director of Nursing's infection reports and summation to determine they meet the requirements outlined by F441. b. Audits will continue for 3 months by the ICP. Results of the audits will be brought to the QA team meeting and	

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F 441	Continued From page 16 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to establish an infection control program including surveillance and investigation of infections. This had the potential to affect 49 of 49 residents in the facility. Findings include: The facility's infection control documentation was reviewed for the period of July 2012 through June 2013. Although staff had documented the date on onset, location of infection and antibiotics used for treatment of resident infections, there was inconsistent monitoring of the organism causing the infection, signs and symptoms displayed, identification of whether the infection was community or facility acquired, and whether or not treatment was effective. During interview with the director of nursing (DON) on 7/18/13, at 2:32 p.m., the DON stated she is responsible for the infection control program and verified the current infection control program lacked consistent monitoring of all appropriate components.	F 441	the team will determine the need for further audits. 5. The Correction will be monitored by: a. The Long Term Care Administrator or designee.	
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH	F 463		

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F 463	Continued From page 17 The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure 1 of 30 residents (R2) had a functional call light. Findings include: R2 ' s call light attached to recliner was not functioning. During an observation on 7/16/13, at 10:15 a.m., R2's call light attached to her recliner was tested. The light outside the room did not turn on when the call light was activated. R2 was interviewed at 12:55 p.m. on 7/16/13. R2 stated she routinely utilized the call light attached to her recliner. Environmental services staff-A was interviewed on 7/16/13, at 12:10 p.m.. He stated R2's call light attached to her recliner was still not functioning.	F 463	**F463** 1. Corrective Action: a. The call light in resident R2's room was replaced on 7/18 by the maintenance staff worker and it was brought to the attention of the DON at that time. R2 who can verbalize her needs did not report the call light not working. All the call lights were audited on the night shift of 7/15 and this was not reported to be not working at that time. R2 can move about her room and transfers herself independently from her recliner chair. The call light cord was replaced on 7/18. 2. Corrective action as it applies to others: a. The Policy and Procedure for Call Light System Monitoring was developed. A routine was set up that all call lights will be checked and logged on a weekly basis. b. All staff working in the nursing home were educated on notification regarding call lights malfunction at meetings on 8/22 & 8/26 and the need to promptly report. 3. All Corrective Actions will be completed by: Aug 27th, 2013. 4. Reoccurrence will be prevented by: a. Audits will be conducted by Household coordinator or designee on a weekly basis, auditing 4 call bells each week, varying locations. b. Audits will continue for 90 days. Results of the audits will be brought to the QA team meeting and the team will determine the need for further audits. 5. The Correction will be monitored by: a. The Director of Nursing or designee.	
F 465 SS=C	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	F 465		

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F 465	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the environment was maintained in a clean and sanitary manner; free standing oscillating fans in 2 of 3 hallways (200 & 300 wing) and in the main dining room, were coated with dust, and 1 of 1 ice machine on the 200 wing was also dirty. These deficient practices had the potential to affect 49 of 49 residents currently residing in the facility. Findings include: On 7/16/13, at 2:02 p.m., a rotating standing fan was observed on the 200 wing hallway, with a thick layer of dust on the entire fan head. The fan was blowing air into the hallway. On 7/16/13, at 2:10 p.m., a standing fan was observed on the 300 wing hallway with a thick layer of dust on the entire fan head. The fan was blowing air into the hallway. On 7/18/13, at 1:07 p.m., a standing fan was observed to be on in the main dining room. The fan had a thick layer of dust on the entire fan head. There was no food being served or eaten in the dining room at the time of this observation. During interview with environmental services staff-A on 7/17/13, at 12:28 p.m., environmental services staff-A verified these three fans were dirty, and stated there was no routine cleaning schedule for the fans. Environmental services staff-A also verified there was no facility policy for maintenance of the fans, and no recorded logs of when the fans had been cleaned.	F 465	F465 1. Corrective Action: a. The fans in the 200 wing, 300 wing, and main dining room were cleaned on July 23, 2013. b. The ice machine surfaces were cleaned on July 17, 2013 and the external fan areas on Aug. 13, 2013. 2. Corrective action as it applies to others: a. The Policy and Procedure for cleaning fans was developed and includes proper cleaning weekly and completing a log book by the technicians. b. The ice machine surfaces are cleaned weekly with an anti-lime cleanser by the environmental services staff. The maintenance staff cleans the inside of the machine with a specialty cleanser every 3 months according to the manufacturer's instructions. As well maintenance will clean the fan areas of the ice machine by removing the metal covers every 3 months and as needed. The current ice machine tray and spout covers have replacements purchased. c. Education on the policy and plan was provided to the Environmental Services and Maintenance Staff on Aug. 20, 2013. Nursing staff was educated on Aug. 22nd and Aug. 26th. 3. All Corrective Actions will be completed by: Aug 27th, 2013. 4. Reoccurrence will be prevented by: a. Audits of the ice machine and fans will be conducted by the environmental services director or designee on an every 2	

