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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: D90Q

Facility ID: 00149

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245223**

2. STATE VENDOR OR MEDICAID NO. (L2) **955270700**

3. NAME AND ADDRESS OF FACILITY
(L3) **RED WING HEALTH CENTER**
(L4) **1412 WEST FOURTH STREET**
(L5) **RED WING, MN** (L6) **55066**

4. TYPE OF ACTION: 7 (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **08/11/2014** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35) **09/30**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **145** (L18)

13.Total Certified Beds **145** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
X 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A, 5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	145			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
The facility's request for a continuing waiver involving tag K067 is recommended.

17. SURVEYOR SIGNATURE Date :
Sue Reuss, Supervisor 08/12/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 08/12/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **11/01/1978** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5223

August 14, 2014

Mr. Anthony Linn, Administrator
Red Wing Health Center
1412 West Fourth Street
Red Wing, Minnesota 55066

Dear Mr. Linn:

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

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

Effective August 5, 2014 the above facility is certified for:

145 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 145 skilled nursing facility beds.

Your request for waiver of K067 has been recommended based on the submitted documentation. You will receive notification from CMS only if they do not concur with our recommendation.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. Please note, it is your responsibility to share the information contained in this letter and the results of this PCR with the President of your facility's Governing Body.

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

Please contact me if you have any questions.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124
Fax: (651) 215-9697

Protecting, Maintaining and Improving the Health of Minnesotans

August 12, 2014

Mr. Anthony Linn, Administrator
Red Wing Health Center
1412 West Fourth Street
Red Wing, Minnesota 55066

RE: Project Number S5223023 and Complaint Number H5223074

Dear Mr. Linn:

On July 14, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 27, 2014 that included an investigation of complaint number H5223074 that was not substantiated. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On August 11, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on August 6, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 27, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 5, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 27, 2014, effective August 5, 2014 and therefore remedies outlined in our letter to you dated July 14, 2014, will not be imposed.

Your request for a continuing waiver involving the deficiency cited under K067 at the time of the June 27, 2014 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit. Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245223	A. Building B. Wing	8/11/2014

Name of Facility	Street Address, City, State, Zip Code
RED WING HEALTH CENTER	1412 WEST FOURTH STREET RED WING, MN 55066

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0157** Reg. # **483.10(b)(11)** LSC	**08/05/2014**	ID Prefix **F0253** Reg. # **483.15(h)(2)** LSC	**08/05/2014**	ID Prefix **F0334** Reg. # **483.25(n)** LSC	**08/05/2014**
ID Prefix **F0356** Reg. # **483.30(e)** LSC	**08/05/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	**08/05/2014**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	SR/AK	08/12/2014	16022	08/11/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 6/27/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245223	A. Building B. Wing 01 - MAIN BUILDING 01	8/6/2014

Name of Facility	Street Address, City, State, Zip Code
RED WING HEALTH CENTER	1412 WEST FOURTH STREET RED WING, MN 55066

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0029	07/24/2014	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By PS/AK	Date: 08/12/2014	Signature of Surveyor: 25822	Date: 08/06/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 6/24/2014		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: D90Q

Facility ID: 00149

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245223**

2. STATE VENDOR OR MEDICAID NO. (L2) **955270700**

3. NAME AND ADDRESS OF FACILITY
(L3) **RED WING HEALTH CENTER**
(L4) **1412 WEST FOURTH STREET**
(L5) **RED WING, MN** (L6) **55066**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **06/27/2014** (L34)

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital, 02 SNF/NF/Dual, 03 SNF/NF/Distinct, 04 SNF, 05 HHA, 06 PRTF, 07 X-Ray, 08 OPT/SP, 09 ESRD, 10 NF, 11 ICF/IID, 12 RHC, 13 PTIP, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC 2 AOA 3 Other

FISCAL YEAR ENDING DATE: (L35) **09/30**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **145** (L18)

13.Total Certified Beds **145** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
X 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **B, 5*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	145			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

The facility's request for a continuing waiver involving tag K067 is recommended.

17. SURVEYOR SIGNATURE: Mary Capes, HFE NE II Date: 08/04/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL: Anne Kleppe, Enforcement Specialist Date: 08/12/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **11/01/1978** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6356 5217

July 14, 2014

Mr. Anthony Linn, Administrator
Red Wing Health Center
1412 West Fourth Street
Red Wing, Minnesota 55066

RE: Project Number S5223023 and Complaint Number H5223074

Dear Mr. Linn:

On June 27, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the June 27, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5223074.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the June 27, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5223074 that was found to be unsubstantiated.

