DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 4, 2023

Administrator
Hendricks Community Hospital
503 E Lincoln Street
Hendricks, MN 56136

RE: CCN: 245467
Cycle Start Date: October 25, 2022

Dear Administrator:

On December 29, 2022, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 4, 2023

Administrator
Hendricks Community Hospital
503 E Lincoln Street
Hendricks, MN 56136

Re: Reinspection Results
Event ID: YENM12

Dear Administrator:

On December 29, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on October 25, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

Electronically delivered
November 14, 2022

Administrator
Hendricks Community Hospital
503 E Lincoln Street
Hendricks, MN 56136

RE: CCN: 245467
Cycle Start Date: October 25, 2022

Dear Administrator:

On October 25, 2022, a survey was completed at your facility by the Minnesota Department of Health 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting

the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

DEPARTMENT CONTACT

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

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by January 25, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by April 25, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

Electronically delivered
November 14, 2022

Administrator
Hendricks Community Hospital
503 E Lincoln Street
Hendricks, MN 56136

Re: State Nursing Home Licensing Orders
Event ID: YENM11

Dear Administrator:

The above facility was surveyed on October 24, 2022 through October 25, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

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

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

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

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 _____	C 10/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On October 24, 2022 through October 25, 2022, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirments for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H54675267C (MN87832), with a deficiency cited at F689. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 689		12/23/22

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

Electronically Signed | 11/17/2022

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

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F 689	Continued From page 1 Based on observation, interview, and documentation review, that facility failed to comprehensively assess and evaluate causal factors for falls and failed to ensure adequate supervision and interventions were implemented to reduce falls for 3 of 3 residents (R1, R2 and R3) reviewed for falls. Findings include: R1's diagnosis list dated 10/24/22, included dementia with behavioral disturbances and risk for falls. R1's quarterly Minimum Data Set (MDS) dated 7/26/22, identified R1 had minimal difficulty with hearing but rarely/never understood, had unclear speech, and impaired vision with glasses. R1's MDS further indicated that R1 had severe cognitive impairment with behaviors of inattention and disorganized thinking, with physical and verbal behaviors directed at others. Additionally, refused cares and wandered. R1 required extensive assistance with toileting, and limited assistance with transfers, and supervision with walking. R1 was frequently incontinent of bladder and occasionally incontinent of bowel. The MDS further indicated that R1 had two falls without injury since the prior assessment. R1's current care plan printed 10/24/22, did not include a toileting program/schedule. R1's fall care plan indicated R1 was at risk for falls with the following interventions: -Non-skid well-fitting shoes while up, adequate lighting in room, keep floor free of obstacles, balance observation quarterly, use of walker with ambulation, glasses need to be clean and worn, know that R1 is on a diuretic and may need to	F 689	Director of Nursing identified a lack of a comprehensive fall assessment resulting in accidents/hazards not being removed and inadequate supervision. Corrective action will be accomplished for those residents found to have been affected as well as residents that have the potential to be affected by implementing a new comprehensive post-fall assessment and root cause analysis tool. DON reviewed all October falls, previous IDT meetings and care planning following the survey. It was found there was not a comprehensive assessment of the fall or root cause identified, meaningful interventions put in place, or correlated care plan updates. This resulted in a lack of resident centered interventions for all impacted and potentially impacted residents. Measures were put into place to prevent deficient practice from recurring: 1.) On November 2, 2022, a comprehensive fall assessment with root cause analysis form was developed to ensure contributing factors and root cause is being identified and adequate interventions are being put in place and monitored. This process was developed with nurse managers, ADON, and DON. 2.) November 3, 2022, education was provided to nursing staff at a nurse meeting. Nurses were made aware of the comprehensive form that would need to be filled out following any falls. Nurses made aware of the possibility of changes with the form and encouraged to provide	