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F 466	Continued From page 19 During interview on 7/18/13, at 1:13 p.m., registered dietician/dietary manager verified there was a thick layer of dust on the fan located in the main dining room. During an observation on 7/17/13 at 9:36 a.m., the ice machine room on the 200 wing of the facility was observed to have a large area of black debris on the right side of the machine, with lime build up on both sides toward the back of the machine. The vents on the side had thick dust in them. The environmental service manager (ESM)-A verified in an interview on 7/17/13 at 10:35 a.m., that there are "issues" with the ice machine, including a calcium build up on it. The ESM stated, "I'd like to get rid of it." ESM-A stated the facility has had several people look at the problem, but was aware the machine was still in use and unclean. In an interview on 7/18/2013 at 12:10 p.m., maintenance technician (MT)-A verified the lime and dust build-up on the ice machine in the 200 wing. MT-A stated the maintenance department was responsible for the cleaning of the ice machine, which was completed "about every six months."	F 466	week basis to check the logs and the equipment. b. Audits will continue for a minimum of 90 days. Results of the audits will be brought to the QA team meeting and the team will determine the need for further audits. 5. The Correction will be monitored by: a. The Environmental Services Director and Maintenance Director or designees.	

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K 000	INITIAL COMMENTS	K 000		

Dc: 08.27.2013

EXIT: 07.18.2013

FIRE SAFETY

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 FORM 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, on July 18, 2013. At the time of this survey, Hendricks Community Hospital Nursing Home was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:

Health Care Fire Inspections
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145, or

POC ok
B 8-23-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 8-15-13

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 _____	**07/18/2013**

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	K 000		

By E-Mail to:
Barbara.Lundberg@state.mn.us, and
Marian.Whitney@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 nursing home is separated from a critical access hospital by a two-hour fire wall, and the opening protective consisted of a labeled, self-closing, positive latching, 90-minute fire rated door assembly.

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K 000	Continued From page 2 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 49 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide smoke barrier walls construction that meets the requirements of NFPA 101 - 2000 edition, Sections 19.3.7.3 and 8.3. This deficient practice could affect all 49 residents including, staff and visitors.	K 025	The north and south smoke barrier walls that have penetrations around the conduits and sprinkler piping have been properly sealed with a fire rated sedant by our maintenance department.	8/21/13

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K 025	Continued From page 3 Findings include: On facility tour between 9:30 AM and 1:00 PM on 7/18/2013, it was observed that the north and south smoke barrier walls have penentrations around conduits and sprinkler piping that were not properly sealed with fire rated material not in accordance with 19.3.7.3. This deficient practice was confirmed by the Maintenance Supervisor.	K 025		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Observations revealed that some electrical installations are not in accordance with NFPA 70 "The National Electrical Code 1999 edition. This deficiency could negatively effect any resident, staff and visitors in this area of the facility. Findings include: On facility tour between the hours of 9:30 AM and 1:00 PM on 7/18/13, observations revealed that the west wing kitchenette had a microwave and refrigerator plugged into electrical power strip. This deficient practice was verified by the Maintenance Supervisor.	K 147	The refrigerator and microwave in the west wing kitchenette have been removed off the power strip and plugged directly into a wall outlet by our maintenance staff.	7/20/13

Minnesota Department of Health

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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: On July 15th, 16th, 17th and 18th, 2013, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of	2 000	RECEIVED AUG 2 0 2013 Minnesota Dept of Health Mankato Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state	

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2 000	Continued From page 1 Compliance Monitoring, Licensing and Certification Program; 12 Civic Center Plaza, Suite 2105, Mankato, Minnesota 56001	2 000	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. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	

