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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: G3Q6

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — 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 **07/09/2015** (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):
Facility's request for a continuing waiver involving K67 is recommended.

17. SURVEYOR SIGNATURE — Date :
Susanne Reuss, Unit Supervisor — 07/09/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 08/05/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
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: **00** (L30)

VOLUNTARY
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
07/06/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245223
August 5, 2015

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 July 29, 2015 the above facility is certified for or recommended 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.

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

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

August 5, 2015

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

RE: Project Number S5223024 & H5223078

Dear Mr. Linn:

On June 10, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 21, 2015 that included an investigation of complaint number H5223078 which was 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 July 9, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction, on July 6, 2015 the Minnesota Department of Public Safety completed a PCR, and on July 29, 2015 an investigator from the Minnesota Department of Health, Office of Health Facility Complaints 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 May 21, 2015 and the investigation completed June 1, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 29, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 21, 2015, and corrected the licensing orders found during the investigation completed on June 1, 2015, effective July 29, 2015 and therefore remedies outlined in our letter to you dated June 10, 2015, will not be imposed.

Your request for a continuing waiver involving the deficiency cited under K067 at the time of the May 21, 2015 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 are a copies of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245223	A. Building B. Wing	7/9/2015

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	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0165** Reg. # **483.10(f)(1)** LSC	Correction Completed **06/30/2015**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	Correction Completed **06/30/2015**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **06/30/2015**
ID Prefix **F0244** Reg. # **483.15(c)(6)** LSC	Correction Completed **06/30/2015**	ID Prefix **F0248** Reg. # **483.15(f)(1)** LSC	Correction Completed **06/30/2015**	ID Prefix **F0253** Reg. # **483.15(h)(2)** LSC	Correction Completed **06/30/2015**
ID Prefix **F0254** Reg. # **483.15(h)(3)** LSC	Correction Completed **06/30/2015**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **06/30/2015**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **06/30/2015**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **06/30/2015**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **06/30/2015**	ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	Correction Completed **06/30/2015**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **06/30/2015**	ID Prefix **F0328** Reg. # **483.25(k)** LSC	Correction Completed **06/30/2015**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **06/30/2015**

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	SR/KJ	08/05/2015	165022	07/09/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245223	A. Building B. Wing	7/9/2015

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	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0353** Reg. # **483.30(a)** LSC	Correction Completed **06/30/2015**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **06/30/2015**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **06/30/2015**
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **06/30/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **06/30/2015**		

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	SR/KJ	08/05/2015	165022	07/09/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
5/21/2015			

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245223	A. Building B. Wing 01 - MAIN BUILDING 01	7/6/2015

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 K0033	06/30/2015	ID Prefix Reg. # NFPA 101 LSC K0076	06/30/2015	ID Prefix Reg. # NFPA 101 LSC K0144	05/28/2015
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/KJ	Date: 08/05/2015	Signature of Surveyor: 25822	Date: 07/06/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 5/22/2015		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: G3Q6

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — 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 **05/21/2015** (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:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	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):
Facility's request for a continuing waiver involving K67 is recommended.

17. SURVEYOR SIGNATURE Date :
Momodou Fatty, HFE NE II 06/24/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 07/02/2015 (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
AW K67 sent to Rochi 07/06/2015 Co.
Posted 07/06/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 0470 0000 5262 1765

June 15, 2015

****This document redacts and replaces the previous letter dated June 10, 2015****

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

RE: Project Number S5223024

Dear Mr. Linn:

On May 21, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained

at the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-3793
Fax: 651-215-9697

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 June 30, 2015, 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 June 30, 2015 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 August 21, 2015 (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 November 21, 2015 (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
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting 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 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 0470 0000 5262 1758
June 10, 2015

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

RE: Project Number S5223024

Dear Mr. Linn:

On May 21, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

<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
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3793 Fax: (651) 215-9697
Enclosure
cc: Licensing and Certification File

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 May 21, 2015, 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 May 21, 2015 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 August 21, 2015 (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 November 21, 2015 (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
Health Regulation Division

P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting 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

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Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
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Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
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 _____	05/21/2015

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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	RECEIVED JUN 24 2015 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION 6/24/15 SER	
F 165 SS=E	483.10(f)(1) RIGHT TO VOICE GRIEVANCES WITHOUT REPRISAL A resident has a right to voice grievances without discrimination or reprisal. Such grievances include those with respect to treatment which has been furnished as well as that which has not been furnished. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure resident rights to voice grievances without fear of reprisal was honored for 6 of 6 residents (R13, R16, R18, R32, R52, R124) in the sample who expressed grievances. Findings include: R13, R16, R18, R32, R52 and R124 expressed staff retaliation concerns at the resident council meeting without a resolution to the concerns expressed. A review of the resident council minutes for	F 165	**F 165** **Immediate corrective action:** Interviews for residents (R 13, R16, R18, R 32, R52 and R124) were conducted as soon as the facility became aware of the grievances. Grievance forms were completed and submitted to the IDT for review and follow-up. LPN (A), NA (A) and NA (B) staff members received immediate re-education on 5/19/15 once the facility became aware of the residents' concerns.	6/30/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 6/19/2015

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

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F 165	Continued From page 1 2/2/15, under the section marked Nursing, read, "Tell nursing the aides on 2E need to be shadowed. (residents think they should've been fired on day one.)" The section titled Social Service read, "*Right to respect. 2E doesn't feel their needs are being met. 2E Lights aren't being answered, can take 1/2 hour to an hour. Talked back to, resident is trying to be helpful but nurses/aides don't want to hear it." Residents who were present at this meeting were R13, R32 and R124. A review of the March 2015 and April 2015 resident council minutes lacked mention of the resolution to the February 2015 resident council concerns. When interviewed on 5/18/15, at 9:20 a.m., R16 expressed having to wait long periods of time for the staff to help with cares and position changes. R16 referred to, "other people that live here try to watch out for me, but when the staff get mad at me they make me wait longer, I don't want to complain." Furthermore, R16 stated, "some of the regular day staff are sticks in the mud, I don't want them mad at me." R16 stated, "If I complain, the staff will push and pull on me more when they take care of me and that hurts. I already have problems being comfortable in this chair and I am afraid they will make me wait longer for help." R16 validated the facility management was aware of the problem from resident council which R16 validated attending with [R13, R52 and R124] whom she considers people who watch out for her. Review of R16's medical record indicated an annual minimum data set (MDS) completed 3/18/15,which assessed R16 as cognitively intact	F 165	**Corrective action as it applies to others:** The policy and procedure titled "Resident Grievance" was reviewed and remains current. All interviewable residents were interviewed and grievance forms were completed for any voiced grievance and submitted to the IDT for review and follow-up. All staff will be re-educated on the policy by 6/30/2015 **Recurrence will be prevented by:** 2 random weekly resident interviews will be conducted on each unit for 90 days to ensure residents with grievances have had their concerns. Interview findings will be shared with the monthly QA committee for their input and recommendations for continued monitoring. **The correction will be monitored by:** Social Service Director and/or designee	

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F 165	Continued From page 2 and able to make decisions about care. During an interview with R52 on 5/18/15, at 3:15 p.m., a concern was expressed about , "If I complain the staff will get back at me so I don't want to complain. We complained and nothing was done about it." R52 made reference to the resident council meeting in February 2015 when R52 expressed concerns about having to wait long periods of time for assistance, that the wheel chair is very uncomfortable, and she is in constant pain from a knee injury. R52 would like to see better customer service training for the staff but does not want them to, "Get back at me." Review of R52's medical record indicated a quarterly MDS completed 4/30/15, which R52 was assessed as cognitively intact and able to make decisions about care. During an interview on 5/19/15, at 10:32 a.m., R32 validated the concerns addressed at the February 2, 2015 resident council meeting and confirmed the residents continued to be upset about the lack of resolution and that the residents were afraid of retaliation from the staff. R32 stated, "Be sure to talk to [R13] and [R124] because they are seriously concerned about the staff being mean to them." Review of R32's medical record indicated a quarterly MDS completed 2/18/15, which R32 was assessed as cognitively intact and able to make decisions about care. When interviewed on 5/19/15, at 10:37 a.m., R124 talked about licensed practical nurse (LPN)-A and stated, "[LPN-A] is always so mad at me, One day she came into my room	F 165		

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F 165	Continued From page 3	F 165		

screaming at me for reporting her to the director of nursing (DON). They know [LPN-A] is a problem but because she has been here for so long they won't do anything about her retaliation to us." R124 continued to talk about the February resident council meeting when the residents told the staff that nursing assistants (NA)-A and NA-B try to control the residents. "These nursing assistants do not allow choices, you better do it their way or expect to wait a long time if you should need something." Furthermore, R124 explained the residents on this end of the building talk and watch out for each other. R124 recommended that R13, R16, and R52 be interviewed, because they also expressed concerns regarding LPN-A, NA-A] and NA-B.

Review of R124's medical record indicated a quarterly MDS completed 3/18/15, which R124 was assessed as cognitively intact and able to make decisions about care.