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F 689	Continued From page 2 toilet quickly. -up with assistance, place footrests on wheelchair when pushing as R1 will try to stop any forward motion (6/25/22). R1's incident reports reviewed from 8/7/22 thru 10/20/22, indicated that R1 had 14 falls without injury and two falls with injury. R1's record consistently lacked completion of a comprehensive fall assessments, identification of root cause, and not evident immediate appropriate interventions were developed and implemented to mitigate risk and/or prevent recurrent falls. Incident reports in conjunction with care plan revisions were reviewed and identified the following: - On 8/7/22 R1 had an unwitnessed fall. She was found on floor in room at 7:40 p.m. with no injury, smeared stool was noted on floor. Incident report included intervention to increase monitoring (no frequency identified) and complete orthostatic blood pressures. R1's care plan was revised on 8/7/22 with intervention to complete orthostatic blood pressures, however, did not identify increase in monitoring. -On 8/8/22, R1 had witnessed fall at 4:30 p.m. R1 stood up from wheelchair and went to hands and knees. Interventions included continue frequent checks (no frequency identified) and psychotropic medication review. R1's care plan was revised on 8/8/22 with the fall intervention for mental health clinic to review psychotropic medications in relation to falls and physical therapy ordered. R1's care plan did not identify the intervention to continue frequent checks. -On 8/9/22, R1 had unwitnessed fall, she was	F 689	feedback to improve the process. 3.) DON, ADON, and nurse managers met on November 8, 2022, to assess how the process was going with the new comprehensive assessment tool. Needed adjustments made to the form. Reiterated importance of communicating new interventions with staff and timely care plan updates. 4.) Nurse managers will educate all staff on where to locate care plans in the patient EMR. This will be completed by December 9, 2022. 5.) A fall risk indicator will be added to the CNA grid sheet and staff educated on the meaning of the indicator by December 9, 2022. 6.) November 17, 2022, the Fall Evaluation and Injury Prevention policy was updated to reflect new process. This policy will be reviewed at December nursing and CNA meetings. DON will audit the comprehensive fall assessment to ensure completion and identification of a root cause for QAPI monitoring. Audits will be completed on 100% of the falls for 3 months then 10% of the falls for 3 months. F689 will be corrected by December 23, 2022.	

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F 689	Continued From page 3 found on floor in room at 3:15 p.m. last seen 2:30 p.m. Report identified staff took R1 to the bathroom R1's brief was saturated with strong smelling urine. R1's care plan was revised on 8/9/22 with fall intervention of pending labs for urinary tract infection. -On 8/10/22, at 10:55 p.m. R1 had unwitnessed fall, found on the floor in south pod. R1 received a skin tear that was treated. The intervention listed was R1 was reminded to use her walker and increase monitoring (frequency was not identified). R1's care plan was not revised until 8/11/22 with fall intervention to discontinue Depakote related to falls. Further the care plan did not identify increased monitoring. R1 had subsequent unwitnessed falls on 8/12/22 at 2:29 p.m., 8/25/22 at 4:35 p.m., on 8/27/22 at 11:55 a.m., and on 8/28/22 at 5:58 p.m. In addition, R1 had two more witnessed falls on 8/28/22 at 7:41 p.m. and 9:40 p.m. No care plan revisions were evident after R1 fell on 8/12/22, 8/25/22, 8/27/22, and 8/28/22. Care plan interventions that were identified in the incident report but not in the care plan included: 8/12/22 included monitor resident and hourly checks, 8/25/22 report included educate staff on motion alarm placement, 8/27/22 report included educate staff on closely observing R1 and hourly checks, and 8/28/22 reports included increase monitoring and remind R1 not to stand on her own. -On 9/2/22, at 5:45 p.m. R1 had a witnessed fall. She was lowered to the floor from wheelchair. Her bottom was hanging over the edge of wheelchair seat. R1's care plan was not revised until 9/3/22 to include fall intervention of dycem (non-slip gripping aid to prevent falls).	F 689		