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2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a resident's care plan was updated to reflect necessary care changes for skin and mobility for 1 of 3 residents (R18) reviewed for pressure ulcers. The findings include: Although R18 had a known history of pressure ulcers, the resident's plan of care was not revised to include interventions recommended by therapy, nor was the care plan revised to indicate the resident required assistance with repositioning and mobility when the resident experienced a decrease in her activity of daily living (ADL) abilities.	2 570		

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2 570	Continued From page 3 During observations on 7/17/13 at 6:58 a.m., R18 was observed in her room seated in a wheelchair on two cushions. An egg crate cushion was also observed on the seat of the recliner located in R18's room. The resident's record was reviewed. According to documentation on the Big Stone Therapy Caregiver Education Sheet dated 6/24/13, an Occupational Therapist (OT) had recommended "use gel T-foam cushion in wheelchair and E-Z dish cushion in recliner to decrease pressure on [R18's] coccyx." The OT's recommendations were not added to the resident's care plan. During interview with nursing assistant (NA)-G on 7/17/13 at 2:21 p.m., NA-G verified R18 used to reposition herself but had declined in her ability to do so, and was no longer able to reposition herself as much as she used to. During an observation on 7/17/13, at 1:41 p.m., registered nurse (RN)-E removed a Tegaderm hydrocolloid dressing from R18's buttocks. The skin on the left buttock was observed to have several sporadic red areas, dry in appearance, varying in size from 0.75 centimeters (cm) x (by) 0.2 cm. In addition there was a large, 10 cm x 4 cm, deep purple area observed extending from the resident's left buttock to the right buttock. The area was observed to be blanchable when the nurse pressed on the resident's skin with her fingers. A smaller non-blanchable red area measuring 2.0 cm x 3.0 cm, was observed on the resident's coccyx. The area appeared dry and irregularly shaped. Another dry reddened area was observed on the resident's right buttock measuring 4.0 cm x 5.0 cm. RN-E stated the resident's skin was, "worse since yesterday,	2 570		

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2 570	Continued From page 4 probably from sitting too much." According to the record R18 had been admitted to the facility on 3/2/10, and had diagnoses that included: weight loss, diabetes and history of pressure ulcers, venous stasis ulcers and peripheral vascular disease. Documentation in the nurses' notes indicated R18 had experienced stage 2 pressure ulcers on both her right and left buttocks. The stage 2 pressure ulcers had been noted on 4/23/13, and had subsequently healed on 6/23/13 when there were no longer open areas present. A quarterly minimum data set (MDS) dated 5/22/13, indicated R18 was at risk for developing pressure ulcer and had three stage 2 ulcers. The MDS indicated there was no pressure ulcer reducing device for chair or bed, and no turning or repositioning program in place. In addition, the MDS indicated R18 was continent of bowel and bladder, required one person physical assist for transfers and toilet use, and was not walking. The care plan included a problem initiated 3/6/13, which indicated R18 had three small stage 2 pressure ulcers on her right buttock related to immobility and peripheral vascular disease. The care plan goal was for the stage 2 pressure ulcers to show signs of healing, and remain free from breakdown and infection. In addition, the care plan indicated problems initiated 3/17/11, that the resident had a problem of being at risk for falls and had a decline in ADL function due to dementia. The care plan interventions continued to indicate the resident transferred herself to the bathroom independently, was independent with bed and chair mobility, propelled her wheelchair independently using her feet, and could reposition herself. The resident's care plan had not be revised to	2 570		

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2 570	Continued From page 5 reflect the resident's current need for assistance with repositioning and transfers. A nurse's note dated 7/16/13, indicated R18 continued to be tired and weak. During interview with NA-E on 7/18/13, at 8:54 a.m., NA-E stated R18 had been independent with repositioning, cares and toileting, up until last week when R18 experienced a decline. During interview on 7/18/13, at 9:08 a.m., NA-F verified R18's decline and physical weakness since last week. 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 reviewing and revising the care plan as necessary. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
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	2 900		