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

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

> **<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **<u>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;**

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

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3793
Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by August 6, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by August 6, 2014 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

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

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by September 27, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may

still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 27, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

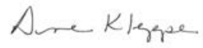
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

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

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124   Fax: (651) 215-9697

Enclosure

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
	245223	A. BUILDING ______ B. WING ______	06/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RED WING HEALTH CENTER	1412 WEST FOURTH STREET RED WING, MN 55066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A recertification survey was conducted and complaint investigation(s) were also completed at the time of the standard survey. An investigation of complaint H5223074 was completed. The complaint was not substantiated.	F 000 7/29/14 SEC	RECEIVED JUL 25 2014 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of	F 157	**F 157** **Immediate corrective action:** Resident (R57) no longer resides in the facility. **Action as it applies to others:** The Policy and Procedure for updating the Physician/ NP for Change of Condition was reviewed and revised on July 22, 2014. All licensed nursing staff will be re-educated on the policy for Physician/NP notification of change in condition by August 5th, 2014	8/5/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE Administrator (X6) DATE 7/24/2014

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING ______ B. WING ______	06/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RED WING HEALTH CENTER	1412 WEST FOURTH STREET RED WING, MN 55066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 1 treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and closed record/document review, the facility failed to ensure the physician/nurse practitioner was promptly notified of a change in condition for 1 of 3 deceased residents (R57). Findings include: Closed record review of R57's hospital discharge summary, indicated R57 had diagnoses including acute respiratory failure, hypotension, and chronic obstructive pulmonary disease (COPD). In addition, "Respiratory distress/pulm [pulmonary] insufficiency were issues throughout the hospitalization with her history of COPD. Patient never had any pulmonary related infection and at time of discharge was off Bipap [noninvasive ventilation system used for COPD patients] and supplemental oxygen. [R57] remained on	F 157	**Date of completion:** August 5th, 2014 **Recurrence will be prevented by:** Daily, during clinical meeting, residents with a noted change in condition will be reviewed by the DON/designee to ensure timely notification to the MD/NP has occurred. Random weekly chart audits will be conducted on each unit to ensure all residents who have had a noted change in condition received timely physician/np notification. Audits will be completed for a period of 90 days and audit results will be reviewed by the QA committee to determine the need for ongoing monitoring. **The correction will be monitored by:** Ongoing compliance will be monitored by the Director of Nursing and/or designee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING ______ B. WING ______	06/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RED WING HEALTH CENTER	**1412 WEST FOURTH STREET RED WING, MN 55066**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 2	F 157		

scheduled nebulizers with addition PRNs [as needed]."
Physician orders directed staff, "Respiratory assessment every shift: (Vital signs, Lung sounds, resp. [respiration] rate, pattern and depth, oxygen, oxygen saturations, suction, sputum, nebs [nebulizer], skin color, mental status, cough. Document amount of time for respiratory assessment and treatments). Code status: Full code. Vital signs every shift for 6 days. Vital Signs every 4 hours for 24 hours. May utilize Standing House Orders. Discharge Potential- Home."
The facility's standing orders, dated 1/14, reads, "May use oxygen at 2-3 L [liters] per cannula to maintain oxygen sats [saturations] at 90%, if unable to keep sats at 90% or greater on 3L of oxygen, call MD."

According to the treatment administration record (TAR), R57's vital signs were as follows:
5/6/14 at 12:00 p.m. Temperature (T): 97 degrees Farenheit (F), Blood pressure (BP): 125/75, Pulse (P): 126, Respirations (R): 14, Oxygen saturation (O2): 90%.
5/6/14 at 4:00 p.m. T: 97 degrees F, BP: 129/84, P: 98, R: 24, O2: 90%.
5/6/14 at 8:00 p.m. T: 95.9 degrees F, BP: 123/78, P: 80, R: 35, O2: 90%.
5/7/14 at 12:00 a.m. T: 98.4 degrees F, BP: 91/54, P: 85, R: 28, O2: 95%.
Nurse progress notes read as follows:
1). 5/6/2014 at 11:45 p.m., revealed, "Res is very lethargic, Sats at 87-90 at 2 L (liters) on O2 cannula. Wheeled to dining room for meals but took only a few bites and sips of milk...TF [tube feeding] of Isosource HN at 75 ml [milliliter] started at 1800 to run for 14 hrs [hours]. Will continue to monitor. IV meds [intravenous

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING ______ B. WING ______	06/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RED WING HEALTH CENTER	1412 WEST FOURTH STREET RED WING, MN 55066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 3	F 157		

medications] and Vancomycin flushes to stoma (surgically created opening on the abdomen) not available."
2). 5/7/2014, at 12:44 a.m. reads, electronic medication administration record (eMAR) "Medication Administration ... labored breathing, wheezing"
3). 5/7/2014, at 1:52 a.m. stated, "eMAR-Medication Administration ... PRN Administration [of nebulizer treatment] was: Ineffective"
There was no further documentation to indicate that the MD had been notified of the resident's labored breathing, wheezing, ineffective nebulizer treatment and vital signs.
The next entry documentation on the nurse progress notes, dated on 5/7/14 at 5:32 a.m., indicated the resident expired at 4:30 a.m.