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 689	Continued From page 4 -On 9/11/22, at 7:15 a.m. R1 had a witnessed fall when she attempted to stand up out of the recliner. Identified intervention was assist R1 into wheelchair when she gets up in the morning and take R1 to breakfast. R1's care plan was not revised. R1 had subsequent falls where interventions were identified on incident report, however care plan did not reflect revision. On 9/14/22 at 2:10 a.m. R1 had unwitnessed fall. Report identified intervention of hourly rounds. On 9/17/22, at 9:30 a.m. R1 had witnessed fall. Report identified interventions of hourly rounds and close observation. R1 had unwitnessed fall on 9/26/22, report included interventions of hourly rounding, close observation, gripper socks, reminders to use call light. On 10/6/22 R1's care plan identified R1's motion alarm was removed. Monitor recommendations and if need for motion alarm to continue. The record did not identify an evaluation of effectiveness prior to the alarm being removed. -On 10/20/22 at 1:50 a.m. R1 had an unwitnessed fall. She was found in room on floor in front of TV with a head laceration. Was taken to emergency department for sutures. R1's care plan was revised on 10/20/22 to include interventions the motion alarm to be used at night while resident in bed. Grid sheets, utilized by the nursing assistants (NA) for resident's cares, did not indicate R 1 was at risk for falls and did not identify fall interventions used to prevent/minimize falls.	F 689		

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F 689	Continued From page 5 Observation at 10:15 a.m. on 10/24/22, R1 was noted to be wandering up and down the halls in her wheelchair with gripper socks on. R1 had a dark bruise area above her right eye. R1 did not have her glasses on (per the care plan). During a continuous observation on 10/24/22 that began at 11:45 a.m. and ended at 12:29 p.m. R1 was noted to wander and attempt self-transfer without staff awareness. -Between 11:45 a.m. and 12:01 a.m. R1 was in the dining self-propelling around tables. Registered nurse (RN)-A redirected R1 back to her table twice. - At 12:02 p.m. dietary aide (DA)-A pushed R1 into the hallway, pointing R1 towards R1's room. DA-A came back into the dining room. -At 12:03 p.m. RN-A stated she was no able to see R1 in the hallway and did not know where she went. -At 12:04 p.m. to 12:09 p.m. R1 was observed in room 200 without supervision. R1 was wringing her hands together and trying to get her wheelchair away from a commode that was in the room. At 12:10 p.m. unknown nursing assistant (NA) entered the room, pushed R1 into the hallway and walked away down the hall. -At 12:11 p.m. after NA had walked away, R1's wheelchair got stuck by the wall. R1 stood up using the handrail and started walking alone. Surveyor notified nurse manager (NM)-B. NM-B stayed next to R1, while another unidentified staff retrieved R1's gait belt and walker from her room. NM-B then walked R1 to her room and into the bathroom. At 12:21 pm. NM-B assisted R1 to bed and put the motion alarm on. During a continuous observation on 10/25/22, that began at 10:10 a.m. and ended at 11:00 a.m.	F 689		

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HENDRICKS COMMUNITY HOSPITAL	503 E LINCOLN STREET HENDRICKS, MN 56136