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2 900	Continued From page 6 B. a resident who has pressure sores 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 ensure 1 of 3 residents (R18) reviewed with pressure ulcers was provided with the necessary interventions to promote healing and prevent reoccurrence of pressure ulcers. Findings include: During observations on 7/17/13 at 6:58 a.m., R18 was observed in her room seated in a wheelchair on two cushions. An egg crate cushion was also observed on the seat of the recliner located in R18's room. The resident's record was reviewed. According to documentation on the Big Stone Therapy Caregiver Education Sheet dated 6/24/13, the recommendation by the therapist included "use gel T-foam cushion in wheelchair and E-Z dish cushion in recliner to decrease pressure on [R18's] coccyx." Nursing assistant (NA)-G was interviewed on 7/17/13, at 7:03 a.m.. NA-G verified R18 was sitting on two cushions in her wheelchair and that the recliner had an egg crate cushion in place on the cushion. During continuous observations on 7/17/13 from 7:10 a.m. until 8:57 a.m., R18 was observed to remain seated in her wheelchair in the dining	2 900		

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room for breakfast. After breakfast was completed, the health unit coordinator (HUC) transported R18 to an audiology appointment located in the adjoining hospital.

Upon return from the appointment on 7/17/13 at 10:05 a.m., the HUC stated she'd stayed with R18 throughout the audiology appointment. The HUC also verified that R18 had remained seated in the wheelchair during the entire appointment. Following the appointment, R18 was observed to remain seated in her wheelchair and to participate in a resident group activity.

NA-G was interviewed at 11:30 a.m. on 7/17/13. NA-G stated R18 had been repositioned at 10:30 a.m. (three hours and twenty minutes without repositioning). During additional interview on 7/17/13 at 2:21 p.m., NA-G verified R18 used to reposition herself but had declined in her ability to do so, and was no longer able to reposition herself as much as she used to.

During an observation on 7/17/13, at 1:41 p.m., registered nurse (RN)-E removed a Tegaderm hydrocolloid dressing from R18's buttocks. The skin on the left buttock was observed to have several sporadic red areas, dry in appearance, varying in size from 0.75 centimeters (cm) x (by) 0.2 cm. In addition there was a large, 10 cm x 4 cm, deep purple area observed extending from the resident's left buttock to the right buttock. The area was observed to be blanchable when the nurse pressed on the resident's skin with her fingers. A smaller non-blanchable red area measuring 2.0 cm x 3.0 cm, was observed on the resident's coccyx. The area appeared dry and irregularly shaped. Another dry reddened area was observed on the resident's right buttock measuring 4.0 cm x 5.0 cm. RN-E stated the

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2 900	Continued From page 8 resident's skin was, "worse since yesterday, probably from sitting too much." During an observation on 7/17/13, at 2:46 p.m., R18 was observed to be layed on her right side in bed. The large purple area observed extending from the left buttock to the right buttock was less purple in color. A small purple area was observed to remain on R18's right buttock however, other areas that had been previously purple were now red and blanchable. According to the record R18 was admitted on 3/2/10, and had diagnoses that included: weight loss, diabetes and history of pressure ulcers, venous stasis ulcers and peripheral vascular disease. Documentation in the nurses' notes indicated R18 had experienced stage 2 pressure ulcers on both her right and left buttocks. The stage 2 pressure ulcers had been noted on 4/23/13, and had subsequently healed on 6/23/13 when there were no longer open areas present. A quarterly minimum data set (MDS) dated 5/22/13, indicated R18 was at risk for developing pressure ulcer and had three stage 2 ulcers. The MDS indicated there was no pressure ulcer reducing device for chair or bed, and no turning or repositioning program in place. In addition, the MDS indicated R18 was continent of bowel and bladder, required one person physical assist for transfers and toilet use, and was not walking. The care plan included a problem initiated 3/6/13, which indicated R18 had three small stage 2 pressure ulcers on her right buttock related to immobility and peripheral vascular disease. The care plan goal was for the stage 2 pressure ulcers to show signs of healing, and remain free from breakdown and infection.	2 900		

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2 900	Continued From page 9 A nurse's note dated 7/16/13, indicated R18 continued to be tired and weak and that there were "some shears to loose skin, but negative for pressure ulcers." During interview on 7/17/13, at 2:27 p.m., the director of nursing (DON) verified she had not been aware that staff were utilizing two cushions in R18's wheelchair as opposed to the therapists' gel cushion recommendation. During interview on 7/18/13, at 8:54 a.m., NA-E stated R18 had been independent with repositioning, cares and toileting, up until last week when R18 experienced a decline. During interview on 7/18/13, at 9:08 a.m., NA-F verified R18's decline and physical weakness since last week. The facility's Skin Policy Procedure dated October 2012 included: " Policy: To ensure a resident who enters the facility without pressure ulcers does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable. To provide care and services to prevent pressure ulcer development, to promote the healing of pressure ulcers/wounds that are present, and prevent development of additional pressure ulcers/wounds." SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could review policies and procedures regarding care for residents at risk for, or with pressure ulcers, educate staff on pressure ulcers protocols and develop a monitoring system to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one	2 900		