During an interview on 5/19/15, at 2:30 p.m., R13 discussed being very concerned about retaliation from LPN-A and referred to a situation a while back where a culture of a wound site was required. R13 said "[LPN-A] came into the room early in the morning, took off the appliances, did the culture and then left me, she did not put it back together again. R13 felt it was "in spite" because he has complained about her." R13 stated, "The residents watch out for each other here." R13 referred to [R124], [R16], [R52] as residents who discussed the concerns on the nursing unit. R13 shared another situation that R13 considered to be, "bullying like in grade school", which occurred one day in April when LPN-A laughed at R13 after an incident that was upsetting. R13 stated, "I felt angry, that I was not

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F 165	Continued From page 4 worth anything. It was like being a kid and being laughed at." R13 feels the NA-A has retaliated against him by not talking to him for a period of time and this is "to get back at me because I complained about her." Review of R13's medical record indicated an annual MDS completed 3/11/15, which R13 was assessed as cognitively intact and able to make decisions about care. During an interview with R18 on 5/19/15, at 2:00 p.m., a concern was expressed that the staff are mean to him because they push him around in a rough way, but he doesn't want to complain for fear of retaliation because "these people have been here a long time and are the usual staff in the unit." R18 stated, "Maybe I have done something wrong to them so they treat me this way." R18 validated he did not report to management because he stated, "I am afraid they will get back at me." Review of R18's medical record indicated an annual MDS completed 4/8/15, which R18 was assessed as cognitively intact and able to make decisions about care. During an interview with the director of social services (DSS), the director of nursing (DON) and registered nurse (RN)-A on 5/19/15, at 10:45 a.m., the minutes of the February Resident Council were reviewed. The DSS, DON and RN-A, validated there was no investigation into the concerns expressed at the February 2015 Resident Council meeting. There were no resident or staff interviews conducted from the resident council meeting or on the 2E unit, that was addressed in the resident council minutes.	F 165		

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F 165	Continued From page 5 According to the DSS, the person who recorded the resident council minutes no longer works at the facility. When interviewed, the DSS, DON and RN-A validated the concerns should have been investigated and the residents should have been reassured and protected from any form of retaliation.	F 165		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225	**F 225** **Immediate corrective action:** An internal investigation was conducted for resident (R58) on 5/20/15 RN-B and RN-C received re-education on abuse reporting. **Corrective action as it applies to others:** The policy and procedure for Abuse Prevention was reviewed on 6/11/15 and remains current. Licensed nursing staff will be re-educated on the policy and procedure for Abuse Prevention by 6/30/2015.	6/30/15

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F 225	Continued From page 6 The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to investigate allegations of potential mistreatment for 1 of 2 residents (R58) who had reported to facility staff possible neglect of care. Findings include: A review of R58's electronic health record (eHR) revealed a Brief Interview for Mental Status (BIMS) had been completed on 4/21/15, revealed R58 scored 14/15, indicating R58 was cognitively intact. The eHR care plan dated 8/12/13, revealed R58 was able to "reliably recognize a dangerous situation", but "cannot remove myself to safety in a dangerous situation, I would need staff to assist me to safety." The most recent quarterly minimum data set (MDS) dated 4/21/15, revealed R58 was always incontinent of urine and required the extensive assistance of one staff for grooming, and toileting. On 5/18/15, at 11:37 a.m., R58 stated during an individual interview, there were times when nursing assistant (NA)-F ignored R58 by not answering the call light, not assisting the resident and not changing R58's incontinent product. R58	F 225	**Recurrence will be prevented by:** All alleged occurrences of suspected abuse or neglect will be thoroughly investigated by the Director of Nursing and /or designee in accordance with facility policy. Prior to the completion of the investigation, the investigative report will be reviewed with the Administrator and/or Social Service Director to ensure the investigation is through and complete including: relevant dates and times, summary of all investigative interviews with all staff involved in the incident, identification of alleged staff member, identification of the resident and interventions implemented to prevent a recurrence of the incident. All investigative summaries of incidents of alleged abuse and will be reviewed by the QA committee monthly for IDT input and recommendations. This will be an ongoing practice. **The correction will be monitored by:** Administrator and/or designee	

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F 225	Continued From page 7	F 225		

stated reporting NA-F to registered nurse (RN)-C, and also stated NA-F no longer worked at the facility. On 5/20/15, at 11:00 a.m., R58 was interviewed again about NA-F and how R58 felt when cared for by NA-F and R58 stated not feeling very good and explained that NA-F had not treated him well and NA-F had an "attitude" that NA-F was better than others.

On 5/20/15, at 9:50 a.m.,. the director of nurses (DON) was interviewed regarding R58's report of alleged neglect. The DON reported never hearing of the incident.

On 5/20/15, at 9:58 a.m., RN-C reported not recalling speaking with R58 regarding NA-F not providing cares to R58.

On 5/20/15, at 10:23 a.m., NA-D stated that about one and a half months ago, R58 reported to NA-D and NA-C there was a nursing assistant [NA-F] who ignored R58, did not do anything for R58 and was not caring for the resident properly.

NA-D stated that NA-D and NA-C, immediately wrote everything down that R58 had told them and presented the information to RN-C and RN-B. NA-D stated R58 seemed happier now and was not mentioning any more "bad information."

On 5/20/15, at 11:04 a.m. R58's alleged neglect issue was discussed with RN-B, who stated "I guess I don't recall that", and denied having received any written information of the alleged neglect incident.

On 5/20/15, at 11:20 a.m., NA-C stated, had verbally told RN-C what R58 had verbalized and had provided RN-B with the written information.

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	245223	A. BUILDING _____ B. WING _____	05/21/2015

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F 225	Continued From page 8 NA-C stated the information was brought to RN-B after R58 made the report. NA-C stated R58 verbalized wanting to die. NA-C stated that R58's behavior and attitude changed whenever NA-F cared for R58 and explained that R58 would report not having a good evening because of having to do things without help, such as self-transferring into bed. On 5/20/15, at 11:25 a.m., social worker(SW)-A stated not being aware of any possible neglect of care for R58. SW-A stated R58 had recently seen a psychologist as R58 had been complaining about a new resident in the next room being noisy at night. SW-A stated staff felt R58 did not do well with changes and that seeing the psychologist would be good for the resident, and R58 was doing better since having seen the psychologist. On 5/20/15, at 11:33 a.m., the DON stated she had spoken to RN-C, and RN-C did not recall receiving information from either NA-C or NA-D regarding R58's alleged neglect incident. On 5/20/15 at 1:20 p.m. NA-D stated NA-D and NA-C had written the information down on a large piece of paper and that NA-C who had delivered the written information to RN-B and RN-C. NA-D stated NA-D and NA-C felt, "very frustrated" that RN-B or RN-C stated they had not received the information. On 5/20/15, at 2:00 p.m. the DON was interviewed regarding NA-F. The DON stated NA-F had been terminated because of a vulnerable adult (VA) incident with a resident. A review of NA-F's personnel file revealed the VA incident the DON was referring to did not involve	F 225		

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F 225	Continued From page 9 R58, but another resident residing in the facility.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to investigate allegations of potential mistreatment, per facility policy, for 1 of 2 residents (R58), who reported to facility staff possible neglect of care. Findings include: The facility's policy titled Vulnerable Adult & Abuse & Neglect Prevention and dated 5/12, revealed all incidents of mistreatment or suspected mistreatment were to be reported immediately and upon receipt of the report the nursing supervisor on duty was to begin investigating the situation by conducting a physical assessment of the resident, speaking to all staff involved in the situation and document the findings. Based on the information received from R58, the facility failed to follow the policy and procedure. A review of R58's electronic health record (eHR), revealed a Brief Interview for Mental Status (BIMS) had been completed on 4/21/15, which revealed R58 scored 14/15, indicating R58 was	F 226	**F 226** **Immediate corrective action:** An internal investigation was conducted for resident (R58) on 5/20/15 Corrective action as it applies to others: The policy and procedure for Abuse Prevention was reviewed on 6/11/15 and remains current. The Director of Nursing services and Nurse Managers were re-educated on the policy and procedure for Abuse Prevention with respect to completing thorough investigations per policy guidelines.	6/30/15