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F 689	Continued From page 6 R1 was unsupervised without staff's awareness of her whereabouts from 10:16 a.m. to 10:38 a.m. -At 10:30 a.m. RN-B indicated an awareness of R1's location. RN-B started looking for R1. At 10:32 a.m. RN-B used walkie to see if other staff knew R1's whereabouts; other staff joined in the search. -At 10:38 a.m. R1 was found in another resident's room at the end of the 200 hallways. NA-D took R1 to activities, but then at 10:45 a.m. was noted in hallway with NA-D, to take her to the restroom because she was incontinent. During an interview on 10/24/22, at 2:09 p.m. NA-B stated that the fall interventions for R1 were an alarm in her room and hourly rounding. NA-B indicated R1 also required redirection when she wandered. NA-B stated that they were made aware of the changes to the care plan through report or the communication book. NA-B did not know where to look for the care plan in the electronic health record (EHR). During an interview on 10/24/22, at 2:28 p.m. NA-C stated that the fall interventions included take R1 to the bathroom when she was antsy. NA-C stated there used to be a motion alarm in her room but that went away about a month ago. NA-C did not know where to get the care plan in the EHR but staff were made aware of anything new during report. During an interview on 10/24/22, at 3:57 p.m. NM-A stated R1 was falling due to her cognition and R1 was not able to express her needs. NM-A stated nurse managers were responsible update care plans with interventions as needed. NM-A indicated the facility just started a quality assessment program improvement (QAPI)	F 689		

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	245467	A. BUILDING _____ B. WING _____	C 10/25/2022

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F 689	Continued From page 7 project for falls on 10/1/22. During an interview on 10/25/22, at 1:00 p.m. director of nursing (DON) reviewed R1's incident reports. DON stated the incident reports did not include a comprehensive fall assessment and lacked root cause/causal analysis. DON stated interventions from 8/7/22, 8/9/22, 8/10/22 interventions were not appropriate; interventions did not remove the immediate risk for falls and/or R1 was not cognitive. Further, the care plan was not revised with interventions identified on the fall incident reports dated 8/12/22, 8/25/22, 8/27/22, all falls on 8/28/22, 9/11/22, 9/14/22, 9/17/22, and 9/26/22. DON was unable to articulate or define a frequency for terms "increased monitoring" and "frequent checks". Reviewed observation of R1 on 10/24/22 and DON indicated that the facility does not have the staff for one on one and that R1 and other residents with dementia need to be kept in main dining room until staff are able to help them. If R1 is not able to be kept in the main dining room, then the nurse needs to be assigning someone at that point to watch R1. R2 R2 diagnosis list dated 10/24/22 included generalized weakness, dementia, osteoporosis and chronic pain. R2's quarterly MDS dated 7/28/22 identified R2 had severe cognitive impairment with no behaviors. R2 required extensive assistance with toilet use, and personal hygiene and limited assistance, walking, transfers, and bed mobility. R2 used a walker and wheelchair. R2 was occasionally incontinent of bladder and always	F 689		

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F 689	Continued From page 8 continent of bowel. R2 had no fall history. R2's fall care plan printed 10/24/22, identified R2 was at risk for falls related to unstable mobility. Care plan intervention included the following: -Staff are to encourage R2 to use call light for all attempted transfers. Know that she does have dementia but will always yell out for help instead of using call light. Call light in reach at all times. -Staff to anticipate R2's needs. Answer call light in a timely manner, place personal items within reach, keep room clutter and spill free and war non-skid sock/shoes. -Fall interventions, all interventions were in place at time of fall. R2 was encouraged to use call light again, and staff were instructed to place call light in reach and offer her items she may utilize before leaving room to prevent falls (start date 9/14/22). R2's fall incident report dated 9/13/22 at 4:40 p.m. R2 had an unwitnessed fall, found sitting on floor in front of recliner, no injuries noted. The intervention listed was all interventions were in place and R2 did not use call light and education given. R2's record lacked comprehensive fall assessment, did not identify root cause, and did not identify appropriate immediate intervention to mitigate risk for falls. Grid sheets, utilized by the nursing assistants (NA) for resident's cares, did not indicate R2 was at risk for falls and did not identify R2's fall interventions. During an observation on 10/24/22, at 11:55 a.m. R2 sat in her wheelchair in the dining; she was being assisted with eating by an unknown nursing assistant.	F 689		