During an interview with registered nurse (RN)-B on 6/26/14, at 1:15 p.m. RN-B explained, R57 was admitted on 5/6/14 from the hospital with primary diagnoses of acute respiratory failure. R57 had been at the local hospital in town and was transferred to Regions hospital on 3/27/14, and was there for a while. RN-B further indicated that according to R57's discharge summary, it noted the resident was frail but stable with labored breathing. Resident had palliative counsel (for comfort care) while at the hospital, and upon time of discharge from the hospital, R57 had air movement from the bases of the lungs. RN-B said that upon admission R57's status appeared to be stable, was alert but had multiple co-morbidities and had been in the hospital since March 2014. "[R57] was very de-conditioned".
During an interview with director of nursing (DON) on 2/27/14, at 10:20 a.m., DON stated, "My expectation with respiration issues may be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING ______ B. WING ______	06/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RED WING HEALTH CENTER	1412 WEST FOURTH STREET RED WING, MN 55066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 4 another intervention and/or call NP [nurse practitioner]". Policy and Procedure: tiled Resident change in condition, dated 2/14, indicated, "PLAN: upon observation, data collection the nurse/Nurse manager/Designee will act upon the following changes by adding resident to 24 hour report and continue to monitor with interventions and notifying the MD/NP of any resident changes in condition. Family/Responsible party will also be notified of changes in a resident's condition. A progress note will be made in the medical record when the MD/NP and Family/Responsible party were notified."	F 157		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, document review, and interview, the facility did not maintain an odor-free environment for 1 of 2 residents (R43) reviewed for urinary incontinence. Findings include: During observations on 6/24/14, at 10:29 a.m., the room of R43 had a strong urine odor. That odor continued on 6/26/14 when the room was observed several times throughout the day. The door to the room of R43 was generally closed during observations. On 6/26/14, at 12:20 p.m.,	F 253	**F 253** **Immediate corrective action:** The rocking chair in R43's room was removed. R43's room was cleaned and is now free from odors. **Action as it applies to others:** R43's room is now on a daily deep cleaning schedule. The Policy and Procedure for 5-Step Daily Patient Cleaning and 7-Step Washroom Cleaning was reviewed on July 22, 014 and remains current.	8/5/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING ______ B. WING ______	06/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RED WING HEALTH CENTER	1412 WEST FOURTH STREET RED WING, MN 55066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 5 the cushion under the pad on the rocking chair in R43's room had a mild to moderate odor of urine and some dried, yellowish-brown stains. R43 had been assessed for urinary incontinence and nursing staff was observed following the plan of care for incontinence on 6/26/14. During interview on 6/26/14, at 12:20 p.m., housekeeper (H)-A stated that she believed the urine odor in R43's room may be coming from urine soaking into a rocking chair cushion in the room. When interviewed on 6/26/14, at 1 p.m. nursing assistant (NA)-A stated that R43 is frequently incontinent of urine and does not wear incontinence products. R43 has urinated directly onto the floor in room in the past and will also take off urine soaked clothing and put it back into the closet and drawers. NA-A stated that she had removed two pair of urine soaked slacks from R43's closet that morning. When interviewed on 6/26/14, at 12:40 p.m., the director of housekeeping stated that he believed the source of urine odor in R43's room is the rocking chair. He stated that the bed mattress has a plastic cover and R43's bedding is cleaned frequently. He explained that nursing generally lets him know when the rocking chair needs deep cleaning and the cushion is removed and laundered--usually around every six weeks. He stated that housekeeping staff also sprays the wood on the rocking chair with a urine cleanser.	F 253	Housekeeping staff will be re-educated on the policy for 5-Step Daily Patient Cleaning and 7-Step Washroom Cleaning by August 5th, 2014. **Date of completion:** August 5th, 2014. **Recurrence will be prevented by:** Random weekly audits will be completed on each unit to ensure the facility maintains a clean homelike environment. Audits will be completed for a period of 90 days and audit results will be reviewed by the QA committee to determine the need for ongoing monitoring. **The correction will be monitored by:** Ongoing compliance will be monitored by the Director of Nursing, Director of Environmental Services and/or designee	
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS	F 334	**<u>F 334</u>** **Immediate corrective action:** Residents (R110, R116, R129) received pneumovax vaccines on **7/24/2014.**	8/5/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING ______ B. WING ______	06/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RED WING HEALTH CENTER	1412 WEST FOURTH STREET RED WING, MN 55066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 334	Continued From page 6 The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;	F 334	**Action as it applies to others:** All resident charts will be reviewed to ensure pneumovax vaccines have been offered. Residents requiring vaccination will receive them by August 5th, 2014. The Policy and Procedure for Pneumovax vaccination was reviewed and revised on July 22, 2014. All licensed nursing staff will be re-educated On the policy for Pneumovax vaccines by August 5, 2014.. **Date of completion:** August 5th, 2014. **Recurrence will be prevented by:** Random weekly chart audits will be conducted on each unit to ensure residents remain current with pneumovax vaccination. Audits will be completed for a period of 90 days and audit results will be reviewed by the QA committee to determine the need for ongoing monitoring. **The correction will be monitored by:** Ongoing compliance will be monitored by the Director of Nursing and/or designee,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING ______ B. WING ______	06/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RED WING HEALTH CENTER	**1412 WEST FOURTH STREET RED WING, MN 55066**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 334	Continued From page 7 (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility did not provide documentation of pneumococcal immunization for 3 of 5 residents (R110, R116, R129) reviewed for immunizations. Findings include: Record review on 6/25/14 revealed no documentation of pneumococcal vaccination in the records of R110, R116, and R129. The Admission Record and Diagnosis Report for	F 334		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING ______ B. WING ______	06/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RED WING HEALTH CENTER	1412 WEST FOURTH STREET RED WING, MN 55066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 334	Continued From page 8	F 334		