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2 900	Continued From page 10 (21) days.	2 900		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure food and ice were served in a sanitary manner which had the potential to affect 49 of 49 residents currently residing in the facility. Findings include: During observations of the evening meal on 7/15/13 at 5:03 p.m., in the main dining room, dietary aide (DA)-A was dishing up meals from behind a steam table, then handing off the plates to other dietary staff who then distributed the plates to residents in the dining room. Among the menu items served during the evening meal were cheese sandwiches, which were pre-prepared, stacked, and unwrapped, in a serving tray along with other foods on the steam table. Residents in the dining room were asked to indicate their menu choices on slips of paper, which the serving staff then collected and gave to the dietary worker who dished up the individual food choices. At 5:11 p.m., DA-A was observed to handle a resident's menu choice paper with her gloved left hand, read the slip, ladled soup into a bowl, and	21015		

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placed the bowl on top of a serving plate. Then, with the gloved left hand, DA-A grabbed an unwrapped cheese sandwich from the pan containing the sandwiches, and placed the sandwich on the plate, next to the bowl of soup. DA-A then handed the plate to another dietary worker, who transported the meal to a resident.

At 5:12 p.m., DA-A lifted a tray of clean soup bowls from below the steam table, placing the tray at waist-high level for service. With the same gloved-left hand, DA-A grasped and looked at another resident's menu choice slip, read the paper, placed a filled soup bowl on plate. Again, DA-A touched an unwrapped cheese sandwich off the tray-line sandwich pan, and placed the sandwich on this plate. DA-A then passed the plate to another aide for distribution to a resident.

During an interview with DA-A on 7/15/13 at 5:26 p.m., DA-A acknowledged having touched resident menu choice paper slips with a gloved left hand, and without changing gloves, also having touched unwrapped cheese sandwiches to served to residents. DA-A could not recall having received specific training on how to properly handle unwrapped sandwiches, but knew the sandwiches should not be touched "with my dirty gloves or bare hands."

On 7/17/13 at 7:21 a.m., nursing assistant (NA)-A was observed using a portable food cart to serve breakfast to residents right outside their rooms at the far end of the 200 unit wing hallway of the facility. The cart, approximately 3 feet by 5 feet, had storage drawers accessible on the long end side, which held containers of cereal, plastic utensils, covered juice bottles, and breakfast condiments. On top of the cart were a toaster, a bread cutting board, a small container with butter

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21015	Continued From page 12	21015		

and butter knife, loaves of sliced bread in plastic bags, a stainless steel container with a ladle for hot oatmeal, a container filled with fruit, a coffee carafe, and hand sanitizer.

At 7:34 a.m., NA-A used sanitizer to cleanse hands prior to entering R1 room to take a breakfast order. While standing in R1's room talking to the resident, NA-A placed hands on her hips, and also placed both hands into the pockets of her scrub top. NA-A then exited R1's room, went to the cart, sanitized hands, and began gathering the requested breakfast order items from the portable food cart. NA-A reached into the bread bag with an ungloved hand and retrieved a slice of bread, and placed it in the toaster. NA-A then opened a drawer on the cart, and pulled out a closed plastic container and poured dry cereal into a bowl. After putting the container away, NA-A pulled plastic utensils and a single-serving container of jam from another drawer. NA-A filled a small bowl with fruit from a larger container atop the cart. After the slice of bread popped up in the toaster, NA-A touched the toasted bread, bare handed, placed it on the cutting board, and buttered the toast. NA-A then placed the buttered toast onto a disposable plate and carried the plate to R1's room.

During an interview on 7/17/13 at 7:42 a.m., NA-A verified having placed her hands on her hips and having tucked her hands inside the pockets of her scrub top while talking taking the breakfast order in R-1's room. NA-A also confirmed that she touched R1's bread with bare hands before and after toasting. NA-A felt this was not a problem and didn't think about it "because I used hand sanitizer before I touched the bread."

