Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 18, 2024

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

RE: CCN: 245467
Cycle Start Date: May 30, 2024

Dear Administrator:

On May 30, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by August 30, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by November 30, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates

specified for compliance or the imposition of remedies.

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

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245467	A. BUILDING _____ B. WING _____	C 05/30/2024

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
E 000	Initial Comments Surveyor: 34083 On 5/28/24 through 5/30/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS Surveyor: 34083 On 5/28/24 through 5/30/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H54674031C (MN00100310). An RN Waiver was previously approved by the State Agency. This waiver will remain IN EFFECT until such time as the facility achieves compliance. 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	F 000		

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

Electronically Signed | 06/28/2024

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 000	Continued From page 1 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-	F 580		7/30/24

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F 580	Continued From page 2 (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Surveyor: 34083 Based on interview and document review the facility failed to notify the resident representative and/or physician for 1 of 1 resident (R48), who experienced a witnessed fall on 12/10/23. Findings include: Review of the 12/10/23 at 10:45 a.m., nursing progress note, and incident report identified R48 was combative toward an unidentified nursing assistant (U-NA) as he was assisting him to toilet and placed his soiled pants into a plastic bag for laundering. R48 had attempted to grab the bag from the NA when he fell to the floor. R48 denied injury and was seated on his bed when licensed practical nurse (LPN)-B was called to the room.	F 580	It was found that a resident s family/provider was not notified within a reasonable time of a fall. Corrective action will be taken to ensure proper notification to family and providers for residents with a fall. The following measures will be put in place: 1. It was found our current fall policy does include the expectation to inform the residents family and provider within a reasonable time. 2. Nursing staff will be educated on the policy and the expectations of the notification process via email communication by July 1st and then reviewed at the July staff meeting. 3. The DON, ADON, or case managers will monitor falls to ensure notifications	

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F 580	Continued From page 3 He reported he wanted his pants back, when asked what had happened. LPN-B explained his pants needed to be washed and dried because they had BM on them. R48 voiced no further concerns, denied pain, his range of motion was intact, but he refused to allow vital signs to be checked x 3. There was no mention R48's physician or family had been notified of his fall. Review of the 12/10/23, Post Fall Huddle-SBAR identified R48 attempted to grab the U-NA with his soiled hands as he was placing the soiled pants into a clear plastic bag. The U-NA called for assistance due to R48 being "combative" due to thinking his soiled pants were being discarded when he was being toileted. R48's call light and assistive devices were noted to have been within his reach at the time of the fall. There was no mention R48's physician or family had been notified of his fall. Review of R48's 12/10/23 at 5:49 p.m. incident report failed to identify notification of either the resident's responsible party (power of attorney-POA) nor his physician. The electronic medical record also failed to contain any documentation of notification of the POA or provider for R48's fall. R48's 12/14/23 at 1:06 p.m., physician progress note identified R48 was assessed for hip pain after being notified of new onset pain that day earlier at 11:00 a.m. X-rays were ordered which showed a fracture of his right hip. The facility and family were notified. R48's family agreed with a transfer to the regional hospital for further assessment and potential surgical repair. Interview on 5/30/24 at 10:00 a.m. with family	F 580	are being done appropriately on 100% of falls will be reviewed for 3 months, then 50% of falls will be reviewed for 3 months, then 25% of falls will be reviewed for 6 months starting with falls in June 2024. This will also be added to the quality scorecard for review at the QAPI meetings.	

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F 580	Continued From page 4 member (FM)-A reported she had not been informed of R48's fall and it was not until 12/14/23 when she had come to visit and R48 reported to her, he was not able to get out of bed or lift his right leg due to lower right calf area pain. FM-A spoke with the director of nursing (DON) regarding her concerns and questioned she had not been notified and why there was a delay in medical assessment. She reported if she had been notified, she would have wanted him to be "checked out" (examined by a physician) right away at the time of the fall. Interview on 5/30/24 at 10:01 a.m. with the DON reported her expectation for staff to notify both the physician and family of a fall or incident within a reasonable amount of time (i.e., 1 hour or sooner). A policy for incident/accident notification of responsible parties and medical providers was requested but not provided.	F 580		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property,	F 604		7/30/24

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F 604	Continued From page 5 and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Surveyor: 47497 Based on observation, interview, and record review, the facility failed to develop a plan to reduce or discontinue the use of a seatbelt type of restraint for 1 of 1 resident (R17). Findings include: R17's 4/9/24, significant change Minimum Data Set (MDS) assessment identified R17's cognition was severely impaired, with diagnosis of non-traumatic brain injury, Alzheimer's disease, dementia, anxiety, depression, history of falls, and delusions (misconception of beliefs that are firmly held, contrary to reality). R17 used a wheelchair, was dependent on staff for ADL's (activities of daily living), and had a trunk restraint in place.	F 604	It was found that the restraint removal plan was not included in the care plan of a resident that had a restraint in place. Below are the measures put in place to correct this deficiency. 1. Removal plan was put in place and added to the care plan immediately following notification of omission of the plan from the care plan. 2. Therapy was also consulted to assist in finding a safe alternative to her restraint. 3. No other restraint orders are currently in place for other residents. 4. Care plans will reflect interventions to eliminate the restraint. Interventions such as but not limited to planned supervised periods for removal of the restraint. 5. The restraints policy will be updated to include the expected timeframe for the resident to be seen by the provider.	