R110 showed that this resident was 50 years old and had diagnoses of alcohol dependence and drunkenness.

The Admission Record and Diagnosis Report for R116 showed that this resident was 66 years old and had a diagnosis of diabetes.

The Admission Record and Diagnosis Report for R129 showed that this resident was 50 years old and had diagnoses of pulmonary insufficiency, history of pneumonia, and pulmonary embolism.

The facility's Pneumococcal Vaccination-Person Served policy read "A. All Person Served will be offered and encouraged to receive the pneumococcal vaccine (PPSV) if they need vaccination based on the following criteria: a. Age 65 or older with no or unknown history of prior receipt of PPSV. b. Age 64 years or younger with no or unknown history of prior receipt of PPSV and of the following conditions: ...iii. Chronic pulmonary disease...iv. Diabetes Mellitus v. Alcoholism ..."

When interviewed on 6/26/14, at 9:45 a.m. registered nurse (RN)-C was asked if she thought that these residents should have been offered pneumococcal vaccination and she stated that the physician should have been contacted for orders to give these residents pneumococcal vaccinations because they are in the high risk group.

During interview on 6/26/14, at 12:20 p.m. RN-D confirmed that she could not locate documentation of pneumococcal vaccination in the records of R110, R116, and R129.

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

PRINTED: 07/14/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING ______ B. WING ______	06/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RED WING HEALTH CENTER	1412 WEST FOURTH STREET RED WING, MN 55066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 356	Continued From page 9	F 356	**F 356**	8/5/14
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the required daily, nurse staffing information posting included	F 356	**Immediate corrective action:** The template for posting staffing hours was updated to include the actual hours worked by each discipline on June 30, 2014. **Action as it applies to others:** The policy and procedure for Posting Daily Nursing Hours was reviewed and revised on July 22, 2014. The facility scheduler (SCH) was updated on the policy for posting staffing hours July 22, 2014. **Date of completion:** August 5th, 2014. **Recurrence will be prevented by:** Random weekly audits will be conducted to ensure nursing hours are posted in accordance with facility policy. Audits will be completed for a period of 90 days and audit results will be reviewed by the QA committee to determine the need for ongoing monitoring.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING ______ B. WING ______	06/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RED WING HEALTH CENTER	1412 WEST FOURTH STREET RED WING, MN 55066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 356	Continued From page 10 the actual hours worked by each category of nursing staff. This had the potential to affect all 111 residents residing in the facility, family members and any visitors who may have chosen to view this information. Findings include: During the initial tour of the facility on 6/23/14 at 12:48 p.m., an observation was made of posted nursing staff hours for the facility. The posting included the facility name, current date, current census, start time of the day shift, start time of the evening shift, start time of the night shift, and the hours and FTE worked on the day, evening, and night shifts for registered nurses (RN), licensed practical nurses (LPN), and assistants/Techs (NA). The posting did not list the actual hours worked by each discipline. Additional observations on 6/25/14 at 11:00 a.m.,and 6/26/14 at 9:00 a.m., were the same posting format as used to display the nurse staffing hours. During interview on 6/26/14 at 9:40 a.m., the facility scheduler (SCH) verified the posting lacked information regarding the actual shift hours worked. SCH further stated the facility had used a template to print up the information. The SCH indicated he/she posts the form when he/she comes to work in the morning, and it is not changed throughout the day A Staff Posting policy was requested, but not produced.	F 356	**The correction will be monitored by:** Ongoing compliance will be monitored by the Director of Nursing and/or designee	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING ______ B. WING ______	06/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RED WING HEALTH CENTER	1412 WEST FOURTH STREET RED WING, MN 55066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 11 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by:	F 441	F 441 **Immediate corrective action:** (RN) A– was re-educated on the policies and procedures for performing a Dressing, Clean and Cleaning and Disinfection on Jul 22, 2014. **Action as it applies to others:** The Policy and Procedure for Dressings, Clean was reviewed and revised on July 22, 2014. The Policy and Procedure for Cleaning and Disinfection was reviewed on July 22, 2014 and remains current. All licensed nursing staff will be re-educated on the policies Dressing Clean and Cleaning and Disinfection by August 5th, 2014. **Date of completion:** August 5th, 2014. **Recurrence will be prevented by:** Random weekly audits will be conducted on each unit to ensure staff performs clean dressing changes and cleaning of reusable equipment according to facility policy.