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F 689	Continued From page 9 During interview on 10/24/22, at 1:51 p.m., NA-A indicated R2's fall intervention was to take R2 to the bathroom before and after meals. NA-A was not able to articulate all R2's fall interventions. During interview on 10/24/22, at 2:09 p.m. NA-B indicated R2's fall interventions included rounding every 2 hours and to put R2 in recliner after meals. NA-B was not able to articulate R2's fall interventions in accordance with the care plan. During interview on 10/24/22, on 2:28 p.m. on 10/24/22, NA-C indicated for R2's fall interventions was to use grippy socks. NA-C was not able to articulate all R2's fall interventions identified on the care plan. During interview on 10/25/22, at 12:50 p.m. NA-D indicated R2's fall interventions were a fall mat beside her bed while she was sleeping and to take her to the bathroom. NA-D did not know how often R2 was supposed to be assisted to the bathroom. During an interview on 10/25/22, at 1:00 p.m. DON reviewed R2's fall record and stated the intervention to remind R2 to use the call light was not appropriate because R2 had memory issues. DON indicated the record did not include a comprehensive fall assessment and no root cause was identified. R3 R3's diagnosis lists dated 10/24/22 included tremors in both hands, dementia, and high blood pressure. R3's annual MDS dated 10/12/22, identified that	F 689		

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F 689	Continued From page 10 R3 had moderate cognitive impairment with no behaviors. R3 required limited assistance with bathing, personal hygiene, toilet use, dressing, walking in corridor, transfers, and locomotion on and off the unit. Supervision for walking in room and independent with eating. R3's current care plan printed on 10/24/22, identified R3 was at risk for falls related to history of falls. Care plan identified most of R3's falls relate to using the bathroom. Interventions included -Fall follow up after each fall to determine appropriate intervention. IDT to review interventions with each fall. -Toilet between the hours 2-4 am. This is a prime time for her falls while toileting 01/01/22 and most of her falls relate to using bathroom -Door to be kept open with R3's permission -Sign placed by call light to remind R3 to use call light prior to transferring. Encourage waiting for assistance (start date 8/22/22) -staff education on toileting before and after meals and offering every 2-3 hours (start date 10/17/22). R3's incident report dated 8/22/22 at 5:25 p.m. R3 had unwitnessed fall, found on floor in room, hit head- bump on back of head. The report identified intervention to place commode at beside. R3's care plan was updated with placing a sign by call light to remind R3 to use call light prior to transferring and encourage waiting for assistance. The record lacked comprehensive fall assessment, did no identify root cause, and care plan was not revised to identify commode at bedside. R3's incident report dated 10/16/22 at 4:55 p.m.,	F 689		

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F 689	Continued From page 11 R3 had unwitnessed fall. She was found on floor in bathroom, head lying against the floorboard, no injuries noted. Care plan was updated on 10/17/22 to re-educate staff on toileting before and after meals and offer toileting every 2-3 hours. Grid sheets, utilized by the nursing assistants (NA) for resident's cares, did not indicate R3 was at risk for falls and lacked interventions used to prevent/minimize falls. During an observation on 10/25/22, at 10:05 a.m. R3 was in her room standing in front of her chair, she was holding onto the bedside table to balance. R3's wheelchair and walker were across the room by the bathroom. Surveyor made NM-A aware who was standing in the hallway. NM-A entered R3's room and assisted R3 to sit on the toilet and reminded her to use her call light when she was done. NM-A then exited the bathroom, closing the bathroom door ¾ of the way and then exited R3's room, leaving that door ¼ of the way open. -At 10:13 a.m. NM-A came back to check on R3, she then shut the bathroom door again ¾ of the way and left R3's room again. -From 10:18 a.m. to 10:55 a.m. no staff had entered the room to assist R3 off the toilet. At 10:55 a.m. R3 was observed in her recliner across the room. R3 had not used the call light for assistance. During an interview on 10/24/22, at 2:09 p.m. NA-B indicated that R3 would take self to the bathroom, thought that physical therapy was working with R3 for balance, and was on hourly rounding.	F 689		