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F 604	Continued From page 6 R17's current care plan identified she was at risk for falls with interventions to keep room clear from clutter, provide adequate lighting, ensure gripper socks are on, provide PT/OT as needed, provide activities such as word find puzzles when attempting to self- transfer. The care plan also had interventions of anti-lock brakes on wheelchair, and a seat belt type restraint that she was not always able to remove independently and a bed alarm at night. Staff were to toilet her every 2 hours while awake, and every 2-3 hours at night. R17's care plan also identified she was vulnerable to injury during use of a restraint related to mobility deficits and falls with injury. The care plan identified a goal to decrease or eliminate restraint usage, however, it did not identify any plan or intervention to achieve that goal. Observation on 5/28/24 at 11:16 a.m., R17 is seated in her wheelchair near the nurse's station with a seatbelt buckled across her abdomen. The buckle is black with an orange button that has to be pushed in to release the belt. Review of 1/4/24 physician order identified facility was to start lorazepam 0.5 mg 3 times daily by mouth and a seat belt type restraint while in wheelchair for anxiety and mobility deficits. Review of behavior monitoring from 4/1/24 through 5/29/24, identified R17 displayed behaviors of not wanting to stay in bed 5 times and attempted elopement 3 times, with interventions of getting R17 out of bed and into her wheelchair, bringing R17 to a safe place, and on one occasion, administering lorazepam. Documentation noted interventions were effective.	F 604	6. Nursing staff will receive education on the restraint policy at the July staff meeting. 7. New restraint orders and care plans will be audited by the DON, ADON, or MDS nurse to ensure correctness for FY25. Care plans for residents with restraints will be audited with each MDS review, sig changes, and anytime a new restraint has been ordered. Audits will be completed for 100% of new orders for FY25. This will be added to the quality scorecard for review at the QAPI meetings starting July 2024.	

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F 604	Continued From page 7 R17's medical record identified she was seen on routine nursing home rounds 2/13/24. That visit had not taken place until 40 days after her restraint was initially ordered. The physician identified behaviors had significantly improved but that R17 had a gradual decline in general overall health. Nursing was very pleased that her behaviors have decreased substantially since the scheduled lorazepam. The dictation also identified R17 had a seatbelt in place that she could unlock herself and that the therapy department and nursing were monitoring weekly. Observation and interview on 5/29/24 at 9:32 a.m., R17 with registered nurse (RN)-C identified R17 was asked to remove her seatbelt. R17 was unable to remove it and was asked by RN-C a total of 3 times to remove her seat belt. R17 appeared confused and asked RN-C, "I have a seat belt?". She felt around her abdomen area, then stated "I can't.". RN-C agreed R17 was unable to remove the locked seatbelt upon request. Interview on 5/29/24 at 11:00 a.m., with assistant director of nursing (ADON) stated "we are not assessing the seat belt enough" She identified they had not developed a plan for removal because they do not have enough staff to supervise her on a 1:1 trial basis. Interview on 5/29/24 at 11:40 a.m., with director of nursing (DON) identified they had not tried anything less restrictive and had not developed a plan for removal. She identified that the facility would start working on a plan for removal immediately.	F 604		

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F 604	Continued From page 8 Interview on 5/30/24, at 9:48 a.m., with the administrator identified he would expect nursing to follow the facility policy, the facility should only use restraints on a short-term basis if there were no alternative and to start developing a plan for removal immediately after the restraint is in place. Review of the Use of Restraints facility policy last revised April of 2017, identified use of restraints is permitted if their use is immediately necessary to prevent the resident from injuring himself/herself or others. The emergency use of restraints must not extend beyond the immediate episode. The facility must obtain a written order from the physician that includes the specific reason for the restraint, how the restraint will be used to benefit the resident's medical symptom, the type of restraint, and period of time for the use of the restraint. Orders for restraints will not be enforced for longer than twelve hours unless the resident's condition requires continued treatment. Re-orders are issued only after a review of the resident's condition by his or her physician. The care plan shall also include the measures taken to systematically reduce or eliminate the need for restraint use.	F 604		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.	F 695		7/30/24

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F 695	Continued From page 9 This REQUIREMENT is not met as evidenced by: Surveyor: 39988 Based on observation, interview, and document review the facility failed to ensure oxygen flow rate parameters were identified for an oxygen order, failed to deliver the supplemental oxygen according to the physician order, and revise the care plan for 1 of 1 (R3) resident reviewed. Findings include: R3's 4/13/24, quarterly Minimum Data Set (MDS) assessment identified R3's cognition was moderately impaired, she had no behaviors, she needed supervision for most cares with some assistance. R3 had no pain and was not short of breath. R3 took an antidepressant, diuretic, an antibiotic, and she did not use oxygen during the assessment period. R3's 5/29/24, printed diagnosis list identified diagnoses of dementia, anxiety, sleeping difficulty, depression, anemia, confusion, congestive heart failure, history of stroke, shortness of breath, coronary artery disease, and hypertension. R3's 5/29/24, printed care plan identified R3 had impaired respiratory status due to congestive heart failure. R3 would maintain her respiratory status with the use of oxygen as needed. R3 had current order for as need oxygen at 1 liter per minute (L) to keep her oxygen level above 90%. Staff were to check her oxygen level if she complained of shortness of breath. R3's 9/27/23, current oxygen order identified	F 695	It was noted that an oxygen order was inappropriately placed. Below are measures that were put in place to correct this deficiency. 1. This was immediately fixed in the resident s chart after verification. 2. All other residents with oxygen orders were reviewed and found to be correctly entered. 3. Reeducation for nursing staff on entering oxygen orders will be completed at the July nurses meeting. 4. New oxygen orders will be audited by the DON, ADON, or MDS nurse to ensure correctness for FY25. Audits will be completed weekly x4 weeks, 2x per month for 2 months, and monthly x 9 months. This will be added to the quality scorecard for review at QAPI meetings starting July 2024.	