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING ______ B. WING ______	06/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RED WING HEALTH CENTER	1412 WEST FOURTH STREET RED WING, MN 55066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 12 Based on observation, interview, and document review, the facility failed to ensure appropriate handwashing and cleaning of reusable equipment during a dressing change by nursing staff for 1 of 2 residents (R44) observed during a dressing change. Findings include: R44's quarterly Minimum Data Set (MDS) dated 3/16/14, indicated R44 was admitted on 9/26/13, for malnutrition and required a jejunostomy tube (J-tube). On 6/26/14, at 7:45 a.m. registered nurse (RN)-A did not wash hands before changing the J-tube dressing for R44 and did not cleanse scissors removed from pocket used for cutting of gauze to place around J-tube site before/after use. Observations were conducted on 6/26/14, of a J-tube dressing change for R44 by RN-A. Although RN-A had washed hands after administering R44's medications via J-tube, no hand washing occurred after RN-A left the unit to get sterile water for cleansing around the J-tube site before applying a clean dressing. At 7:45 a.m. RN-A returned to R44's bedside and applied gloves before changing the dressing around J-tube site. No hand washing was observed before the gloves were applied. RN-A asked R44 to roll over onto the back, took a clean gauze with sterile water and wiped around J-tube ostomy site. The area around the J-tube ostomy site was inflamed/reddened approximately two to three inches around. RN-A stated R44 would scratch self and there was some leaking around J-tube site, "sometimes it looks good and sometimes it looks bad." RN-A removed gloves and went to medication cart outside of R44's room to get	F 441	Audits will be completed for a period of 90 days and audit results will be reviewed by the QA committee to determine the need for ongoing monitoring. **The correction will be monitored by:** Ongoing compliance will be monitored by the Director of Nursing and/or designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING ______ B. WING ______	06/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RED WING HEALTH CENTER	1412 WEST FOURTH STREET RED WING, MN 55066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 13 Nystop powder (a topical powder used to treat skin infections caused by yeast) to sprinkle around J-tube site. At 7:55 a.m. RN-A gloved (no hand washing occurred), and folded a clean gauze in half taking scissors from his/her pocket to cut halfway through gauze and placed the scissors back into his/her pocket (no cleansing of scissor before/after use). RN-A sprinkled the Nystop powder around the J-tube ostomy site and applied the cut gauze around the J-tube ostomy site and taped in place. RN-A picked up the wrappers from the gauze packages and placed in trash can, removed gloves, and then washed hands. At 8:05 a.m. after the dressing change RN-A verified did not wash hands before applying gloves when returned to resident's room after leaving the unit "I was nervous" and after returning from the medication cart with the Nystop powder. RN-A also verified had not cleansed the scissors used to cut the gauze for placement around R44's J-tube ostomy site. Policy/procedure for Dressings/Dry/Clean dated 12/11, indicated, "Wash and dry your hands thoroughly. Put on clean gloves. Loosen tape and remove soiled dressing. Pull glove over dressing and discard into plastic or biohazard bag. Wash and dry your hands thoroughly. Open dry, clean dressing (s) by pulling corners of the exterior wrapping outward, touching only the exterior surface. Using clean technique, open the other products (ie. prescribed dressing; dry, clean gauze). Pour prescribed cleansing solution over the dry, clean gauze into clean basin section of tray. Put on clean gloves. Assess the wound and surrounding skin for edema, redness, drainage, tissue healing progress and wound stage. Cleanse the wound. " " If using gauze, use a clean gauze for each cleansing stroke. Clean	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING ______ B. WING ______	06/27/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RED WING HEALTH CENTER	1412 WEST FOURTH STREET RED WING, MN 55066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 14 from least contaminated area to the most contaminated area (usually, from the center outward). Use dry gauze to pat the wound dry. Apply the ordered dressing and secure with tape. Discard disposable items into the designated container. Remove disposable gloves and discard into designated container. Wash and dry your hands thoroughly." On 6/26/14, at approximately 11:00 a.m., an interview was conducted with the RN-C related to cleansing of reusable equipment like scissors used during a dressing change. RN-C's expectation was the scissors should be cleansed with alcohol. RN-C did not recall specifically training nursing staff on cleansing of scissors.	F 441		