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F 226	Continued From page 10 cognitively intact. The eHR care plan dated 8/12/13, revealed R58 was able to "reliably recognize a dangerous situation", but "cannot remove myself to safety in a dangerous situation, I would need staff to assist me to safety." R58 was also identified as frequently incontinent of urine and required staff assistance. The most recent quarterly minimum data set (MDS) dated 4/21/15, revealed R58 was always incontinent of urine and required the extensive assistance of one staff for grooming, and toileting. On 5/18/15, at 11:37 a.m., R58 stated during an individual interview, there were times when NA-F ignored R58 by not answering the call light, not assisting the resident and not changing R58's incontinent product. R58 stated reporting NA-F to registered nurse (RN)-C. R58 also stated NA-F no longer worked at the facility. On 5/20/15, at 11:00 a.m., R58 was interviewed again about NA-F and how R58 felt when cared for by NA-F and R58 stated not feeling very good and explained that NA-F had not treated him well and NA-F had an "attitude" that NA-F was better than others. On 5/20/15, at 10:23 a.m., NA-D stated that about one and a half months ago, R58 reported to NA-D and NA-C, there was a nursing assistant [NA-F] who ignored R58, did not do anything for R58, and was not caring for the resident properly. On 5/20/15, at 11:20 a.m., NA-C stated to have verbally told RN-C what R58 had verbalized and had provided RN-B with the written information. NA-C stated the information was brought to RN-B after R58 made the report. NA-C stated R58 verbalized wanting to die. NA-C stated that R58's behavior and attitude changed whenever NA-F cared for R58 and explained that R58 would	F 226	**Recurrence will be prevented by:** All alleged occurrences of suspected abuse or neglect will be thoroughly investigated by the Director of Nursing and /or designee in accordance with facility policy. Prior to the completion of the investigation, the investigative report will be reviewed with the Administrator and/or Social Service Director to ensure the investigation is through and complete including: relevant dates and times, summary of all investigative interviews with all staff involved in the incident, identification of alleged staff member, identification of the resident and interventions implemented to prevent a recurrence of the incident. All investigative summaries of incidents of alleged abuse and will be reviewed by the QA committee monthly for IDT input and recommendations. This will be an ongoing practice. **The correction will be monitored by:** Administrator and/or designee	

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F 226	Continued From page 11	F 226		

report not having a good evening because of having to do things without help, such as self-transferring into bed. NA-D stated that NA-D and NA-C, immediately wrote everything down that R58 had told them and presented the information to RN-C and RN- B. NA-D stated R58 seemed happier now and was not mentioning any more "bad information."

On 5/20/15, at 11:04 a.m. R58's alleged neglect issue was discussed with RN-B, who stated "I guess I don't recall that", and denied having received any written information of the alleged neglect incident.

On 5/20/15, at 11:25 a.m., social worker(SW)-A stated not being aware of any possible neglect of care for R58. SW-A stated R58 had recently seen a psychologist, as R58 had been complaining about a new resident in the next room being noisy at night. SW-A stated staff felt R58 did not do well with changes and that seeing the psychologist would be good for the resident and R58 was doing better since having seen the psychologist.

On 5/20/15, at 11:33 a.m., the director of nursing (DON) stated she had spoken to RN-C and RN-C did not recall receiving information from either NA-C or NA-D regarding R58's alleged neglect incident.

On 5/20/15 at 1:20 p.m., NA-D stated NA-D and NA-C had written the information down on a large piece of paper and that NA-C who had delivered the written information to RN-B and RN-C. NA-D stated NA-D and NA-C felt, "very frustrated" that RN-B or RN-C stated they had not received the information.

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F 226	Continued From page 12 On 5/20/15, at 2:00 p.m., the DON was interviewed regarding NA-F. The DON stated NA-F had been terminated because of a vulnerable adult (VA) incident with a resident. A review of NA-F's personnel file revealed the VA incident the DON was referring to did not involve R58, but another resident residing in the facility.	F 226		
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on document review, and interview, the facility failed to act upon grievances from the resident council meeting for 6 of 6 residents (R13, R16, R18, R32, R52, R124) who voiced specific care and service issues on 2 east. Findings include: R13, R32 and R124 attended the February 2015 Resident Council meeting and expressed the concerns of a group of resident's from the second floor regarding staff education and treatment. R16, R18, and R52 further corroborated resident concerns but were not at the meeting. A review of the resident council minutes for 2/2/15, under the section marked Nursing, read,	F 244	**F 244** **Immediate corrective action:** Interviews for residents (R 13, R16, R18, R 32, R52 and R124) were conducted as soon as facility became aware of the grievances. Grievance forms were completed and submitted to the IDT for review and follow-up. Three staff members received immediate re-education on 5/19/15 based upon the grievance findings.	6/30/15

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F 244	Continued From page 13 "Tell nursing the aides on 2E need to be shadowed. (residents think they should've been fired on day one.)" The section titled Social Service read, "*Right to respect. 2E doesn't feel their needs are being met. 2E Lights aren't being answered, can take 1/2 hour to an hour. Talked back to, resident is trying to be helpful but nurses/aides don't want to hear it." Residents who were present at this meeting were R13, R32 and R124. A review of the March 2015 and April 2015 resident council minutes lacked mention of the resolution to the February 2015 resident council concerns. When interviewed on 5/18/15, at 9:20 a.m., R16 expressed having to wait long periods of time for the staff to help with cares and position changes. R16 referred to, "other people that live here try to watch out for me, but when the staff get mad at me they make me wait longer, I don't want to complain." Furthermore, R16 stated, "some of the regular day staff are sticks in the mud, I don't want them mad at me." R16 stated, "If I complain, the staff will push and pull on me more when they take care of me and that hurts. I already have problems being comfortable in this chair and I am afraid they will make me wait longer for help." R16 validated the facility management was aware of the problem from resident council which R16 validated attending with [R13,R52 and R124] whom she considers people who watch out for her. Review of R16's medical record indicated an annual minimum data set (MDS) completed 3/18/15,which assessed R16 as cognitively intact and able to make decisions about care.	F 244	**Corrective action as it applies to others:** The policy and procedure titled "Resident Council Meetings and Concerns" was reviewed and remains current. All interviewable residents were interviewed and grievance forms were completed for any voiced concern per facility policy and submitted to the IDT for review and follow-up. All staff will be re-educated on the policy by 6/30/15 **Recurrence will be prevented by:** Following each resident council meeting, resident council minutes will be reviewed by the IDT to ensure resident concerns are addressed and have appropriate follow-up. Grievances voiced at each prior monthly meeting will be reviewed during the current	

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F 244	Continued From page 14 During an interview with R52 on 5/18/15, at 3:15 p.m., a concern was expressed about , "If I complain the staff will get back at me so I don't want to complain. We complained and nothing was done about it." R52 made reference to the resident council meeting in February 2015 when R52 expressed concerns about having to wait long periods of time for assistance, that the wheel chair is very uncomfortable, and she is in constant pain from a knee injury. R52 would like to see better customer service training for the staff but does not want them to, "Get back at me." Review of R52's medical record indicated a quarterly MDS completed 4/30/15, which R52 was assessed as cognitively intact and able to make decisions about care. During an interview on 5/19/15, at 10:32 a.m., R32 validated the concerns addressed at the February 2, 2015 resident council meeting and confirmed the residents continued to be upset about the lack of resolution and that the residents were afraid of retaliation from the staff. R32 stated, "Be sure to talk to [R13] and [R124] because they are seriously concerned about the staff being mean to them." Review of R32's medical record indicated a quarterly MDS completed 2/18/15, which R32 was assessed as cognitively intact and able to make decisions about care. When interviewed on 5/19/15, at 10:37 a.m., R124 talked about licensed practical nurse (LPN)-A and stated, "[LPN-A] is always so mad at me, One day she came into my room screaming at me for reporting her to the director	F 244	monthly meeting until each grievance is resolved. Resident council minutes will be shared with the monthly QA committee for their input and recommendations for continued monitoring. This will be an ongoing process. **The correction will be monitored by:** Social Service Director and/or designee	

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of nursing (DON). They know [LPN-A] is a problem but because she has been here for so long they won't do anything about her retaliation to us." R124 continued to talk about the February resident council meeting when the residents told the staff that nursing assistants (NA)-A and NA-B try to control the residents. "These nursing assistants do not allow choices, you better do it their way or expect to wait a long time if you should need something." Furthermore, R124 explained the residents on this end of the building talk and watch out for each other. R124 said to interview [R13], [R16], and [R52] because they also expressed concerns about [LPN-A] and [NA-A] and [NA-B].

Review of R124's medical record indicated a quarterly MDS completed 3/18/15, which R124 was assessed as cognitively intact and able to make decisions about care.

During an interview on 5/19/15, at 2:30 p.m., R13 discussed being very concerned about retaliation from LPN-A and referred to a situation a while back where a culture of a wound site was required. R13 said "[LPN-A] came into the room early in the morning, took off the appliances, did the culture and then left me, she did not put it back together again. R13 felt it was "in spite" because he has complained about her." R13 stated, "The residents watch out for each other here." R13 referred to [R124], [R16], [R52] as residents who discussed the concerns on the nursing unit. R13 shared another situation that R13 considered "bullying like in grade school" was one day in April when LPN-A laughed at R13 after an incident that was upsetting. R13 stated, "I felt angry, that I was not worth anything. It was like being a kid and being laughed at." R13 feels

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F 244	Continued From page 16	F 244		

the NA-A has retaliated against him by not talking to him for a period of time and this is "to get back at me because I complained about her."

Review of R13's medical record indicated an annual MDS completed 3/11/15, which R13 was assessed as cognitively intact and able to make decisions about care.