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F 695	Continued From page 10 Oxygen continuous to keep oxygen level above 90%. The order had no flow rate or flow rate range identified. Review of R3's oxygen level monitoring from 4/2/24 through 5/29/24 identified that R3 did not use oxygen during that time frame, starting on 5/17/24 through 5/29/24 R3's documentation identified R3's oxygen level had been checked 20 times and she was provided oxygen at 2L for 10 of the 20 times and 1L for 7 of the 20 times. Review of the facility infection control surveillance identified that R3 had been diagnosed with influenza A on 5/15/24. Observation on 5/28/24 at 9:53 a.m., R3 was laying in bed with her nasal cannula positioned on her forehead, the oxygen concentrator flow rate was set at 1L. Observation on 5/28/24 at 12:37 p.m., R3 was laying in her bed sleeping with no oxygen on, the oxygen tubing was laying on the concentrator about 3 feet from her bed. Observation on 5/28/24 at 5:30 p.m., staff wheeled R3 into the dining room and parked her at the table. R3 had oxygen on at 1.5L via nasal cannula. Observation on 5/28/24 at 6:52 p.m., R3 was laying on her bed with her nasal cannula on, oxygen flow rate at 1.5L still attached to the portable tank on the back of her wheelchair. Observation on 5/29/24 at 9:02 a.m., R3 was seated at the dining room table with no oxygen on. No oxygen tubing connected to the portable	F 695		

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F 695	Continued From page 11 tank on the back of her wheelchair and the portable oxygen tank was off. Observation on 5/29/24 at 9:31 a.m., R3 was sitting in the recliner in her room, she had her oxygen on via nasal cannula at 1L from her concentrator. Interview on 5/29/24 at 11:00 a.m. with director of nursing (DON) identified R3's current order was oxygen as needed at 1L to keep oxygen level above 90% and staff were to check her oxygen level if she complained of shortness of breath. The DON then provided a copy of the order upon request which identified the order date of 9/26/22 and a review date of 7/1/23. Interview on 5/29/24 at 1:29 p.m., with assistant director of nursing (ADON) identified R3's oxygen order was for continuous oxygen to keep oxygen level above 90%. The ADON provided a copy of the order upon request which identified order date 9/27/23, oxygen frequency as continuous to keep oxygen level above 90%. There was no flow rate or flow rate range identified on the order. The ADON confirmed that there was no flow rate or range indicated and that staff were able to make their own judgement on the flow rate in order to keep R3's oxygen level above 90%. Interview on 5/29/24 at 2:28 p.m., with DON identified the nurse would receive an order and then would enter the order into the computer system. The provider reviewed medication orders during visits but the order list that the provider reviewed only contained medications and did not contain oxygen orders or treatments. The DON revealed the provider would not know what the resident's oxygen level had been running if	F 695		

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F 695	Continued From page 12 monitored or what the current flow rate was unless the case manager documented that information for the provider to review. She agreed if the nurse did not bring that information forward for the provider to review the provider may be unaware that the resident was even on oxygen. She agreed this was concerning. When asked about R3's current order for continuous oxygen to keep oxygen level above 90% with no flow rate or range identified she confirmed that the nurse or trained medication aide would have to make that judgement call on what to set the oxygen rate at and that also was not appropriate. She was unaware that the order did not have a flow rate or range for the nursing staff to use. She confirmed that the order should have been clarified. Interview on 5/29/24 at 3:11 p.m., with trained medication aide (TMA)-A who pulled up R3's oxygen order on the computer at her medication cart and identified that R3 had an order for oxygen as needed at 1L to keep her oxygen level above 90%. She reported that the nursing staff checked R3's oxygen level every shift. She did not bring up the current oxygen order dated 9/27/23. Interview on 5/29/24 at 3:20 p.m., with licensed practical nurse (LPN)-A who pulled up R3's oxygen order on the computer at the medication cart and identified that R3 had an order for oxygen as needed at 1L to keep her oxygen level above 90%. He did not bring up the current oxygen order dated 9/27/23. Interview on 5/29/24 at 4:52 p.m., with ADON who was informed that the staff had pulled up the old order that identified oxygen as needed at 1L verses the current order of continuous oxygen to	F 695		

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F 695	Continued From page 13 keep oxygen level above 90% stated that the DON had just obtained a new order for as needed at 1L to keep her oxygen level above 90%. She identified that the medical record was being update. Review of October 2010, Oxygen Administration policy identified staff were to verify the physician's order for oxygen administration and review the resident care plan for any special needs. The policy identified unless otherwise ordered to start the oxygen flow rate at 2 to 3 liters per minute. Review of November 2014, Medication Orders policy identified oxygen orders were to contain specified rate of flow, route, and rationale.	F 695		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Surveyor: 34083 The facility's request for a waiver was accepted	F 727	Waivered tag: no plan of correction required.	7/9/24