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

F5223022

PRINTED: 07/14/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING 01 - MAIN BUILDING 01 B. WING	06/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RED WING HEALTH CENTER	1412 WEST FOURTH STREET RED WING, MN 55066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Red Wing Health Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K 000	POC ok w/AW for K67 8-4-14 RECEIVED AUG - 4 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

Exit: 6-27-14 Dc: 8-6-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 7/24/2014

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING 01 - MAIN BUILDING 01 B. WING	06/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RED WING HEALTH CENTER	1412 WEST FOURTH STREET RED WING, MN 55066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Red Wing Health Center is a 3-story building with a partial basement. The building was constructed at 2 different times. The original building was constructed in 1965 and was determined to be of Type II(222) construction. In 1972, addition was constructed to the West Wing that was determined to be of Type II(222) construction. Because the original building and the 1 addition are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 145 beds and had a census of 113 at the time of the survey.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING 01 - MAIN BUILDING 01 B. WING	06/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RED WING HEALTH CENTER	1412 WEST FOURTH STREET RED WING, MN 55066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke-resisting partitions and doors in accordance with the following requirements of 2000 NFPA 101, Section 19.3.2.1. The deficient practice could affect 30 out of 113 residents. Findings include: On facility tour between 8:30 AM and 11:30 AM on 06/24/2014, observation revealed that the following the following was found: 1. Room # 1-064, 2-064 and 3-064 are storage rooms over 50 sq. ft. and has open penetrations	K 029	**K 029:** Open penetrations in storage rooms 1-064, 2-064 and 3-064 were sealed with intumescent caulk on 6-24-14. Members of the maintenance department inspected the building to verify all penetrations were properly sealed by 7-24-2014. To prevent a reoccurrence the Plant ~~Operations Director~~ will inspect maintenance and outside vendors work after it is completed making sure penetrations are properly sealed. Door closures for storage room doors 1-072, 1-057 and 1-053 were adjusted on 6-24-14 to shut and latch. Doors will be monitored by the Plant Operations Director monthly to assure they shut and latch.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING 01 - MAIN BUILDING 01 B. WING	06/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RED WING HEALTH CENTER	1412 WEST FOURTH STREET RED WING, MN 55066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 3 on south walls around cables 2. Room # 1-072, 1-057 and 1-003 are storage rooms over 50 sq. ft. and do not shut and latch These deficient practices were confirmed by the Plant Operations Director (MF) at the time of discovery.	K 029		
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observations and staff interviews, it was verified that the facility's general ventilating and air conditioning system (HVAC) is not installed in accordance with the LSC, Section 19.5.2.1 and NFPA 90A, Section 2-3.11 and 3-4.7. A noncompliant HVAC system could affect all 113 residents. Findings include: On facility tour between 8:30 AM and 11:30 AM on 06/24/2014, observations revealed that the following was found: 1. Ventilation system on the 1st, 2nd, and 3rd floors in the 1965 addition utilizes the egress corridor as the return air for the resident rooms.	K 067	**K067:** Fire smoke damper testing was completed on 7-15-2014. The Plant Operations Director will be responsible for ensuring smoke damper testing is completed every 4 years. To assure compliance, scheduling of the next test will be made at the time of the current test. A Life Safety Code Waiver is being applied for from CMS for the following reasons: 1) There will be no adverse effect on the health and safety of the facility's residents and staff since: a. The building is protected throughout by an addressable supervised automatic fire alarm system installed in accordance with NFPC 72 in corridors, hazardous areas, and spaces open to the corridor.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	06/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RED WING HEALTH CENTER	**1412 WEST FOURTH STREET** **RED WING, MN 55066**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 067	Continued From page 4 There was no balancing report available. 2. Last documented 4 year fire/smoke damper testing was completed on 4/9/2010 These deficient practices were confirmed by the Plant Operations Director (MF) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 067	b. The building has automatic shutdown of all ventilation fans upon detection of smoke or activation of the building fire alarm system. c. Annual service and maintenance contracts exist to service all the facility's fire protection systems (e.g. fire alarm system, sprinkler system, and portable extinguishers.) as applicable. d. The building fire alarm system is monitored to provide automatic fire department notification. e. Fire safety training is provided on an annual basis for all employees and during orientation for all new hires. f. Fire drills are conducted quarterly on each shift. g. The building is protected by a sprinkler system. 2) Compliance with this provision will impose an unreasonable hardship to the facility since:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	06/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RED WING HEALTH CENTER	1412 WEST FOURTH STREET RED WING, MN 55066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 067			a. The $470,000 cost to implement such a system is prohibitive as evidenced by the losses of $2,081,801 shown on our most recent cost report which is from 2013 and is included for your reference. b. WHV estimates that the work will disrupt the normal use of patient areas for 6 months. c. There is about two years left on the facility's lease which means we would not be able to recover any meaningful portion of the cost. d. Since the building is leased there is no collateral to pledge for the needed financing. e. The lease on the building runs out in about two years making the remaining useful life of the building after the 6 month project bout 1.5 years.	