During an interview with R18 on 5/19/15, at 2:00 p.m., a concern was expressed that the staff are mean to him because they push him around in a rough way, but he doesn't want to complain for fear of retaliation because "these people have been here a long time and are the usual staff in the unit." R18 stated, "Maybe I have done something wrong to them so they treat me this way." R18 validated he did not report to management because he stated, "I am afraid they will get back at me."

Review of R18's medical record indicated an annual MDS completed 4/8/15, which R18 was assessed as cognitively intact and able to make decisions about care.

During an interview with the director of social services (DSS), the director of nursing (DON) and registered nurse (RN)-A on 5/19/15, at 10:45 a.m., the minutes of the February Resident Council were reviewed. The DSS, DON and RN-A, validated there was no investigation into the concerns expressed at the February 2015 Resident Council meeting. There were no resident or staff interviews conducted from the resident council meeting or on the 2E unit addressed in the resident council minutes. According to the DSS, the person who recorded the resident council minutes no longer works at

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F 244	Continued From page 17 the facility. When interviewed, the DSS, DON and RN-A validated the concerns should have been investigated.	F 244		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide an individualized program of activities to meet the psychosocial wellbeing of each resident for 1 of 3 residents (R83) reviewed for activities. Findings include: R83 did not receive activities as directed by the plan of care. During observations on 5/17/15, at 3:00 p.m. and at 7:00 p.m., R83 was laying in bed on the right side. Eyes were open but there was no response to verbal communication. There was no radio, no television, no CD or tape playing in the room. During observations on 5/18/15, at 9:00 a.m., 10:48 a.m., and 1:00 p.m., R83 was laying in bed on the right side. Eyes were open but there was no response to verbal communication. There was	F 248	**F248** **Immediate corrective action:** Recreation staff will coordinate with nursing to have Resident (R83) brought out to movies, Bible study, and reading group on a weekly basis, and provide 1:1 visits throughout the week by recreation staff and volunteers. **Corrective action as it applies to others:** Recreation will provide for all residents in persistive vegative state, one to one visits by the recreation staff and/or volunteers throughout the week. Recreation staff will highlight activities on the resident's activity preference and needs worksheet and, place this in the resident's room next to their monthly activities schedule.	6/30/15

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F 248	Continued From page 18 no radio, no television, no CD or tape playing in the room. When interviewed on 5/18/15, at 11:32 a.m. Family member (F)-A expressed being "upset and discouraged" because R83 is not involved in activities as much as possible and F-A would like to see R83 "more involved." F-A expressed [R83] being so young and involved with music, movies, and videos, which were a big part of [R83's] life, which should still be a part of his life. F-A verified the facility was aware and F-A talked about activities in the March 2015 care conference. F-A stated several family members who visit frequently and have expressed concern because they are not seeing activity involvement. Document and electronic medical record (eMR) review revealed R83 was admitted to the facility on 11/21/13. The active diagnoses from R83's plan of care, dated 5/19/15, listed, but was not limited to tracheostomy, septicemia, endocarditis, and unspecified intracranial hemorrhage. The Minimum Data Set (MDS) assessment dated 4/29/15, indicated under section B Hearing , Speech and Vision, read; Comatose, Persistent vegetative state/no discernable consciousness. R83 was assessed on the quarterly Minimum Data Set (MDS) dated 1/28/15, as severe cognition impairment and unable to answer questions. Document review of the activity plan of care, dated 4/10/14, read, Quality of Life: Continuing these activities I did prior to admission are important to me; I like this type of music: Rap, I like these types of TV programs: Sitcom, Movies; Action, like the pirates of the Caribbean.	F 248	Recreation staff will make a Get to Know Me Poster of resident's interests for new incoming residents. Recreation staff will highlight activities that are appropriate for residents that can not communicate their activity interests and, will coordinate with nursing staff to help implement their activity attendance. Recreation staff will implement a monthly music group for persistive vegetative state residents to attend in the 2W lounge. Recreation and nursing staff will be re-educated by 6/30/2015 **Recurrence will be prevented by:** 2 random weekly audits will be conducted on each unit for 90 days to ensure resident activity needs are addressed according to individual preference and to ensure residents are attending activities in accordance with their plan of care. Audit results will be shared with the monthly QA committee for their input and recommendations for continued monitoring.	

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F 248	Continued From page 19 During observation on 5/18/15, at approximately 1:30 --2:30 p.m. movie Happy Gilmore was showing in the dining room. R83 did not attend the movie. During an interview with the activity aide (AA)-A on 5/19/15, at 9:42 a.m., revealed R83 has a volunteer visitor who comes every two weeks for hand massage but AA-A is not sure of the sensory stimulation for R83 and exactly what he would benefit from because stated, "I am not sure what [R83] can comprehend." Furthermore AA-A expressed not being sure about R83 being in a crowded group setting and stated, "We do not know if [R83] can see anything or what the brain is doing." AA-A verified R83 was not brought to group setting activities and that the nursing staff should be turning on the television and music for R83.	F 248	**The correction will be monitored by:** Director of activities and/or designee	
F 253 SS=E	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, interview and document review, the facility failed to maintain a sanitary, orderly and comfortable environment. 2 of 3 (2 west and 3 east) unit hallways had noticeable urine odors. 2 of 10 (R13, R18) residents room window curtains were visibly torn and had frayed hemming. 6 of 8 residents (R16, R18, R28, R29, R40, and R52) wheel chairs were dirty. 2 of 10	F 253	**F253** **Immediate corrective action:** 2West and 3East unit hallways where cleaned. Resident (R13 and R18) had their window curtains replaced. Wheelchairs where cleaned for residents (R16, R18, R28, R29, R40, and R52). Rooms of resident (R40 and R164) had touch up painting done in their rooms, and resident (R98) had the floor stain removed.	6/30/15

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F 253	Continued From page 20 resident rooms (R40, R164) required paint and repair and 1 of 10 resident rooms (R98) had dark staining on the flooring. Findings include: Throughout various times, each day of the survey 5/17, 5/18, 5/19 and 5/20/15, there was a strong urine odor observed to be present in the 2 west and 3 east hallways. During a family member (F-A) interview on 5/18/15, at 11:32 a.m., F-A stated, "Everytime I come into this building it smells like piss, there must be something they can do for that. I've been aware of it for months,and complaining, why can't they figure it out and get rid of the smell." F-A verified family member was not cognitively intact to complain about the odor but the family members have complained about the odor in the facility on behalf of the resident who cannot speak up and would not like the odor. During an observation on 5/19/15 at 12:00 p.m., housekeeper (H)-A was spraying a substance into the hallway and stated, "We are trying to cover up the smell." H-A validated there was a strong urine odor in the 3 east hallway and was not sure where the odor was coming from. The product being sprayed was called, Good Sense Odor Counteractant. During observation of room order on 5/18/15, at 1:30 p.m., on 2 east hallway, there were 2 of 10 resident (R13, R18) window curtains that had frayed, undone hemming along the entire length of the 24 to 36 inch edgings. When interviewed on 5/18/15 at 1:30 p.m., R18 said he could not see the frayed drapery because of blindness but	F 253	**Corrective action as it applies to others:** Carpets will be deep cleaned to eliminate odors once a week and will be spot scrubbed daily with urine odor removed as needed. Housekeeping staff will be re-educated on placing information in the Tels maintenance communication system for repairs needed in resident's rooms. Maintenance will receive information on all discharging residents to insure that any repairs needed to that room can be addressed. Wheelchairs scheduled for deep cleaning will be announced in the morning so nursing can assist housekeeping to coordinate wheelchair cleaning. Dirty wheelchairs are being wiped down by housekeeping and nursing on a daily basis after meals. Housekeeping and nursing staff will be re-educated by 6/30/2015 **Recurrence will be prevented by:** 2 random weekly audits will be conducted on each unit for 90 days to ensure hallways are free	

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F 253	Continued From page 21 validated his family would not appreciate seeing the frayed edges during visits and stated, "Maybe it will bother them, so I think they should be fixed." When interviewed on 5/19/15, at 2:30 p.m., R13 verified the unhemmed, frayed curtain was "irritating" because R13 expressed "taking pride" in his room and would like things to be in good repair. During observation of the curtains in R13 and R18's bedroom, with the director of laundry and housekeeping (DLH) on 5/19/15, at 2:30 p.m. the DLH verified the curtains needed to be taken down and repaired and/or replaced. During various observations on 5/17, 5/18 and 5/19/15, the wheel chairs of R16, R18, R28, R29, R40, and R52, had a build up of grime and crumbs present on the sides of the wheel chair, under the cushions and in some instances on the foot plates of the wheel chair. During observation of the wheel chairs for R16, R18, R28, R29, R40, and R52, with the director of laundry and housekeeping (DLH) on 5/19/15, at 2:30 p.m. the DLH verified the wheel chairs needed to be cleaned and the DLH stated, "They will be taken care of today." The DLH verified there was not a system to monitor the cleaning of the wheel chairs and the housekeeping staff were to clean the wheel chairs once a month when the room is "deep cleaned." Document review of the facility housekeeping form titled, Deep Clean Checkoff List, revealed R18 had the wheel chair cleaned on 4/8/15, R28 had the wheel chair cleaned on 4/2/15 and R40	F 253	of odor and resident rooms and wheelchairs are clean and in good repair. Audit results will be shared with the monthly QA committee for their input and recommendations for continued monitoring. **The correction will be monitored by:** Director of Laundry and Housekeeping and/or designee	