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F 727	Continued From page 14 and approved by the State Agency following the survey dated 7/17/23. The tag was re-issued however, NO plan of correction is required. This will remain in effect until such time as the registered nurse (RN) coverage can be filled and the facility achieves compliance. F727: CFR 483.35 (b)(1), RN coverage 8 consecutive hours a day, 7 days a week. Findings include: Review of the facility nursing staff schedules for February 2024, March 2024 and April 2024 identified in: 1) February 2024, there no 8-hour consecutive RN coverage for 6 of 29 days: 2/3; 2/4; 2/10, 2/11; 2/18, and 2/25/24 2) March 2024, there was no 8-hour consecutive RN coverage for 2 of 31 days: 3/3 and 3/17/24. 3) April 2024, there was no 8-hour consecutive RN coverage for 2 of 30 days: 4/14 and 4/28/24. Interview on 5/28/24 at 12:41 p.m. with licensed practical nurse (LPN)- B (staff scheduler), reported she completed assignments and notified management of call-ins. She reported when there was a call-in, she communicated the open shift via text message and updated the administration team. Interview on 5/29/24 at 12:16 p.m. with the administrator reported he had reached out to many resources in addition to utilizing online websites to obtain licensed employees. Interview on 5/29/24 at 12:21 p.m. with human resources (HR) identified she had posted staff openings on Indeed, the facility website,	F 727		

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F 727	Continued From page 15 Handshake (for college students), and Lake area tech. She reported she had not had much luck with responses. She reported the facility had attempted one local job fair in Hendricks and had been involved with job fairs held with South Dakota state university. She reported most to the applications had been a result of Indeed or the website and when she received an application, she immediately contacted the applicant to set up an interview with the facility. Interview on 5/30/24 at 10:30 a.m. with the director of nursing (DON) reported the facility continued to struggle with consecutive registered nurse (RN) 8 hour/24-hour coverage, but the facility was attempting to find more staff but at the present time needed to continue with the RN waiver. Review of the July 2023, Scheduling and Absenteeism Policy -HCHA Long Term Care identified the facility policy was to maintain staff staffing levels and provide the necessary care and safety to the residents in the facility, Staffing was identified according to need with the number of residents residing in the facility. The policy identified the goal of RN coverage a minimum of 8 hours/24 hours, 7 days/week.	F 727		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic;	F 758		7/30/24

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F 758	Continued From page 16 (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for	F 758		

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F 758	Continued From page 17 the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Surveyor: 47497 Based on interview and record review the facility failed to ensure 1 of 5 resident (R33) had a qualifying diagnosis for routine use of an antipsychotic. Findings include: R33's 4/13/24, quarterly Minimum Data Set (MDS) identified R33 had moderate difficulty hearing, uses a hearing aid, speaks clearly, she can make her needs known, and usually understands others. R33's cognition was moderately impaired, she required extensive assist from staff for transfers, dressing, and hygiene. She had diagnosis of depression and dementia. R33 was being administered an antipsychotic on a routine basis and had other behavior symptoms not directed toward others on 4 to 6 days during the look back period. R33's current physician orders identified she was receiving Lexapro 10 milligrams (mg) (antidepressant) daily for depression and risperidone 0.5 mg (antipsychotic) daily at bedtime for agitation. R33's 4/29/24 through 5/29/24, behavior monitoring identified R33 had behaviors of calling out for help, not using call light for help, requesting to use the bathroom every 15 minutes, yelling into the hallway for help to the bathroom and yelling for help when staff were in the room. Staff provided interventions were to re-educate resident to use call light, offer food, water, and/or	F 758	It was noted that one of our residents did not have an appropriate diagnosis for the antipsychotic medication she was prescribed. Below are measures that have been put in place to ensure correction of this deficiency. 1. Actions to address residents dx and medication were not completed due to resident being on hospice and passing away prior to being able to complete this process. 2. The IDT team will review all residents with existing psychotropic. 3. IDT Risk review prior to the start of medication will be implemented. 4. Provider education will be completed regarding qualifying diagnosis for psychotropic medication. 5. The IDT team will explore additional non-pharmaceutical routes for residents that can be implemented prior to additional medication requests. 6. The facility has elected reduction of antipsychotic medications as our QIP for the year. 7. Care plan will be monitored by the MDS nurse to ensure they reflect their current behaviors and current interventions. 8. New orders for psychotropics will be monitored by the DON, ADON, or MDS nurse to ensure appropriate diagnosis code in place. All new orders will be reviewed for FY25. The QAPI team will revisit necessity of audits at the end of FY25. This will be added to the Quality Scorecard for review at the QAPI	

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F 758	Continued From page 18 toileting. R33's current care plan identified she had behaviors of yelling out for staff and not using call light related to dementia with interventions for staff to ask R33 if she had pain or discomfort and to instruct her to use her call light as she is cognitive and remind her that it is not necessary to yell. Staff were to answer call light promptly as yelling may be from feeling the urge to toilet related to cancer history. R33's medical record lacked any indication that a root cause analysis had been completed to determine the cause of her behaviors of yelling out and frequent urges to urinate. Interview on 5/29/24, at 4:31 p.m., with director of nursing (DON) identified she agreed that R33 did not have an appropriate diagnosis for the use of an antipsychotic medication. She identified the reason for the antipsychotic medication was for her behaviors of yelling out for assistance and toileting or if she is unable to sleep at night. She identified staff are to reminder to use her call light. Interview on 5/30/24 at 9:48 a.m., with the administrator identified he would expect staff to follow the policy for antipsychotic use. Review of the December 2016, facility Antipsychotic Medication Use policy identified antipsychotic medications shall generally be used only for conditions/diagnoses as documented in the record and consistent with the definitions in the Diagnostic and Statistical Manual of Mental Disorders: schizophrenia, schizo-affective disorder, schizophrenia disorder, delusional disorder, mood disorders (e.g. bipolar disorder,	F 758	meetings starting July 2024.	