Sheehan, Pat (DPS)

From: Sheehan, Pat (DPS)
Sent: Monday, August 04, 2014 11:48 AM
To: 'rochi_lsc@cms.hhs.gov'
Cc: gary.schroeder@state.mn.us; 'tony.linn@welcov.com'; Dietrich, Shellae (MDH); 'Fiske-Downing, Kamala'; Henderson, Mary (MDH); 'Johnston, Kate'; Kleppe, Anne (MDH); Leach, Colleen (MDH); Meath, Mark (MDH); Zwart, Benjamin (MDH)
Subject: Red Wing Health Center (242230) 2014 Annual K67 Waiver Request - Previously Approved - No Changes

This is to inform you that Red Wing HC is again requesting an annual waiver for K67, corridors as a plenum. The exit date was 6-27-14.

I am recommending that CMS approve this waiver request.

Patrick Sheehan, Fire Safety Supervisor
Office: 651-201-7205 Cell: 651-470-4416
Health Care & Corrections Fire Inspections
Minnesota State Fire Marshal Division Est. 1905
445 Minnesota St., Suite 145, St Paul, MN 55101-5145
FAX: 651-215-0525
Web: fire.state.mn.us

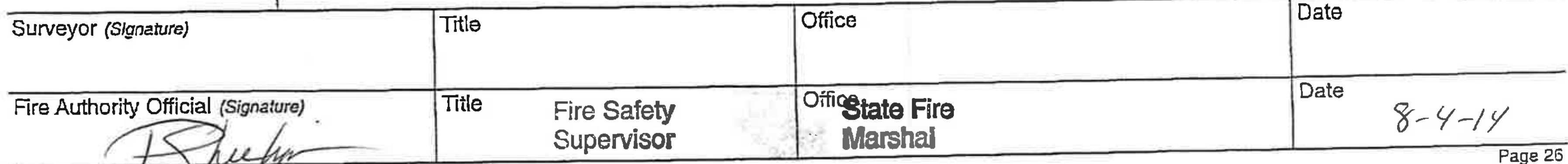
Name of Facility: Red Wing Health Center

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K84 K067	An annual waiver is requested for the following reasons: 1) There will be no adverse effect on the health and safety of the facility's residents and staff since: a. The building is protected throughout by an addressable supervised automatic fire alarm system installed in accordance with NFPC 72 in corridors, hazardous areas, and spaces open to the corridor. b. The building has automatic shutdown of all ventilation fans upon detection of smoke or activation of the building fire alarm system. c. Annual service and maintenance contracts exist to service all the facility's fire protection systems (e.g. fire alarm system, sprinkler system, and portable extinguishers.) as applicable. d. The building fire alarm system is monitored to provide automatic fire department notification. e. Fire safety training is provided on an annual basis for all employees and during orientation for all new hires. f. Fire drills are conducted quarterly on each shift. g. The building is protected by a sprinkler system. **Continued on the next page…**