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F 689	Continued From page 12 During an interview at 2:28 p.m. on 10/24/22, NA-C indicated that R3 was independent in her room and that R3 once had a motion alarm but that was discontinued. NA-C reviewed R3's care plan, stated R3 was supposed to be walked with assist of one and a gait belt and care plan did not identify R3 could be independent in her room. During an interview at 12:50 p.m. on 10/25/22, NA-D indicated that R3's fall intervention was to assist R3 to her recliner when she was in her room. During an interview on 10/25/22, at 1:00 p.m. DON reviewed R3's incident reports. DON indicated for fall that occurred on 8/22/22, the intervention was not appropriate due to R3's cognitive impairment. Regarding the fall that happened on 10/16/22, the intervention identified a standard of care and R3 should have been taken to the bathroom. DON stated R3's fall reports did not include a comprehensive assessment and did not identify root cause. Further stated R3 should not have been left alone in the bathroom by herself because R2 required limited assist with one for toileting and walking. DON indicated falls were reviewed at IDT meetings and make changes to the care plans as needed. DON stated that it was her expectation that care plans were updated and followed, staff knew where to look for the care plans, and that the interventions put into place were appropriate for each resident. Review of the facilities revised policy Fall Evaluation and Injury Prevention dated 06/2022 indicated -2. resident specific interventions were to be implemented to reduce likelihood of falls,	F 689		

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F 689	Continued From page 13 -4. Other identified interventions should be added to the resident's plan of care using appropriate intervention and frequency, -10. Care plan review and updated, and -11. Review the care plan and add any changes to the care plan by adding, deleting, or updating current interventions that were discovered during the post fall huddle.	F 689		

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MAYO CLINIC HEALTH SYSTEM - LAKE CITY	500 WEST GRANT STREET LAKE CITY, MN 55041

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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 11/18/22, 11/21/22 and 11/22/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date	2 000		

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2 000	Continued From page 1 when they will be completed. The following complaints were found to be SUBSTANTIATED: H52185606C (MN88154,MN88157) and H52186060C (MN88620) with licensing order issued at 0830. The Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule 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 surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available a<https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility	2 000		

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2 000	Continued From page 2 is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to monitor, comprehensively assess respiratory status changes, and ensure timely physician notification for 1 of 3 residents (R1) reviewed for hospitalizations Findings include: R1's after visit summary (AVS) dated 10/21/22,	2 830	CORRECTED	12/12/22

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2 830	Continued From page 3 indicated R1's recent history of hospitalizations related pneumonia. The summary identified a hospitalization from 10/16/22 to 10/21/22, R1 was hospitalized with pneumonia likely caused by aspiration secondary to neuromuscular weakness and poor secretion clearance. R1 was discharged to the facility in stable condition and without supplemental oxygen usage. R1's admission record dated 11/22/22, identified the following diagnoses: dysphagia-oropharyngeal stage (difficulty swallowing), pneumonia, hypoosmolality and hyponatremia (electrolytes lower than normal which can result in dehydration), type 2 diabetes, and generalized muscle weakness. R1's admission Minimum Data Set (MDS), dated 10/27/22, indicated R1's cognition was intact and had complaints of difficulty or pain with swallowing. Further identified R1 did not require oxygen. R1's care plan dated 10/21/22, indicated R1 had an activity of daily living (ADL) self-care performance deficit related to the diagnosis of pneumonia along with shortness of breath upon exertion. Further had dysphagia, required a dysphagia diet, and staff supervision during meals. Interventions included: observe for choking and signs and symptoms of aspiration, thin liquids, and follow speech therapy orders. An additional focus dated 10/30/22, indicated R1 was at risk for fluid electrolyte imbalance related to aspiration pneumonia, variable intake, and low sodium levels. Interventions to encourage to drink fluids of choice and obtain and monitor lab/diagnostics work as ordered. R1's admission MD Visit dated 10/24/22, R1	2 830		