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F 758	Continued From page 19 depression with psychotic features, and treatment refractory major depression), psychosis in the absence of dementia, medical illnesses with psychotic symptoms and/or treatment-related psychosis or mania, Tourette disorder, Huntington's disease, hiccups, or nausea and vomiting associated with cancer chemotherapy.	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Surveyor: 49336	F 761	1. The expired medications were	7/30/24

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F 761	Continued From page 20 Based on observation, interview and document review, the facility failed to ensure 1 of 2 E-kits (emergency kit) did not have expired medication and maintain their system for disposition of controlled and/or narcotic substances to immediately detect and reconcile to prevent drug diversion. Findings include: Observation, interview, and document review on 5/28/24 at 10:48 a.m., with registered nurse (RN)-D of the facility's large emergency kit (E-kit) located in medication room had an attached unsigned inventory list that identified for Lorazepam 0.5 mg (milligrams), Hydrocodone/APAP 5/325 mg and Tramadol 100 mg tablets with an expiration date of 5/16/24 on the inventory list. The large e-kit had a plastic lock with the number 12772528 that contained 8 tablets of hydrocodone in a bubble pack with the expiration date of 5/16/24, 11 tablets of tramadol in a bubble pack with the expiration date of 5/16/24, and 2 tablets of Lorazepam in a bubble pack with expiration date of 5/16/24. RN-D stated nurses were to complete e-kit tag verification each shift and the local pharmacy would check the e-kit monthly and was responsible to remove expired medications in the e-kit. She stated the inventory log was provided from the pharmacy and would include a list of controlled medications that are accessible for nurses to use for emergent needs. Observation, interview, and record review on 5/28/24 at 1:34 p.m., with pharmacist (RPh) stated the tramadol, hydrocodone and lorazepam bubble packs were expired and was not replaced. He stated the facility E-kit controlled medications were not checked monthly by pharmacy. The RPh was to receive notification from nursing staff	F 761	immediately removed from the E-kit and replaced with new. 2. No medications were given to residents that were past their expiration date. It was verified that the rest of the medications in the E-kit were not expired. 3. A process was developed with the pharmacist to ensure a monthly review of the E-kit. This review will be done by the pharmacist and the DON or designee and will include a verification of count, expiration date and signature of both parties conducting the review. Either the pharmacist or the DON will bring the information to the QAPI committee meeting. 4. Completion of the monthly review will be monitored and tracked on the Quality Scorecard for FY25 starting in July 2024.	

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F 761	Continued From page 21 of expired controlled substances for refills, but that had not been completed. He agreed the facility needed to ensure no expired medications remained in the e-kit. Interview on 05/28/24 02:55 PM with director of nursing (DON) identified her expectation would be for the pharmacy to check e-kit medication monthly and to ensure controlled substances are recorded on the log by nursing staff with each shift for verification and were accounted for and accurate as stated in the facility policy. Review of 12/2023 LTC Emergency Medication Kit policy identified medications will be reviewed by pharmacy and they were to complete an audit monthly to verify counts and expiration dates.	F 761		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and	F 867		7/30/24

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F 867	Continued From page 22 information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness	F 867		

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F 867	Continued From page 23 of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's	F 867		

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F 867	Continued From page 24 governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Surveyor: 49336 Based on interview and document review, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to identify facility specific concerns, implement an action plan to correct the identified concerns or to ensure the committee participated in the development and oversight of implementation of systems, and to ensure quality of life and quality of care were maintained for 46 residents residing in the facility. Findings include: Review of undated, facility performance improvement plan (PIP) identified a goal for the facility to observe medication administrations in the facility's dining room. The action plan was for education to be provided for nurses and train medication aides (TMA's) on medication administration. The improvement plan had no mention of a target date nor observation dates or times of medication administrations observed. The plan lacked interventions that would analyze	F 867	1. The facility has a Quality Scorecard in place that tracks several quality items and is reviewed at the monthly QAPI meeting as well as the quarterly facility wide QAPI meeting. 2. The Scorecard will be updated to reflect new selections for FY25. These will then be utilized to develop Process Improvement Projects. 3. Education on creating SMART goals to utilize with action plans for process improvement projects was provided at the June QAPI meeting. 4. QAPI meeting minutes will be posted in the staff break room for review as well as reviewed at monthly staff meetings. 5. The process improvement projects will be reviewed at the monthly QAPI meetings.	