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F 253	Continued From page 22 had the wheel chair cleaned 4/27/15. There were no other forms produced for review to indicate if wheel chair cleaning occurred in April or May for R16, R29 and R52. Further interview on 5/19/15, at 2:30 p.m. with the DLH revealed, wheel chairs are cleaned on the day shift, but if a resident is up in the wheel chair the housekeeping staff are unable to clean the wheel chair. The DLH stated, "The wheel chairs are done on the day shift if they can get to them, there is an evening housekeeper from six to ten, but they are busy doing the dining rooms." On 5/20/15, at 10:00 a.m., an environmental tour was conducted with the administrator, maintenance director, housekeeping director and the corporate housekeeping director. During the environmental tour, R40 and R164's rooms were noted to have gouges, scratches, and black marks on the walls. The maintenance director did verify they were in need of repair and painting, and the facility did not have a system in place when a room is to be painted. In addition, R98's room was noted to have several light orange spots observed on the floor by the side of the room that was unoccupied at this time. The resident's wheelchair was placed over the orange spots. The corporate housekeeping director stated the orange marks on the floor are stains; however when he scraped the spot with his shoe, the orange spot did wipe off. The housekeeping director verified the floor needs to be cleaned.	F 253		
F 254 SS=D	483.15(h)(3) CLEAN BED/BATH LINENS IN GOOD CONDITION	F 254		

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F 254	Continued From page 23 The facility must provide clean bed and bath linens that are in good condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide proper fitting linens for 2 of 2 residents (R83, R106) using APM-2 bariatric mattresses. Findings include: During observation of cares on 5/19/15, at 10:30 a.m. R83 was turned from side to side by nursing assistants (NA)-F and NA-K for urinary incontinence care. The bottom sheet was not a fitted bed linen and did not remain in place, which resulted in R83 having his skin on the bare mattress at some times during the incontinence cares. The nursing assistants were observed struggling to keep bed linen under R83 with cares. There was friction and shearing as the nursing assistants pulled on the bed linens in an attempt to keep the linen under R83. When interviewed on 5/19/15, at 10:30 a.m. both NA-A and NA-K verified the facility did not have linen big enough to fit these type of beds. Both nursing assistants validated the frustration of trying to keep the linen under R83 and both expressed concern for the friction and shearing of R83's skin. Both nursing assistants said they have reported the difficulty with nursing management. The facility did not provide proper fitting linens for R106's bariatric mattress.	F 254	**F 254** **Immediate corrective action:** Bariatric fitted sheets were provided for residents (83 and R106) on 5/19/2015. **Corrective action as it applies to others:** Bariatric fitted sheets have been ordered and will be used for all bariatric sized beds. Staff will be educated on the need to place fitted sheets on all bariatric beds. **Recurrence will be prevented by:** 3 weekly random audits will be completed for 90 days to ensure bariatric fitted sheets are available and in use for each resident who requires them. Audit results will be shared with the QA committee for their input on the need for continued monitoring. **The correction will be monitored by:** Director of nursing and/or designee	6/30/15

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F 254	Continued From page 24 According to NA-A and NA-K, R106's family supplied the linen to fit the bed because they were told the facility did not have linen to fit the APM-2 bariatric mattresses. During an interview with the director of laundry (DL) services on 5/19/15, at 3:00 p.m. the DL stated the facility only purchased the one size fits all sheets. The facility did not have a policy regarding proper fitting bed linen.	F 254		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279	**F 279** **Immediate corrective action:** The care plans for residents R17, R117 and R 102 were updated to include interventions regarding shaving/facial hair removal on 5/21/15. **Corrective action as it applies to others:** Resident care plans will be reviewed to ensure each care plan addresses individual preferences regarding facial hair. The policy and procedure for Care Planning was reviewed on 6/11/15 and remains current.	6/30/15

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F 279	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview, the facility did not develop a comprehensive plan of care regarding shaving or facial hair removal for 3 of 4 residents (R17, R117, R102) reviewed for personal cares. Findings include: R17 was observed to have several facial hairs the evening of 5/17/15, and during subsequent days of the survey on 5/18/15 and 5/19/15. The Care Area Assessment (CAA) for Activities of Daily Living (ADL's) functional/Rehabilitation Potential dated 3/9/15, indicated, "Resident is dependent on staff for all ADL's and cares .... Staff will proceed to care plan residents (resident's) dependence on staff and to maintain dignity and cleanliness." The care plan dated 3/18/15, identified R17 had alteration in hygiene/ADL's/shower/bath and directed staff, "I receive a partial bath and a hair wash once a week I am dependent on staff for all hygiene needs. Goals: I would like to be clean and odor-free daily. Interventions ... Staff monitor residents' skin during bath and cares for signs of irritation or breakdown and further evaluates ..." however the care plan did not address shaving facial hair for resident. R117 care plan lacked interventions regarding shaving. R117 was observed to have several facial hairs the evening of 5/17/15, and during subsequent days of the survey on 5/18/15 and 5/19/15.	F 279	Nursing staff will be re-educated on the policy by 6/30/2015 **Recurrence will be prevented by:** 2 random weekly care plan audits will be conducted on each unit for 90 days to ensure resident care plans address shaving according to individual preference and to ensure residents are shaven in accordance with their plan of care. Audit results will be shared with the monthly QA committee for their input and recommendations for continued monitoring. **The correction will be monitored by:** Director of Nursing and/or designee	

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F 279	Continued From page 26 The CAA dated 2/20/15 indicated, " ... Resident is dependent on staff for all ADL's and is incontinent of bowl and bladder. Staff monitor skin during ADL's and peri-care with any changes reported for further eval (evaluation). Staff will proceed to care plan residents risk for skin break down and to maintain skin integrity." The care plan dated 3/4/15 focused, "Cognition: I am cognitively impaired due to: DX of intra-cerebral hemmorage (hemorrhage) and being vent dependent unable to express my needs much of the time. I can nod to yes or no questions. My memory is difficult to assess due to my communication deficits. My abilities are knowing my family, where I am and time of year. Interventions: Staff will assist in decision making as instructed by the family or resident. Please anticipate my needs". However the care plan did not address shaving facial hair for resident. During an interview on 5/19/15 at 10:24 a.m., licensed practical nurse (LPN)-B verified R17 and R117 were unshaven and stated, there was no reason why R17 and R117 were unshaven and they should have been shaven. LPN-B acknowledged the care plan did not address shaving facial hair for R17 and R117. On 5/20/15 at 2:22 p.m., registered nurse (RN)-A verified, the care plan did not address shaving for R17 and R117. Policy and procedure titled care planning process, dated revision March 2013, indicated, "1. The facility must develop a comprehensive care plan for each resident that includes measurable	F 279		

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F 279	Continued From page 27 objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment (the MDS of the RAI). ..... 4. Care plans include problems/strengths, long and short-term goals, objectives and expected outcomes, as well as planned interventions, and specific disciplines responsible. This prevents a plan from becoming merely a list of tasks. It provides rationale for planned intervention and the basis for evaluation....." R102's plan of care did not address shaving. R102 was observed on 5/18/15 at 2:38 p.m.,with darker colored facial hair on his cheeks, upper lip,chin and upper neck. R102 indicated he doesn't mind being shaved. A family member (F)-M in the room indicated R102 liked to be clean shaven however, was usually not shaved when visiting. The visitor added another family member visits frequently and always would shave R102 when visiting. On 5/19/15 at 2:00 p.m., a random observation was made and R102's face continued to have long facial hair on entire face. At this time, F-B was visiting and confirmed R102 had not been shaved for a few days and that she would do it. F-C verified R102 is not usually clean shaven when she visits, and frequently shaves R102. R102's care plan, last revised 5/17/15, indicated R102 would like to be clean, neat and well groomed daily. However the current care plan does not identify personal grooming/shaving needs for R102. On 5/20/15 at 12:00 p.m. the RN-B verified the care plan did not identify personal grooming/shaving needs for R102 and it would be updated as soon as possible. RN-B verified it was the expectation to be shaved daily.	F 279		

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F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to update the care plan for 1 of 3 residents (R163) with a pressure ulcer, 1 of 3 residents (R102) with falls and 1 of 3 residents (R87) with therapy recommendations. Findings include: A Comprehensive Evaluation of Skin Inspection and Risk Factors was completed in R163's electronic health record (eHR) on 5/14/15. The assessment revealed R163 had been admitted to the facility with a scar on the coccyx, which	F 280	**F 280** **Immediate corrective action:** The temporary care plan for resident R 163 was updated on 5/19/2015. The care plan for resident R 102 was updated on 5/20/2015 with the therapy recommendations and the care plan for resident R 87 was updated on 5/20/2015 to include: current fall interventions, the injury of the right humerus, interventions regarding the care and use of the sling and the use of the finger separator and wrist/hand orthotic. On 5/20/2015, the ADON and RN-B received immediate re-education regarding updating resident care plans upon the discovery of any new pressure ulcer, therapy recommendations and fall interventions.	6/30/15