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2 830	Continued From page 4 stated he felt good, no specific questions or concerns, no cough, shortness of breath or wheezing. R1 was alert and interactive, answered questions appropriately and appeared to be well nourished and hydrated. New order to schedule Ipratropium-Albuterol solution 0.5-2.5 mg/3 ml (milligrams/milliliter) to inhale orally twice a day. R1's progress notes on 10/29/22, at 2:48 p.m. R1 noted to have some trouble swallowing larger pills, stated they got stuck in his throat. Progress note indicated R1 was given Mucinex Insta Soothe Throat Lozenge. At 8:07 p.m. oxygen saturations (O2 sats) were 90% (normal 98-100%) on room air. R1 was administered a nebulizer treatment; the neb was effective, O2 sats increased to 96%. The head of the bed was elevated. At 10:34 p.m. R1 had anxiety related to breathing, pain, and trouble swallowing pills. At 10:59 p.m. R1 given a Mucinex Insta Soother Throat Lozenge for sore throat and was effective. R1's progress notes on 10/30/22, at 11:34 a.m. identified family member (FM)-A requested to see the charge nurse as she thought R1 was getting pneumonia again. R1's O2 sats were 92% to 96% on room air, lungs sounds were diminished but clear. Blood pressure 106/51, pulse 88, respiratory rate 18 even and unlabored though R1 stated he was short of breath. No changes in mental status. The note indicated R1 would be seen by the physician on 10/31/22. At 10:30 p.m. R1 was anxious all shift he was worried about his blood pressure of 84/43. R1 had a headache earlier in the shift and was restless. R1's progress note on 10/31/22, at 4:41 a.m. indicated R1 was given Ipratropium-Albuterol nebulizer for shortness of breath and wheezing, at 5:07 a.m. noted to be effective, O2 sats 93%	2 830		

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2 830	Continued From page 5 on room air. R1's Occupational Therapy (OT) note dated 10/31/22, at 11:19 a.m. indicated R1's 02 sats were between 82%-88% with pursed lip breathing. R1 was returned to room, nurse informed, and physician was waiting outside room for meeting with R1. R1 was left in care of nurse with pulse oximeter on and O2 sats in the 80's. R1's progress note dated 10/31/22, at 12:48 p.m. included R1 had diminished lung sounds, Respiratory rate of 20 even and unlabored, R1 was coughing and wheezing, encouraged deep breathing. At 1:52 p.m. R1's oxygen saturations were 90% on room air, head of bed elevated, encouraged deep breathing. The note also included R1 was seen by provider today for low oxygen and low blood pressure. R1's record did not include a physician visit note on 10/31/22 and was not evident R1 was ever evaluated by the physician. Review of R1's blood pressures obtained on 10/31/22 identified R1's blood pressure was not within normal ranges of 120/80: -at 10:14 am: blood pressure was 89/44 -at 11:20 am: blood pressure was 81/31 -at 12:48 pm: blood pressure was 81/31 R1's progress note dated 10/31/22, at 5:27 p.m. Identified R1 was started on oxygen 2 liters per minute (lpm) related to O2 sats of 83% on room air. Even though R1 continued to have hypotension (low blood pressure) on 10/31/22 with low oxygen saturations that required supplemental oxygen the physician was not notified of the ongoing low	2 830		

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	00770	A. BUILDING: _____ B. WING _____	C 11/22/2022