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F 867	Continued From page 25 the underlying cause and opportunities for improvement. Interview on 5/29/24 at 3:52 p.m., with director of nursing (DON) stated the nursing home utilized an online quality scorecard for both the hospital and nursing home that would track PIP's in the facility. She stated the facility would implement quality improvements projects during the fiscal year for month of July 2023 to June 2024. She stated the facility had no PIP's from the month of July 2023 to March 2024. She stated she had encouraged the administration and department heads during the facility monthly meetings to identify areas of improvement that facility could work on and create a PIP on the online quality scorecard. She stated she was aware that a PIP plan had recently been added on the facility scorecard by a department head who identified an improvement for medication administration. She stated the had been posted on SharePoint in the month of April of this year, because the facility had no success in implementing a PIP the last few months. She stated the current PIP needed improvements and stated it lacked audits and consistent data for analyzing performance improvements. Review of the February 2024, QAPI policy identified the QAPI program was to develop and implement performance improvement activities.	F 867		
F 895 SS=F	Compliance and Ethics Program CFR(s): 483.85(a)-(e) 483.85 Compliance and ethics program. §483.85(a) Definitions. For purposes of this section, the following definitions apply:	F 895		7/30/24

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F 895	Continued From page 26 Compliance and ethics program means, with respect to a facility, a program of the operating organization that- §483.85(a)(1) Has been reasonably designed, implemented, and enforced so that it is likely to be effective in preventing and detecting criminal, civil, and administrative violations under the Act and in promoting quality of care; and §483.85(a)(2) Includes, at a minimum, the required components specified in paragraph (c) of this section. High-level personnel means individual(s) who have substantial control over the operating organization or who have a substantial role in the making of policy within the operating organization. Operating organization means the individual(s) or entity that operates a facility. §483.85(b) General rule. Beginning November 28, 2019, the operating organization for each facility must have in operation a compliance and ethics program (as defined in paragraph (a) of this section) that meets the requirements of this section. §483.85(c) Required components for all facilities. The operating organization for each facility must develop, implement, and maintain an effective compliance and ethics program that contains, at a minimum, the following components: §483.85(c)(1) Established written compliance and ethics standards, policies, and procedures to follow that are reasonably capable of reducing the	F 895		

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F 895	Continued From page 27 prospect of criminal, civil, and administrative violations under the Act. and promote quality of care, which include, but are not limited to, the designation of an appropriate compliance and ethics program contact to which individuals may report suspected violations, as well as an alternate method of reporting suspected violations anonymously without fear of retribution; and disciplinary standards that set out the consequences for committing violations for the operating organization's entire staff; individuals providing services under a contractual arrangement; and volunteers, consistent with the volunteers' expected roles. §483.85(c)(2) Assignment of specific individuals within the high-level personnel of the operating organization with the overall responsibility to oversee compliance with the operating organization's compliance and ethics program's standards, policies, and procedures, such as, but not limited to, the chief executive officer (CEO), members of the board of directors, or directors of major divisions in the operating organization. §483.85(c)(3) Sufficient resources and authority to the specific individuals designated in paragraph (c)(2) of this section to reasonably assure compliance with such standards, policies, and procedures. §483.85(c)(4) Due care not to delegate substantial discretionary authority to individuals who the operating organization knew, or should have known through the exercise of due diligence, had a propensity to engage in criminal, civil, and administrative violations under the Social Security Act.	F 895		

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F 895	Continued From page 28 §483.85(c)(5) The facility takes steps to effectively communicate the standards, policies, and procedures in the operating organization's compliance and ethics program to the operating organization's entire staff; individuals providing services under a contractual arrangement; and volunteers, consistent with the volunteers' expected roles. Requirements include, but are not limited to, mandatory participation in training as set forth at §483.95(f) or orientation programs, or disseminating information that explains in a practical manner what is required under the program. §483.85(c)(6) The facility takes reasonable steps to achieve compliance with the program's standards, policies, and procedures. Such steps include, but are not limited to, utilizing monitoring and auditing systems reasonably designed to detect criminal, civil, and administrative violations under the Act by any of the operating organization's staff, individuals providing services under a contractual arrangement, or volunteers, having in place and publicizing a reporting system whereby any of these individuals could report violations by others anonymously within the operating organization without fear of retribution, and having a process for ensuring the integrity of any reported data. §483.85(c)(7) Consistent enforcement of the operating organization's standards, policies, and procedures through appropriate disciplinary mechanisms, including, as appropriate, discipline of individuals responsible for the failure to detect and report a violation to the compliance and ethics program contact identified in the operating	F 895		

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F 895	Continued From page 29 organization's compliance and ethics program. §483.85(c)(8) After a violation is detected, the operating organization must ensure that all reasonable steps identified in its program are taken to respond appropriately to the violation and to prevent further similar violations, including any necessary modification to the operating organization's program to prevent and detect criminal, civil, and administrative violations under the Act. §483.85(d) Additional required components for operating organizations with five or more facilities. In addition to all of the other requirements in paragraphs (a), (b), (c), and (e) of this section, operating organizations that operate five or more facilities must also include, at a minimum, the following components in their compliance and ethics program: §483.85(d)(1) A mandatory annual training program on the operating organization's compliance and ethics program that meets the requirements set forth in §483.95(f). §483.85(d)(2) A designated compliance officer for whom the operating organization's compliance and ethics program is a major responsibility. This individual must report directly to the operating organization's governing body and not be subordinate to the general counsel, chief financial officer or chief operating officer. §483.85(d)(3) Designated compliance liaisons located at each of the operating organization's facilities.	F 895		