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F 280	Continued From page 29 measured 2.5 x 3.5 centimeters and which was the result of previous pressure ulcers. An eHR progress note dated 5/14/15, at 9:38 a.m., noted R163 was admitted with Mepilex in the coccyx area "over a fragile area. Area is closed." Another eHR progress note dated 5/15/15, at 11:11 p.m. revealed there was an "excoriated skin on coccyx." The undated temporary care plan indicated R163 was to be turned and repositioned by one to two staff every two hours and when necessary. However, the temporary care plan was not updated after identification of a new pressure ulcer in the coccyx area which was noted on 5/18/15. On 5/18/15, at 2:45 p.m. R163 was observed receiving perineal care by nursing assistants (NA)-A and NA-H. R163 was noted to be incontinent of stool and an open area was noted on the coccyx area. NA-A and NA-H verified the open area on the resident's coccyx. At 2:50 p.m. the assistant director of nurses (ADON) was informed and verified the presence of the open area on the coccyx. The resident's physician was also present at the time and the ADON reported the open area to the physician, who ordered a Mepilex sponge dressing to the area. On 5/19/15, at 10:55 a.m. the ADON stated the temporary care plan had been updated to reflect R163's new coccyx pressure ulcer. However, upon review of the temporary care plan the coccyx pressure ulcer was not identified. At 11:00 a.m. the ADON reviewed the temporary care plan and had no comment regarding the temporary	F 280	**Corrective action as it applies to others:** The policy and procedure titled "Care Planning, IDT" was reviewed and remains current. Licensed staff will be re-educated on the policy and procedure by 6/30/2015. The individual care plans for residents with current wounds, falls within the last 12 months or those who currently use orthotic devices will be reviewed by 6/30/2015 to ensure the care plans are current including current interventions.	

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F 280	Continued From page 30 care plan not having been updated. R102's plan of care was not updated with a therapy recommendation. On 5/17/15 at 5:43 p.m., during staff interview, the registered nurse (RN)-B reported R102 had a contracture of the left arm and wore a left elbow extension orthotic. During random observation on 5/18, and 5/19/ 2015, R102 did not wear a left elbow brace. On 5/18/15 at 2:40 p.m. R102 was sitting in Broda chair in room watching television and visiting with a family member (F)-M. F-M reported R102 did not wear any splint on the left arm and he was not sure why. On 5/19/15 at 2:40 p.m., R102 was sitting in room in Broda chair. Another family member (F)-N was visiting and R102 had a rectangular brown pillow under the left elbow and between the lower arm and chest wall. F-N was unsure where the elbow splint was. Discharge summary for occupational therapy (OT), dated 4/30/15, was reviewed. The summary indicated R102 "requires maximum physical assistance to appropriately donn, doff bilateral hand and wrist orthotics and left elbow brace ... " and " ... Mother and staff will carry over with elbow orthotic and all staff have been placing arm straps on per program already in place. " A review of the most current care plan lacked evidence the information from OT had been added to the care plan. The care card used by the nursing assistants to direct resident care, lacked any information or update regarding the use of the elbow orthotic. On 5/20/15 at 12:00 p.m. the RN-B verified it appeared the splint was not being used daily and it had not been added to the care plan or care cards for the nursing assistants. RN-B indicated	F 280	**Recurrence will be prevented by:** 2 random weekly care plan audits will be conducted on each unit for 90 days to ensure each care plan addresses current fall interventions, orthotic use, and fall interventions. Audit results will be shared with the monthly QA committee for their input and recommendations for continued monitoring. **The correction will be monitored by:** Director of Nursing and/or designee	

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F 280	Continued From page 31 it must have been missed. The RN-B indicated it would also be added. Resident 87 did not have an updated care plan for a fall with an injury. On 5/17/15 at 7:13 p.m., RN-B reported R87 currently had a fractured right humerus and was wearing a sling for the right arm. R87 had a fall on 5/3/15 at 1:30 a.m. in his room which resulted in a fracture of the right humerus. R87 had another fall on 5/10/15 from the bed to the floor. No injury was reported A review of the facility's Unusual Occurrence Report was completed. The form was dated 5/3/15 and indicated the resident was found on the floor in the resident's room. R87 was sent to the hospital for evaluation and treatment of a fractured right humerus. A post fall assessment was completed and other interventions were developed. They included: therapy to evaluate the use of a transfer pole, and place bed in a low position. A review of the current care plan indicated the transfer pole was being reevaluated and on 5/17/15 the following intervention was added: to keep bedroom door racked open at night and try to keep surrounding area quiet to assist with sleeping. The care plan was not updated to include the injury of the fractured right humerus, or other interventions to direct staff care. The care plan did not include care for the sling, when it was to be worn or removed etc. On 5/20/15 at 2:50 p.m. RN-B reviewed the interventions and the care plan and agreed it had not been updated to include the injury and care and services needed. In addition, a review of the current care plan lacked evidence of R87 having a contracted right	F 280		

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F 280	Continued From page 32	F 280		

arm and wrist. A 5/8/2013 entry identified R87 had a "Special Accommodation" request indicating he was aware of the risks and benefits to not follow normal facility protocol regarding the right upper arm brace and wrist splint. An intervention indicated the accommodation agreement would be reviewed at least quarterly, upon return from hospital or change in condition.
The nursing assistant care card (used to direct residents care) directed statt that R87 had a right hand orthotic to be worn during the day. The medical record lacked any evidence of regular review of the accommodation. No documentation of refusal of wearing the orthotic or specific interventions for the contracted areas.
During interview, on 5/17/15 at 7:13 p.m., the registered nurse (RN)-B indicated R87 had a contracture on right arm, however the splint was not being worn. RN-B reported R87 currently had a fractured right humerus and was wearing a sling for the right arm.
During random observations on 5/17/15 and on 5/19/15 from 7:10 a.m. to 10:20 a.m., R87 sat in the wheelchair in the dining room during the breakfast meal and then in the hallway. R87 would self propel wheelchair short distance such as back into dining room, but would then return to hallway by the nursing station. There was no evidence of a right hand/wrist orthotic being worn.
On 5/20/15 at 1:00-2:30 p.m., R 87 was not wearing a right wrist orthotic.
On 5/20/15 at 11:23 a.m. the occupational therapist (OT)-B verified R87 has a contracted right wrist and was to be using a hand pillow with finger separators and a right hand resting splint. When asked, OT-B indicated R87 could still use the orthotic while wearing the sling for the fractured humerus.
On 5/20/15 at 2:15 p.m. the licensed practical

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F 280	Continued From page 33 nurse (LPN)-C indicated the resident didn't wear a splint, as he would refuse it. On 5/20/15 at 2:32 p.m. nursing assistant (NA)-J reported not seeing anything for his hand since working on unit. On 5/21/15 at 11:00 a.m. RN-B confirmed the findings and added R87 would refuse the finger separator and wrist/hand orthotic. RN-B agreed the care plan had not been revised or updated to identify interventions.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide services in accordance with the residents written plan of care for 2 of 2 residents (R87, R83) for assist with shaving and for not receiving activities. Findings include: R87's care plan, dated 4/15/15 indicated R87 could no longer complete grooming tasks on his own and wanted his grooming needs to be anticipated and met for me by staff. Interventions included staff assist/maintain electric razor cleaning after each use and weekly per protocol. R87 was observed on 5/17/15 at 7:12 p.m. with approximately 5/8 inch long dark and light facial hairs on his checks, chin, upper lip and upper	F 282	**F 282** **Immediate corrective action:** Resident (R87) was shaven on 5/19/2015. NA-I received re-education for failing to follow the plan of care for resident (R87). Activity aid (AA-A) received re-education regarding following the plan of care for resident (R87).	6/30/15

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F 282	Continued From page 34 neck area. The following day 5/18/15, at 2:30 p.m., the facial hair remained on R87's face. On 5/19/15 during random observations from 7:10 a.m. to 10:30 a.m., the facial hair remained on R87's face. On 5/19/15 at 12:30 p.m., nursing assistant (NA)-I verified she did not get to shave R87 during the shift. On 5/19/15 at 2:45 p.m., the registered nurse coordinator (RN)-B was informed R87 had not been shaved since 5/17/15. The care plan was reviewed with RN-B who explained that the nursing assistant should have incorporated the shave during the day as it was the expectation residents are shaved daily. R83 did not receive activities as directed by the plan of care. Document review of the activity plan of care, dated 4/10/14, Directed staff: Quality of Life: Continuing these activities I did prior to admission are important to me; I like this type of music:Rap, I like these types of TV programs; Sitcom, Movies; Action, like the pirates of the Caribbean. During an observation on 5/17/15, at 3:00 p.m. at 7:00 p.m., R83 was laying in bed on the right side. Eyes were open but there was no response to verbal communication. There was no radio, no television, no CD and no books on tape playing. During an observation on 5/18/15, at 9:00 a.m., 10:48 a.m. and 1:00 p.m., R83 was laying in bed on the right side. Eyes were open but there was no response to verbal communication. There was no radio, no television, no CD and no books on tape playing.	F 282	**Corrective action as it applies to others:** The policy and procedure titled "Care Planning, IDT" was reviewed and remains current Nursing and activity staff will be trained on the policy by 6/30/2015. **Recurrence will be prevented by:** 2 random weekly visual audits will be conducted on each unit for 90 days to ensure residents are shaven according to individual preference in accordance with their plan of care and to ensure residents who are dependent on staff to anticipate activity pursuits will attend activity programs according to care planned interventions. Audit results will be shared with the monthly QA committee for their input and recommendations for continued monitoring. **The correction will be monitored by:** Director of Nursing and/or designee	

