

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245510	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/20/2024
NAME OF PROVIDER OR SUPPLIER Evansville Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 649 State Street Northwest Evansville, MN 56326	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>48583</p> <p>Based on interview and document review, the facility failed to ensure the required Notice of Medicare Non-coverage (NOMNC) form-10123 was provided 48 hours prior to discharge for 2 of 3 residents (R22 and R78), and Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) form-10055 was provided timely to 1 of 3 residents (R17) reviewed for liability notices and resident rights.</p> <p>Findings include:</p> <p>Review of R22's Physical Therapy (PT) discharge summary and Occupational Therapy (OT) discharge summary dated 5/21/24, indicated R22 no longer required PT and OT services. R22's NOMNC indicated R22's last covered day for Medicare Part A was 5/29/24, and the form-10123 was signed 5/28/24.</p> <p>Review of R78's Therapy Discharge Notification dated 9/4/24, indicated R78's last covered day was 9/4/24. R78's NOMNC indicated R78's last covered day for Medicare Part A was 9/3/24, and the form-10123 was signed 9/3/24.</p> <p>Review of R17's Therapy Discharge Notification dated 11/11/24, indicated R17's last covered day was 11/13/24. R17's SNFABN indicated R17 may be responsible to pay for services beginning 11/14/24, however R17 dated the form-10055 11/24/24.</p> <p>During an interview on 11/18/24 on 3:19 p.m., Minimum Data Set (MDS) coordinator confirmed the above findings and indicated she was responsible for completing both forms. MDS coordinator stated once a resident received a discharge notification from PT/OT, she would complete the forms. MDS coordinator indicated she was aware the forms needed to be provided at least 48 hours prior to the residents being discharged. MDS coordinator stated R17 put the wrong date on the form and it was supposed to be signed 11/11/24. MDS coordinator confirmed the signed date was incorrect, I actually just caught that too, I didn't realize it was signed incorrectly. MDS coordinator was not able to locate any documentation in R22 or R78's electronic health record that identified the forms were provided 48 hours prior to discharge.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/19/24 at 11:52 a.m., administrator confirmed the above findings and confirmed the MDS coordinator was responsible for providing the forms to the residents who were being discharged from therapy. The administrator stated his expectation were the forms would be provided at least 48 hours in advance so residents had enough time to complete an appeal if they decided to. The administrator indicated progress notes should be placed in the residents file in addition to confirm proper notice had been provided.</p> <p>Review of facility policy titled Medicare Denial Notice Policy undated, identified the facility would meet the requirements of the centers for Medicare and Medicaid services (CMS) for residents to be notified.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48583</p> <p>Based on observation, interview and document review, the facility failed to ensure accurate coding to reflect resident status on the Minimum Data Set (MDS) for 1 of 1 residents (R17) reviewed for assessments.</p> <p>Findings include:</p> <p>The Centers for Medicare and Medicaid (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.18.11 10/23, identified Section J: Health Conditions was to be completed with the intent to document health conditions, such as falls, that impact a resident's functional status and quality of life. The manual indicated Previous falls, especially recurrent falls and falls with injury, are the most important predictor of future falls and injurious falls. Further, the manual provided several assessment steps including: Review all available sources for any fall since the last assessment . Include medical records generated in any health care setting since last assessment and it is important to ensure the accuracy of the level of injury resulting from a fall.</p> <p>R17's significant change Minimum Data Set (MDS) dated [DATE], identified R17 was moderately cognitively impaired and had diagnoses which included a recent hip fracture, diabetes, and anxiety. Indicated R17 required extensive assistance with activities of daily living (ADLs).</p> <p>R17's MDS Section J: Health Conditions dated 10/14/24, indicated the following:</p> <ul style="list-style-type: none"> -Did the resident have a fall any time in the last month prior to admission/entry or reentry, checked no. -Did the resident have a fall anytime in the last 2-6 months prior to admission/entry or reentry, checked no. -Did the resident have any fracture related to a fall in the 6 months prior to admission/entry or reentry, checked no. -Has the resident had any falls since admission/entry or reentry or the prior assessment (OBRA or Scheduled PPS), whichever is more recent, checked no. -Number of falls since Admission or Prior assessment - No Injury, checked none. -Number of falls since Admission or Prior assessment - Injury (except major), checked none. -Number of falls since Admission or Prior assessment - Major injury, checked none. <p>R17's significant change Care Area Assessment (CAA) for falls dated 10/14/24, was not triggered for falls and was left blank.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R17's care plan dated 8/28/24, indicated R17 had decreased physical mobility with potential for falls related to unsteadiness and pain. R17 had interventions to provide the assistance of one and front wheeled walker for transfers. R17 was to wear proper and non slip footwear.</p> <p>Review of facility incident reports revealed the following:</p> <p>-8/15/24, R17 rang her pendant and was found laying on her left side in front of her recliner. R17 stated she was trying to take herself to the bathroom. R17 further stated she raised her recliner a small amount, tried to grab her walker to stand and slid from the recliner to the floor.</p> <p>-8/30/24, R17 rang her pendant and stated she was on the floor. R17 was sitting barefoot with her back against the wall and her legs extended in front of her. R17's walker was to the left side of her. R17 stated she fell backwards while taking herself to the bathroom.