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2 830	Continued From page 6 blood pressures and change in respiratory status. Further, R1's respiratory status and vital signs were not continuously monitored and assessed after 12:48 p.m. R1's progress note dated 10/31/22, identified R1's physician was not notified and/or sent to the hospital for further evaluation until 10:35 p.m. when R1's blood pressure had decreased to 70/32 and further deterioration of respiratory status. R1's progress note dated 10/31/22, 10:35 p.m. R1's blood pressure was 70/32, pulse was 99, oxygen saturations 95% via nasal canula, respiratory rate 24 with use of accessory muscles. Note indicated R1 was transferred to the emergency room. During a phone interview on 11/22/22, at 10:30 a.m. hospital social worker (HSW)-A indicated R1 was admitted from the emergency department with hypotension to our ICU on 11/1/22, with acute hypoxic (low oxygen saturations) respiratory failure. During a phone interview on 11/22/22, at 2:03 p.m. LPN-B stated, she worked on 10/30/22, from 7:00 p.m. until 11:00 p.m. LPN-B verified she was the nurse that was responsible for R1 that shift. LPN-B reported we were pushing fluids because R1 was not drinking and had dark urine. LPN-B indicated R1 was doing ok that evening, however his blood pressure was a little low. LPN-B reviewed R1's record, LPN-B verified on 10/30/22, R1's blood pressure that was recorded was 84/43. During an interview on 11/22/22, at 12:35 p.m. registered nurse (RN)-A stated on 10/31/22, she had worked on 10/31/22 during the day shift. RN-A explained R1 was supposed to be seen by	2 830		

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2 830	Continued From page 7 the physician for an acute visit related low blood pressure and respiratory changes. RN-A reported on 10/31/22, R1 had another change in condition when his blood pressure was lower (81/31) and required supplemental oxygen to keep his O2 levels above 90%. RN-A reported R1 had been seen by the physician; she had been in R1's room during the evaluation. RN-A recalled a discussion between the physician and R1 about getting a chest X-ray and labs. RN-A indicated the physician left the room without leaving any new orders and/or directives. RN-A indicated during her shift on 10/31/22, R1's O2 sats would drop if he did not have oxygen on. RN-A stated she did not follow up with physician to see if he had any new orders or treatments for R1's blood pressure and respiratory status. During a phone interview on 11/22/22, at 12:55 p.m. licensed practical nurse (LPN)-A stated she came to work at 6:30 p.m. on 10/31/22, stated she was the charge nurse that evening. LPN-A explained at around 9:45 p.m. LPN-B reported R1's blood pressure was really low and that he was requesting to be sent to the ED. LPN-A then assessed R1 and verified his blood pressure was extremely low. She called the physician and R1 was transferred to the hospital. During an interview on 11/22/22, at 9:37 a.m. director of nursing (DON) reviewed R1's record. DON explained R1's progress note dated 10/31/22, indicated he had a change of condition when his O2 sats dropped to 83% and required oxygen. DON stated, the moment R1's oxygen levels were at 83% a full comprehensive assessment with a full set of vital signs should have been completed. The physician should have been called immediately or R1 should have been transferred to the hospital for further evaluation.	2 830		

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2 830	Continued From page 8 During an interview on 10/22/22, at 2:47 p.m. DON stated, she could not find any physician notes or evidence R1 was seen by a physician on 10/31/22. DON was unable to articulate why R1 was not seen on 10/31/22. Ebeneezer Policy /Procedure Series, titled, "Change in condition/Notification," revised 10/6/22, indicated Attending physician/NP, or physician on-call, is to be immediately contacted (not by voicemail) of residents change in condition/health status based on a comprehensive assessment. 1. Between reasonable business and typical wakeful hours 7 days a week. Attending physicians/NP or the on-call is to be contacted of all health status changes immediately. After hours the attending physician pr physician on-call should be contacted of a change in condition immediately. This may include but is not limited to: "An injury that has the potential for physical intervention "Abnormal lab values "Acute symptoms "Temperature of 101 degrees or lower if indicated "Change in vital signs "Shortness of breath unrelieved by interventions "Significant oxygen saturation level change Suggested Method of Correction: The Directior of Nursing or designee could review policies and procedures, train staff, and implement measures to assure residents are receiving the necessary services to prevent or improve areas from occuring. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are	2 830		

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2 830	Continued From page 9 implemented; to better ensure implementation of treatment. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		