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F 282	Continued From page 35 When interviewed on 5/18/15, at 11:32 a.m. Family member (F)-A expressed being "upset and discouraged" because R83 is not involved in activities as much as possible and F-A would like to see R83 "more involved." F-A expressed R83 being so young and involved with music, movies, and videos, which were a big part of R83's life, which should still be a part of his life. F-A verified the facility was aware and F-A talked about activities in the March 2015 care conference. F-A has several family members who visit frequently and have expressed concern because they are not seeing activity involvement. During observation on 5/18/15, at approximately 1:30-2:30 p.m. movie Happy Gilmore was showing in the dining room. R83 did not attend the movie. During an interview with the activity aide (AA)-A on 5/19/15 at 9:42 a.m. revealed R83 has a volunteer visitor who comes every two weeks for hand massage but AA-A is not sure of the sensory stimulation for R83 and exactly what he would benefit from because stated, "I am not sure what [R83] can comprehend." Furthermore AA-A expressed not being sure about R83 being in a crowded group setting and stated, "We do not know if [R83] can see anything or what the brain is doing." AA-A verified R83 was not brought to group setting activities and that the nursing staff should be turning on the television and music for R83.	F 282		
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to	F 312		

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F 312	Continued From page 36 maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document interview the facility failed to provide personal hygiene care for 4 of 4 residents (R17, R117, R87, R102) who were dependent upon staff for personal cares. Findings Include: R17 was observed to have several facial hairs the evening of 5/17/15, and during subsequent days of the survey on 5/18/15 and 5/19/15. R17's clinical record noted R17 was admitted to facility on 3/3/11, and had diagnoses, which included respiratory ventilator, anoxic brain damage, cognitive impaired, urinary obstruction, and hypertension. Medication that included Paxil, oxycodone and phenytoin. R17's discharge Minimum Data Set (MDS) dated 3/13/15, identified R17 required total assist with bed mobility, transfers, dressing, toileting, bathing and personal hygiene needs. The Care Area Assessment (CAA) for Activities of Daily Living (ADL's) functional/Rehabilitation Potential dated 3/9/15, indicated, "Resident is dependent on staff for all ADL's and cares .... Staff will proceed to care plan residents (resident's) dependence on staff and to maintain dignity and cleanliness."	F 312	**F 312** **Immediate corrective action:** Residents R17, R117, R87 and R012 were shaven on 5/19/2015. **Corrective action as it applies to others:** The care plans for dependent residents will be reviewed to ensure ADL care including shaving and toileting assistance are addressed on each care plan. The policy titled "Nursing Care Standards" was reviewed and remains current. Nursing staff will be re-educated on the policy and procedure by 6/30/2015.	6/30/15

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F 312	Continued From page 37 The care plan dated 3/18/15, identified R17 had alteration in hygiene/ADL's/shower/bath and directed staff, "I receive a partial bath and a hair wash once a week I am dependent on staff for all hygiene needs. Goals: I would like to be clean and odor-free daily. Interventions ... Staff monitor residents' skin during bath and cares for signs of irritation or breakdown and further evaluates ..." however the care plan did not address shaving facial hair for resident. On 5/17/2015 at 5:48 p.m., during an attempt to interview R17, she was observed to have several gray/white facial hairs to the upper lip and the chin area approximately one half inch long. Resident was unable to communicate her needs when queried. On 5/18/15 at 8:51 a.m. and 11:45 a.m. R17 was observed in her room laying in bed covered with a white sheet and was observed to still have numerous facial hairs. On 5/19/2015 at 7:39 a.m., nursing assistant (NA) -F was observed to complete R17's peri cares. At 7:55 a.m., R17 was left in bed without been shaven by NA-F. R117 was witnessed to have several facial hairs the evening of 5/17/15, and during subsequent days of the survey on 5/18/15 and 5/19/15. R117's clinical record noted R117 was admitted to facility on 2/11/15, and had diagnoses, which included respiratory failure, chronic airway obstruction, muscle weakness, hypertension, diabetes type II. Medication that included Lasix and insulins.	F 312	**Recurrence will be prevented by:** 2 random weekly audits will be conducted on each unit to ensure residents receive assistance with shaving and toileting in accordance with individual preference and their written plan of care. Audits will be conducted for 90 days and audit results will be shared with the QA committee for their input on the need for continued monitoring. **The correction will be monitored by:** Director of nursing and/or designee.	

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F 312	Continued From page 38 R117's quarterly MDS dated 4/16/15 recited, "rarely/never understood, sometimes understands." Identified R117 required total assist with bed mobility, transfers, dressing, eating, toileting, personal hygiene and bathing activities. The CAA dated 2/20/15 indicated, "... Resident is dependent on staff for all ADL's and is incontinent of bowl and bladder. Staff monitor skin during ADL's and peri-care with any changes reported for further eval (evaluation). Staff will proceed to care plan residents risk for skin break down and to maintain skin integrity." The care plan dated 3/4/15 focused, "Cognition: I am cognitively impaired due to: DX of intra-cerebral hemmorage (hemorrhage) and being vent dependent, unable to express my needs much of the time. I can nod to yes or no questions. My memory is difficult to assess due to my communication deficits. My abilities are knowing my family, where I am and time of year. On 2/18/15 my BIMS assessment indicates severely impaired as I am rarely able to express myself. Interventions: Staff will assist in decision making as instructed by the family or resident. Please anticipate my needs". On 5/17/2015 at 5:48 p.m. during an effort to interview R117, was detected to have quite a lot of gray/white facial hairs to the upper lip and the chin area. Resident was unable to communicate his needs when queried. On 5/18/15 at 9:01 a.m. and 11:43 a.m., R117 was observed in his room sitting up in his wheelchair by the bed unshaven. On 5/19/2015 at 7:39 a.m., R117 was laying in	F 312		

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F 312	Continued From page 39 bed with facial hair. During an interview on 5/19/15 at 10:24 a.m., licensed practical nurse (LPN)-B verified R17 and R117 were unshaven and stated, there was no reason why R17 and R117 were unshaven and they should have been shaven. "Nursing assistants are busy and we had many call-ins and I should not use that as an excuse. We don't have enough staff here, but I will tell the nurse assistants to shave them. I don't know if the nursing assistant don't need money or not" During interview on 5/19/15 at 10:37 a.m., NA-F verified that R17 and R117 were unshaven because she was busy due to insufficient nursing assistant staffing and they are always short of nursing assistants. Further stated, "It is very difficult to complete the resident ADLs as required and at times I do not take lunch breaks." NA-F was in tears and pointed out, she was always emotional when talking about residents because they need help and deserve better. "Will go ahead shave [R17] and will try to shave [R117] because at times [R117] would not let them shave him." In addition, NA-F indicated, "I will not bring my family member here because they don't have enough staff." During interview with registered nurse (RN)- A on 5/19/15 at 10:51 a.m., verified that R17 and R117 had facial hair or were unshaven and stated, "My expectation is, residents were supposed to be shaved daily." On 5/20/15 at 2:22 p.m. RN-A indicated, the care plan does not address shaving R17 and R117. Policy and procedure titled nursing care standards dated July 2013, reads, "Assistance	F 312		

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F 312	Continued From page 40 with or supervision of shaving residents as necessary to keep them clean and well groomed. Each resident should have their own shaving equipment." R87 needed assistance from staff for grooming/shaving and was not provided facial hair removal. R87 was observed on 5/17/15 at 7:12 p.m. with approximately 5/8 inch long dark and light facial hairs on his checks, chin, upper lip and upper neck area. The following day 5/18/15, at 2:30 p.m. the facial hair remained on R87 ' s face. On 5/19/15 during random observations, the facial hair remained on the resident's face. The annual minimum data set (MDS) dated 3/5/15 identified diagnoses included cerebrovascular accident, dementia and traumatic brain injury and aphasia (inability to express and understand language).The MDS indicated R87required extensive assist with personal hygiene. R87's care plan, dated 4/15/15 indicated R87 could no longer complete grooming tasks on his own and wanted his grooming needs to be anticipated and met for me by staff. Interventions included Staff assist/maintain electric razor cleaning after each use and weekly per protocol. On 5/19/15, at 12:30 p.m., the nursing assistant (NA)-I verified she did not get to shave R87 during the shift. The nursing assistant indicated R87 does like to get a shave so it should not be a problem the next day. On 5/19/15 at 2:45 p.m., the registered nurse coordinator (RN)-B was informed R87 had not been shaved since 5/17/15 and what the care plan directed . RN-B Indicated the nursing assistant should have incorporated the shave	F 312		