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F 895	Continued From page 30 §483.85(e) Annual review. The operating organization for each facility must review its compliance and ethics program annually and revise its program as needed to reflect changes in all applicable laws or regulations and within the operating organization and its facilities to improve its performance in deterring, reducing, and detecting violations under the Act and in promoting quality of care. This REQUIREMENT is not met as evidenced by: Surveyor: 49336 The facility failed to ensure the development and implementation, and the maintainence of an effective compliance and ethics program for oversight when 1 of 1 employee registered nurse (RN)-D, advised licensed practical nurse (LPN)-E to sign-off on a narcotic documentation form as having witnessed the count, when in fact, they had not. Findings include: Review of the facility west wing Shift Verification of Controlled Substances Count form identified one entry of a nurse signature missed on 5/16/24 for the 6:00 a.m. shift and a second entry of a nurse signature missed on 5/28/24 for the 10:00 p.m. to 6:00 a.m. shift. The documentation lacked supporting evidence to verify if the narcotic counts were completed appropriately. Observation and interview on 5/28/24 at 6:37 p.m., with LPN-E stated he was unaware of who completed the narcotic count with him and was aware the narcotic count was completed before his shift on 5/16/24 and confirmed the form was not sign by the departing nurse.	F 895	1. Verbal review of process to sign off in the narcotic book was completed with staff. 2. The administrative team for the facility will work to update the Ethics Policy to ensure a good process in place. Ethics committee will include: staff provider, local pastor, administrator, acute DON, Director of Aging services, Home Care Director, Social Worker, and Two Community Members. The committee will ensure compliance with completion of staff education related to ethics annually. 3. Once policy is updated and completed, this will be reviewed with staff to ensure their knowledge of the Ethics Committee. 4. The narcotic book for each medication cart will be audited weekly for 2 months, 2 times per month for 2 months and monthly for 6 months. This will be added to the Quality Scorecard for review at the QAPI meeting.	

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F 895	Continued From page 31 Observation and interview on 5/28/24 at 6:39 p.m., with RN-D stated she worked the morning of 5/28/24 and stated LPN-C and LPN-F had completed a narcotic count during the previous shift change and stated LPN-C forgot to sign her name on the form. RN-D stated she observed the two nurses count the narcotics that morning and was sure the narcotic count was completed and stated the missing signature needed to be signed. RN-D then directed LPN-E (who did not perform the count) to sign the form for the date of 5/28/24. LPN-E asked RN-D where his signature should be placed. RN-D pointed to the form for the date of 5/28/24 and advised LPN-E to sign his name. LPN-E placed his pen on the narcotic form and was stopped by the surveyor as LPN-E had not witnessed the count. Review of LPN-E timesheet identified he worked on 5/28/24 beginning at 1:52 p.m. Review of RN-D timesheet identified she worked on 5/28/24 beginning at 5:54 am to 12:45 p.m. and then again from 1:41 p.m. to 6:54 p.m.. Interview on 5/28/24 at 6:52 p.m., with director of nursing (DON) stated her expectations would be for the nurses and trained medication aide (TMA) to count narcotics every shift and sign the narcotic form accurately when the task was completed. Interview on 5/29/24 at 8:58 a.m., with administrator stated it is not an acceptable practice for staff to forge documentation if it was not completed accurately. It was his expectation would be for all staff to complete documentation in a timely manner when the task or work had	F 895		

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F 895	Continued From page 32 been completed. In addition, he stated his expectation would be for employees to not alter documentation, but provide a rationale for not completing documentation in a timely manner. Review of 2/16/24 Skilled Nursing Facilities Orientation Checklist for Direct Care Staff-Nursing assistants and Nurses identified QAPI, Compliance and Ethics training deadline was due upon hire. Interview and record review on 5/29/24 at 10:15 a.m., with DON stated RN-D had a hire date of 2/29/20. She stated the information sent by human resources (HR) noted RN-D lacked documentation of ethics training upon hire. Review of RN-D facility education identified a printed Scorecard: All Competencies dated November, 2023 that listed completion of Ethics training. Interview on 5/29/24 at 3:14 p.m., with administrator stated the facility had no active Ethics committee but had assigned people that would meet, if requested. The facility committee had no meetings scheduled and had no reasons or concerns to meet regularly. Interview on 5/29/24 at 3:23 p.m., with DON stated she unaware of a ethics committee at the facility and had no knowledge of an ethics committee meeting regularly. Review of February, 2024 Controlled Substance Storage and Disposal policy identified controlled substance count verification should be done every shift by two (2) nurses or medication aides; one from previous shift and one form oncoming shift. Nurse and/or TMA going off duty and a	F 895		

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F 895	Continued From page 33 nurse and/or TMA coming on duty would provide their signature. The signature would indicate the medications had been checked and the count was verified to be correct. If the narcotic count was incorrect, staff would notify the DON. Review of June, 2023 Employee Code of Conduct and Confidentiality policy identified employees will be expected to adhere to the regulations. The policy identified employees would complete medical records accurately and are expected to conduct themselves in a moral, honest and courteous manner. Review of August 2023 Ethics Committee policy identified the committee is a advisory resource for end of life situations and available as an advisory group and did not meet regularly, but would be available upon request.	F 895		
F 944 SS=D	QAPI Training CFR(s): 483.95(d) §483.95(d) Quality assurance and performance improvement. A facility must include as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program as set forth at § 483.75. This REQUIREMENT is not met as evidenced by: Surveyor: 49336 Based on interview and document review, the facility failed to provide mandatory training on 1 of 1 facility specific Quality Assurance Performance Improvement (QAPI) Program to include goals and various elements of the program, how the facility intends to implement the program, staff's	F 944	It was brought to the attention of the DON that staff members were unsure of QAPI and the QAPI process within our facility. Below are some measures put in place to help to correct this deficiency. 1. Facility specific education is completed upon hire and annually thereafter. 2. QAPI meeting minutes and goals will	7/30/24