During in interview on 7/17/13 at 2:35 p.m., the

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21015	Continued From page 13 dietary manager (DM)-A stated that unwrapped menu items, such as the cheese sandwiches, should be served using tongs, or by using a gloved hand. DM-A stated that a glove is no longer clean after it comes in contact with paper or other dirty and contaminated surfaces. The director of nursing (DON) said in an interview on 7/17/2013 at 3:02 p.m., that unwrapped food, such as a slice of bread, or breadstick, was to be served with "a tongs or gloved hand," even if a worker used hand sanitizer. The DON said that gloves were not "magic" when used during a food service, and also needed be free of any contamination, and "mindful use of gloves" by the staff was required. On 7/17/2013 at 9:36 a.m. it was observed that water was dripping from a white-colored ice maker, located in the ice machine room on the 200 wing of the facility. It was noted that a lime build up was present on the water dispenser and tray. The environmental service manager, (ESM)-A verified during an interview on 7/17/13 at 10:35 a.m., that there are "issues" with the ice machine as evidenced by the calcium build up present on the dispenser and tray, and stated "I'd like to get rid of it." ESM-A stated the facility had several people looking at the problem, but had been aware that the machine was still in use and remained unclean. In an interview on 7/18/13 at 12:10 p.m., maintenance technician (MT)-A verified the ice machine had lime build up, including the ice dispenser dripped water. MT-A stated the maintenance department had been responsible for the cleaning of the ice machine, which was	21015		

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21015	Continued From page 14 completed "about every six months." MT-A said the facility did not have a policy related to routine cleaning of the ice machine. A facility policy entitled, Meals & Menus General Information revised 1/2006, directed that tongs or other utensils are used in handling food, whenever possible, and if necessary to use hands, they are thoroughly washed with hot water and soap, and plastic gloves (single service) are worn. The policy did not address the covering of food. A review of the facility's "ice machine check sheet" document revealed the ice machine was checked on 7/6/12 and 1/7/13. The check list did not identity what type of cleaning was performed. A SUGGESTED METHOD FOR CORRECTION: The Administrator and the Dietician could review and revise food service policies and procedures to assure that ice is served in a sanitary manner. Staff could be trained as necessary. The Dietary Manager could monitor the service of food and beverage on a periodic basis. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		
21325	MN Rule 4658.0725 Subp. 1 Providing Routine & Emergency Oral Health Ser Subpart 1. Routine dental services. A nursing home must provide, or obtain from an outside resource, routine dental services to meet the needs of each resident. Routine dental services include dental examinations and cleanings, fillings and crowns, root canals, periodontal care, oral surgery, bridges and removable dentures, orthodontic procedures, and adjunctive services that are provided for similar dental patients in the	21325		

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21325	Continued From page 15 community at large, as limited by third party reimbursement policies. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dental services were provided for 1 of 2 residents (R7) reviewed for dental services. Findings include: During resident observation at 10:48 a.m. on 7/16/13, R7 was observed to have broken lower teeth. When questioned at that time, R7 stated, "they don't hurt and I can eat fine". The resident said her family helps her with dental appointments if she needs them, however she could not remember the last time she had received dental care. R7 could not recall whether staff at the facility had asked her if she would like dental services or to get her teeth fixed. R7's record was reviewed. R7 had been was admitted to the facility on 6/17/09. The quarterly minimum data set dated 5/10/13, identified the resident as needing assistance with activities of daily living (ADLs), with one person physical assist and set up with personal hygiene, which included dental. The oral and dental status of the MDS did not indicate the resident had any mouth, facial pain, discomfort or difficulty with chewing, but verified the resident has upper dentures and a lower partial. Document review titled Oral/Dental Status, included notes from the director of nursing (DON) dated 9/26/12 indicating, "tooth has chipped off and is sharp-family requested dental visit." The DON had also documented on the form, "scheduling dental visit per family". Additional review of the resident's record indicated there were no dental notes or treatment following this.	21325		