Surveyor (Signature)	Title	Office	Date
Fire Authority Official (Signature)	Title: Fire Safety Supervisor	Office: State Fire Marshal	Date: 8-4-14



Name of Facility	Red Wing Health Center	2000 CODE

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K84 K067	2) Compliance with this provision will impose an unreasonable hardship to the facility since: a. The $470,000 cost to implement such a system is prohibitive as evidenced by the losses of $2,081,801 shown on our most recent cost report which is from 2013 and is included for your reference. b. WHV estimates that the work will disrupt the normal use of patient areas for 6 months. c. There is about two years left on the facility's lease which means we would not be able to recover any meaningful portion of the cost. d. Since the building is leased there is no collateral to pledge for the needed financing. e. The lease on the building runs out in about two years making the remaining useful life of the building after the 6 month project bout 1.5 years.

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title Fire Safety Supervisor	Office State Fire Marshal	Date

Des Moines Office
2400 86th St., Suite 10
Des Moines, IA 50322
Phone 515·270·4811
Fax 515·331·8037
www.whvr.com

La Crosse Office
1202 Caledonia Street
La Crosse, WI 54603
Phone 608·782·6550
Fax 608·782·1219
www.whvr.com

Winona Office
374 East Second St.
P.O. Box 77
Winona, MN 55987
Phone 507·452·2064
Fax 507·452·6320
www.whvr.com

Rochester Office
1712 Third Ave. SE
Rochester, MN 55904
Phone 507·280·4201
Fax 507·281·7694
www.whvr.com

ESTABLISHED IN 1902

Building Automation • Service/Controls • Testing & Balancing

July 11, 2014

Red Wing Health Care Center
1412 West 4th Str.
Red Wing, Mn 55066

Attn: Mark Haas

Subject: Return Air

You had inquired about the possibility of installing return air duct to each room per the current code.

To extend the return air duct to each room would be extremely costly, if it can even be done. This is due to the many issues that would be encountered such as the following:
-Quantity of rooms
-Constraints above the ceiling as there will be little to no room for duct. Note, need to stay with the head room compliance in the corridors
-Penetration of smoke and load bearing walls
-Unknowns such as structural, insulation, disturbance

The approximate cost to do the return air project would be $470,000.00. However, this is based on being able to do the work, of which is not even established as possible do to the above.

I trust this information is satisfactory. If you have any questions, please feel free to contact me at anytime.

Sincerely,

Joe Ruff

Michael Gostomski, President
An Equal Opportunity Employer

Client: *053-01483500 - Red Wing Health Center*
Engagement: *MD 2013 - Red Wing Health Care, LLC*
Period Ending: *9/30/2013*
Trial Balance: *T-01 - TB*
Workpaper: *T-02 - Medicaid TB Grouping Report*

Account	Description	1st PP-FINAL 9/30/2012	FINAL 9/30/2013
Total [9024] Worker's Compensation Insurance		**144,226.00**	**227,903.00**
Group : [9026]	**Pension or Profit Sharing**		
Subgroup : None			
675316	401K	22,650.00	0.00
675318	DEFERRED COMPENSATION	1,771.00	0.00
891370	BENEFITS-401K	0.00	19,212.00
891380	BENEFITS-Deferred Comp	0.00	7,231.00
Subtotal : None		**24,421.00**	**26,443.00**
Total [9026] Pension or Profit Sharing		**24,421.00**	**26,443.00**
Group : [9080]	**Other Employee Benefits**		
Subgroup : None			
675301	EMP PHYS/DRUG TEST/BACKGROUND	2,211.00	0.00
675302	FRINGE - ALLOWED	3,997.00	0.00
675310	FLEXIBLE BENEFITS	1,653.00	0.00
675314	UNIFORM ALLOWANCE	6,719.00	0.00
891390	BENEFITS-Flex	0.00	373.00
891420	BENEFITS-Uniform Allowance	0.00	8,003.00
Subtotal : None		**14,580.00**	**8,376.00**
Total [9080] Other Employee Benefits		**14,580.00**	**8,376.00**
	Operating Expenses	**9,764,044.00**	**12,383,875.00**
	TOTAL EXPENSE	**9,764,044.00**	**12,383,875.00**
	NET (INCOME) LOSS	**288,816.00**	**2,081,801.00**
	Sum of Account Groups	**0.00**	**(1.00)**