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F 944	Continued From page 34 role in the facility's QAPI program, or how to communicate concerns, problems, or opportunities for improvement to the facility's QAPI program. This had the ability to affect all 46 residents. Findings include: Interview on 5/29/24 at 8:28 a.m., with licensed practical nurse (LPN)-D stated she had attended one QAPI meeting in the past and was aware the facility had scheduled meetings monthly. She stated each department head attended the QAPI meetings and would discuss each departments concerns. She stated she along with another employee were working on a performance improvement project for repositioning residents in the facility to prevent pressure ulcers. She was unaware of how long the performance improvement project (PIP) would take and was unaware of long term goals from the PIP. Interview on 5/29/24 at 8:32 a.m., with LPN-C stated she had not attended any QAPI meetings and received training online (generalized online QAPI training). She stated she was unsure of what specific QAPI projects the facility had in place. Interview on 5/29/24 at 8:35 a.m., with LPN-A stated he had not attended the QAPI meeting but read the notes from the meeting that were located near the nursing station. He stated the facility had hired new staff and the facility had informed all staff of standard infection control practices and confidentiality. He stated he was unaware of anything specific the QAPI committee was working on at the facility.	F 944	be posted in the staff break room and reviewed at monthly staff meetings to ensure knowledge of the process and the goals that facility has in place. Staff will also be encouraged to take part in PIP teams if possible. 3. Completion of QAPI education upon hire and annually will be tracked for FY25. This will be placed on the Quality Scorecard for review at QAPI meetings.	

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	245467	A. BUILDING _____ B. WING _____	C 05/30/2024

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F 944	Continued From page 35 Interview on 5/29/24 at 8:36 a.m., with nursing assistant (NA)-C stated she had not attended any QAPI meetings and was not aware of QAPI since she started working here in the facility recently. She stated she was not aware of any specific PIP the facility had in place. Interview on 5/29/24 at 12:08 p.m., with housekeeping aide (HK)-A stated the facility had QAPI meetings and she had not attend a meeting. She stated she received updates from the QAPI meeting from her supervisor. She stated her supervisor would conduct department meetings and would go over information discussed at the monthly QAPI meetings. Interview on 5/29/24 at 4:20 p.m., with trained medication aide (TMA)-A stated she was not aware of the facility QAPI meetings and was unsure of what the facility had discussed at the QAPI meetings. The overall QAPI training was provided on EduCare an on-line course titled QAPI, Compliance and Ethics. There was no evidence to support the training was facility specific on what the QAPI committee had identified as areas for improvement, what action plans were in place or what was being monitored. Interview on 5/29/24 at 3:59 p.m., with director of nursing (DON) stated that staff were newly introduced to the implementation of QAPI meetings and training. She stated the employees were assigned online QAPI training at hire and were given the online training during their orientation. She stated the employees were not educated thoroughly on the requirements of the QAPI program and had not communicated	F 944		

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F 944	Continued From page 36 appropriately for staff to understand the reasons for QAPI. She stated the staff needed to be trained on how to communicate their concerns and her expectation would be for staff to attend future QAPI meetings, so staff would understand the QAPI program and goals that would improve residents quality of care.	F 944		

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	245467	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/30/2024**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/30/2024. At the time of this survey, Hendricks Community Nursong Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION	K 000		

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

Electronically Signed | 06/28/2024

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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K 000	Continued From page 1 IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. 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	K 000		

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K 000	Continued From page 2 protected, and was determined to be of Type II(111) construction; The second addition was constructed in 1993, is one-story, has no basement, is fully fire sprinkler protected, and was determined to be of Type II(111) construction. The facility was inspected as one building. The nursing home is separated from a critical access hospital by a two-hour firewall, and the opening protective consisted of a labeled, self-closing, positive latching, 90-minute fire-rated door assembly. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. Resident Rooms are protected with automatic smoke detectors, which are interconnected to the building fire alarm control panel [FACP]. The facility has a capacity of 48 beds and had a census of 44 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or	K 923		7/29/24

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K 923	Continued From page 3 within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to store oxygen cylinders per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.6.5.2 and 11.6.5.3. This deficient finding could have an isolated impact on the residents within the facility.	K 923	1. On 6/27 receptacles were placed in the oxygen room to segregate the full and empty oxygen tanks. Signs were also hung to indicate which are full and which are empty. These measures will be kept in place indefinitely. 2. Maintenance employees will audit the	

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K 923	Continued From page 4 Findings include: On 05/30/2024 at 10AM, it was revealed by observation that the oxygen storage room had both full and empty oxygen cylinders being stored in the same location and was not segregated. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 923	oxygen room to ensure the full and empty oxygen tanks are properly stored. Audits will be done weekly for 2 months, then 2 times per month for 2 months, then monthly for 8 months.	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 7, 2024

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

RE: CCN: 245467
Cycle Start Date: May 30, 2024

Dear Administrator:

On May 30, 2024, the Minnesota Departments of Health and Public Safety, 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.

Your request for a 24-hour RN waiver has been approved based on the submitted documentation.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us