</p> <p>-10/3/24, R17 rang her pendant and was found laying on the floor beside her bed. R17's four wheeled walker was tipped over beside her. R17 stated she was getting her pajamas off when she fell and landed on her left hip. R17 further stated she was unable to move her left leg. R17 was transported to the emergency room for evaluation.</p> <p>Review of R17's provider progress notes revealed the following:</p> <p>-10/3/24, R17 had been seen in the emergency room post fall on 10/3/24. R17's xray report indicated R17 had a left hip fracture and was admitted to the hospital.</p> <p>-10/4/24, R17 continued to be hospitalized and was scheduled for surgery on 10/5/24, to repair R17's left hip fracture.</p> <p>During an interview on 11/19/24 at 6:21 p.m., R17 stated she recently received a left hip fracture when she slipped and fell . R17 indicated she was standing at the head of the bed when she slipped and fell .</p> <p>During an interview on 11/19/24 at 6:28 p.m., family member (FM) stated R17 had fallen at the facility and sustained a left hip fracture. FM indicated R17 was planning to return home when she fell and now R17 would remain at the facility long term.</p> <p>During an interview on 11/20/24 at 3:32 p.m., RN-A reviewed R17's fall assessment dated [DATE], and confirmed in was completed incorrectly by RN-A. RN-A stated the assessments should be completed accurately.</p> <p>During an interview on 11/20/24 at 4:15 p.m., director of nursing (DON) confirmed the above findings and indicated she was not aware the assessment had been completed inaccurately. DON stated her expectation was assessments were completed correctly as required.</p> <p>Requested facility policy on completing assessments however, DON confirmed the facility did not have a policy on completing assessments.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49620</p> <p>Based on observation, interview, and document review, the facility failed to ensure a comprehensive, person-centered care plan was developed for 2 of 2 residents (R21, R17) reviewed for care planning.</p> <p>Findings include:</p> <p>R21</p> <p>R21's admission Minimum Data Set (MDS) dated [DATE], identified R21 had intact cognition with diagnoses which consisted of atrial fibrillation, osteoarthritis, coronary artery disease. Identified R21 required limited assistance with bed mobility, transfers, and toilet use.</p> <p>R21's admission Care Area Assessment (CAA) dated 10/28/24, identified R21 required limited assistance with transfers, toilet use and dressing.</p> <p>R21's electronic health record (EHR) lacked a comprehensive care plan.</p> <p>R21's admission record, undated, identified R21 admitted to the facility on [DATE].</p> <p>During an interview on 11/20/24 at 9:34 a.m., nursing assistant (NA)-A stated R21 required assistance with dressing and setup help with personal hygiene. NA-A stated she would ask a nurse if the care sheet did not provide direction on resident cares.</p> <p>During an interview on 11/20/24 at 2:14 p.m., licensed practical nurse (LPN)-A stated a registered nurse (RN) could update a care plan. LPN-A stated a resident's care plan would be circulated with the staff near care conference time to review and provide changes.</p> <p>48583</p> <p>R17</p> <p>R17's significant change MDS dated [DATE], identified R17 was moderately cognitively impaired and had diagnoses which included a recent hip fracture, diabetes, and anxiety. Indicated R17 required extensive assistance with activities of daily living (ADLs).</p> <p>R17's significant change CAA dated 10/14/24, indicated R17 had a hip fracture, cognitive impairment, and anxiety. Identified R17 had pain, a recent surgical procedure, and poor nutrition.</p> <p>R17's care plan dated 10/29/24, lacked updated recommendations from occupational therapy and dietary.</p> <p>Review of R17's progress notes from 9/17/24 to 11/20/24, revealed the following:</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-10/7/2024, occupational therapy (OT) recommended R17 to have no bending at the hips past 90 degrees, no crossing legs, no twisting, and no lifting.</p> <p>-10/18/24, dietary manager indicated R17 would be offered high calorie snacks R17 preferred. R17 was to receive ice cream at every meal and toppings could be added if R17 requested them. Additionally, R17 was to receive a 120 cubic centimeters (cc) mighty shake.</p> <p>-9/17/2024, dietary manager indicated staff were to promote fluids with calories at all meals and increase supplement of choice to 120cc's two times a day.</p> <p>During an observation on 1/19/24 at 6:21 p.m., R17 was laying back in her recliner with her legs crossed.</p> <p>During an observation on 11/20/24 at 12:04 p.m., R17 was sitting in her recliner in her room eating lunch. R17 did not have ice cream as ordered on her lunch tray.</p> <p>During an interview on 11/20/24 at 12:27 p.m., registered dietician (RD) confirmed the above findings and indicated R17 was to have a high calorie shake, high calorie foods and high calorie snacks. RD indicated R17's high calorie shake was increased to two times a day (BID). RD stated R17 was to have ice cream with every meal and she was not made aware R17 was not receiving ice cream every meal.</p> <p>During an interview on 11/20/24 at 1:44 p.m., dietary manager (DM) indicated R17 was to have high calorie shakes and ice cream with every meal.</p> <p>During an interview on 11/20/24 at 3:06 p.m., Minimum Data Set Coordinator (MDSC) confirmed the above findings and indicated R17's care plan did not include the recommendations from OT or RD. MDSC stated it was important care plans contained the most up to date recommendations to facilitate person-center care. MDSC indicated it was important that care plans reflected the needs of the residents.</p> <p>During a follow-up interview on 11/20/24 at 3:14 p.m., MDSC verified after review of the EHR that R21 did not have a care plan. MDSC stated R21 was not on her list for a care plan review and that she did not have an audit system to ensure resident care plans were completed as required.</p> <p>During an interview on 11/20/24 at 4:15 p.m., director of nursing (DON) confirmed the above findings and stated her expectations were care plans were completed as required and contained the most up to date recommendations for residents.</p> <p>A facility policy on care plans was requested and one was not provided.</p>		