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21325	Continued From page 16 A nutritional assessment dated 5/10/13, did not include any identification of broken teeth or eating problems. The care plan dated 11/23/2012 included: "oral/dental health problems; broken teeth." Interventions included, "administer medications as ordered, coordinate arrangements for dental care, transportation as needed, monitor oral cavity every quarter with MDS, monitor/document to physician as need signs and symptoms of oral/dental problems pain, bleeding, teeth missing, loose or broken. Provide mouth care as ADL personal hygiene and consult with dietitian if chewing/swallowing problems noted." During an interview with registered nurse (RN)-A at 11:00 a.m. on 7/18/13, she stated R7 not seen a dental provider in a long time, and stated she was unsure when the resident's last dental exam was done. RN-A said R7's daughter wanted to have her mom seen locally for her dental needs; however the local dentist was not accepting new patients. RN-A verified there was no documentation of attempts to contact the local dental provider. The director of nursing (DON) verified at 11:15 a.m. on 7/18/13, there was no documentation or follow up regarding the resident's dental needs. After the surveyor had brought this to the DON's attention, the DON herself placed a call into the dentist on 7/18/13. The facility's policy Dental Services, revised August 2009, indicated staff were to ensure routine and emergency dental services were available to meet the residents' needs. "2. Routine and emergency dental services are provided to our residents through: a. A contract agreement with a local dentist; b. Referral to the resident's personal dentist; c. Referral to community based dentists; or d. Referral to other health care organizations that provide dental	21325		

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21325	Continued From page 17 services. 3. Nursing will work with Health Unit Coordinators and Social Services in making dental appointments and transportation arrangements as necessary. 4. Dental services must be offered annually. If the resident/family declines, a Risk/Benefit must be given to the resident/family and placed and [sic] the Care Plan." " SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could review the policies and procedures regarding the acquisition of dental services for residents. Audits of the admission forms could be completed to ensure that dental services if indicated or needed have been ordered or done. Training for all personnel could be provided to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days.	21325		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program 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 interview and document review, the facility failed to establish an infection control	21375		

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21375	Continued From page 18 program including surveillance and investigation of infections. This had the potential to affect 49 of 49 residents in the facility. Findings include: The facility's infection control documentation was reviewed for the period of July 2012 through June 2013. Although staff had documented the date on onset, location of infection and antibiotics used for treatment of resident infections, there was inconsistent monitoring of the organism causing the infection, signs and symptoms displayed, identification of whether the infection was community or facility acquired, and whether or not treatment was effective. During interview with the director of nursing (DON) on 7/18/13, at 2:32 p.m., the DON stated she is responsible for the infection control program and verified the current infection control program lacked consistent monitoring of all appropriate components. Suggested Method of Correction: The director of nursing or her designee could review the policies and procedures regarding the infection control program. The director of nursing or her designee could educate staff on the policies and procedures and could develop a monitoring system to ensure compliance with surveillance analysis and trending was completed. Time Period for Correction: Twenty-one (21) days.	21375		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance	21685		

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21685	Continued From page 19 Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure the environment was maintained in a clean and sanitary manner; free standing oscillating fans in 2 of 3 hallways (200 & 300 wing) and in the main dining room, were coated with dust, and 1 of 1 ice machine on the 200 wing was also dirty. Findings include: On 7/16/13, at 2:02 p.m., a rotating standing fan was observed on the 200 wing hallway. with a thick layer of dust on the entire fan head. The fan was blowing air into the hallway. On 7/16/13, at 2:10 p.m., a standing fan was observed on the 300 wing hallway with a thick layer of dust on the entire fan head. The fan was blowing air into the hallway. On 7/18/13, at 1:07 p.m., a standing fan was observed to be on in the main dining room. The fan had a thick layer of dust on the entire fan head. There was no food being served or eaten in the dining room at the time of this observation. During interview with environmental services staff-A on 7/17/13, at 12:28 p.m., environmental services staff-A verified these three fans were	21685		

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21685	Continued From page 20 dirty, and stated there was no routine cleaning schedule for the fans. Environmental services staff-A also verified there was no facility policy for maintenance of the fans, and no recorded logs of when the fans had been cleaned. During interview on 7/18/13, at 1:13 p.m., registered dietician/dietary manager verified there was a thick layer of dust on the fan located in the main dining room. SUGGESTED METHOD FOR CORRECTION: The administrator with the director of maintenance could review and revise policies and procedures regarding upkeep of the physical plant. The director of maintenance could revise the preventative maintenance schedule to assure that identified item are corrected. The director of maintenance could monitor the physical environment on an ongoing basis to identify new concerns as they arise. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21685		