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	245223	A. BUILDING _____ B. WING _____	05/21/2015

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 312	Continued From page 41 during the day. RN-B also verified the care plan does not direct staff on grooming R87 daily, and added, it somehow was missed when care plan developed. R87 was not provided with toileting care and was incontinent of bowel. On 5/19/15 at 7:10 a.m. R87 was sitting in a Broda wheelchair at the dining table waiting for breakfast to be served. R87 sat at the table throughout breakfast and until 8:45 a.m. when moved to the hallway. R87 sat in the wheelchair in the hallway. Carpets were being cleaned so he would move from area to another area by the assistance of staff. At approximately 10:30 a.m. the licensed practical nurse (LPN-C) took R87 to his room. With staff assistance, R87 was able to stand up using a transfer pole. R87 was incontinent of stool. LPN-C provided pericare and applied a clean brief to R87 while standing at the transfer pole. R87's skin was red with deep creases and wrinkles. The annual MDS dated 3/5/15, identified diagnoses included cerebrovascular accident, dementia and traumatic brain injury and aphasia (inability to express and understand language). The MDS indicated R87 needed extensive assist with all activities of daily living including transfers and toileting. The MDS indicated the R87 is incontinent of bowel and bladder. The current care plan directed staff to toilet upon rising, before and after meals and at hour of sleep. On 5/19/15 at 10:35 a.m. LPN-C confirmed resident had been incontinent of stool and the skin on buttocks and thighs was red with multiple deep creases and wrinkles. On 5/19/15 at 12:00 p.m., the nursing assistant (NA)-I verified getting R87 up before 7:00 a.m. and she had not been able to get back to R87. NA-I indicated she was so thankful LPN-C had	F 312		

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F 312	Continued From page 42 helped her. On 5/19/15 at approximately 2:45 p.m., RN-B verified the findings and agreed R87 should have been repositioned and toileted sooner. R102 was dependent on staff for all personal hygiene/grooming and was not provided facial hair removal. R 102 was observed on 5/18/15 at 2:38 p.m. with darker colored facial hair on his cheeks, upper lip, chin and upper neck. R102 indicated he doesn't mind being shaved. A family member (F)-M in the room indicated R102 liked to be clean shaven however, was usually not shaved when visiting. The visitor added another family member visits frequently and always would shave the R102 when visiting. On 5/19/15 at 2:00 p.m. a random observation was made and R102's face continued to have long facial hair on entire face. At this time F-B was visiting and confirmed R102 had not been shaved for a few days and that she would do it. F-C verified R102 is not usually clean shaven when she visits and often frequently shaves R102. The initial MDS dated 11/20/14 identified diagnoses included quadriplegia, and traumatic brain injury. The MDS indicated R102 was totally dependent on staff for all personal hygiene. R102's care plan, last revised 5/17/15, indicated R102 would like to be clean, neat and well groomed daily. However the current care plan does not identify personal grooming/shaving needs for R102. On 5/20/15 at 12:00 p.m. the RN-B verified the care plan did not identify personal grooming/shaving needs for R102 and it would be updated as soon as possible.	F 312		
F 318	483.25(e)(2) INCREASE/PREVENT DECREASE	F 318		

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F 318 SS=D	Continued From page 43 IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide nursing rehabilitative services for 3 of 3 resident (R83, R87, R102) reviewed for rehabilitative services to maintain or increase range of motion (ROM) Findings include: The facility did not coordinate the plan of care between therapy and nursing to provide range of motion (ROM) for R83. During an observation on 5/19/15, at 7:20 a.m., R83 was receiving perineal cleansing from nursing assistants (NA)-F and NA-K who seemed to be struggling to separate R83's legs for the cares. Both NA's encouraged R83 to "relax your legs." When interviewed on 5/18/15, at 11:32 a.m., Family member (F)-A expressed being "discouraged," because it did not seem like the range of motion was being completed for R83 and FM-A expressed thinking R83 was "stiffer and tighter" in the arms and legs. Furthermore, FM-A revealed expressing concerns about R83's	F 318	F 318 **Immediate corrective action:** Orders were received for resident (R83) on 5/21/15 to have therapy screen and establish new ROM guidelines. The care plan for resident R87 was updated to include contracture of the right arm and wrist and nursing intervention for resident (R87) on 5/30/15. OT recommendations for the use of the elbow orthotics for resident (R102) were added to the care plan and care cards. **Corrective action as it applies to others:** The policy "Restorative Nursing Program was reviewed and remains current. Nursing staff will be re-educated on the policy by 6/30/2015. Residents with established restorative nursing guidelines will be reviewed to ensure their individual programs are implemented as directed. Residents with a	6/30/15

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F 318	Continued From page 44 ROM at the last care conference in March 2015. During interviews with nursing assistants NA-F and NA-K on 5/19/15, at 10:50 a.m., both thought that the therapy department was providing ROM for R83. During interviews with licensed practical nurse (LPN)-B and LPN-H both thought nursing did not do ROM for R83 because therapy provided the ROM program for R83. Document and electronic medical record (eMR) review, revealed R83 was admitted to the facility on 11/21/13. The active diagnoses from R83's plan of care, dated 5/19/15, listed, but was not limited to tracheostomy, septicemia, endocarditis, and unspecified intracranial hemorrhage. The Minimum Data Set (MDS) assessment dated 4/29/15, indicated under section B Hearing , Speech and Vision, read; Comatose, Persistent vegetative state/no discernable consciousness. R83 was assessed on the quarterly Minimum Data Set (MDS) on 1/28/15, as severe cognition impairment and unable to answer questions. The document titled, PT-Therapist Progress and Discharge Summary read, End of Care 4/23/15, ROM [range of motion] ankle. Goal-The patient will tolerate PROM [passive range of motion] and stretching program in order to increase B [bilateral] LE [lower extremity] ext. [extension] to -15 degrees and hip ext PROM to neutral and maintain B ankle DF [dorsi-flexion] to effective and safe positioning in bed and prevent development of contracture's. Precautions, high risk for contracture's and skin breakdown due to complete dependence for mobility, Cardiac precautions. Wakeful Unresponsive state. Discharge plan and instructions D/C [discharge]	F 318	functional limitation in ROM or contracture without a restorative nursing program will be evaluated by nursing to determine the need for a program to maintain or attain the resident's highest functional potential. **Recurrence will be prevented by:** 2 random weekly audits will be conducted on each unit to ensure restorative nursing programs are being completed and documented according to the resident's individualized plan of care. Audits will be conducted for 90 days and audit results will be shared with the QA committee for their input on the need for continued monitoring. **The correction will be monitored by:** Director of Nursing and/or designee.	

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F 318	Continued From page 45 to same SNF [skilled nursing facility] with staff management of positioning. The physical therapist (PT)-A responsible for the therapy discharge was interviewed on 5/19/15, at 11:30 a.m., and verified nursing should have been given a referral to continue with PROM and does not know if the facility form was completed. The facility form was asked for from medical records but not received. The director of nursing (DON) was interviewed on 5/20/15, at 8:50 a.m. and verified R83 should have received passive range of motion from the nursing staff and the ROM should be added to the plan of care. On 5/17/15 at 7:13 p.m., RN-B indicated R87 had a contracture on right arm, however the splint was not being worn and R87 had a right humerus fracture. During random observations on 5/17/15 and on 5/19/15 from 7:10 a.m. to 10:20 a.m. R87 sat in the wheelchair in the dining room during the breakfast meal and then in the hallway. R87 would self propel wheelchair short distance such as back into the dining room, but would then return to hallway by the nursing station. There was no evidence of a right hand/wrist orthotic. On 5/20/15 at 1:00-2:30 p.m., R87 was not wearing a right wrist orthotic. The annual minimum data set (MDS) dated 3/5/15 indicated R87 was admitted with diagnoses that included cerebral vascular accident, traumatic brain injury and dementia. The MDS indicated R87 had no impairment of upper/lower extremities and needed extensive assistance with activities of daily living. Current physician orders indicated a diagnoses of	F 318		

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F 318	Continued From page 46	F 318		

contracture of joint of multiple sites. R87 had an physician order for "right hand/wrist orthotic to be worn during the day 0800-2000 as tolerated. staff to apply during morning cares and removed at bedtime. Check skin each shift." A review of the current care plan lacked evidence of R87 having a contracted right arm and wrist. A 5/8/2013 entry identified R87 had a "Special Accommodation" request indicating he was aware of the risks and benefits to not follow normal facility protocol regarding the right upper arm brace and wrist splint. An intervention indicated the accommodation agreement would be reviewed at least quarterly, upon return from hospital or change in condition. The nursing assistant care card (used to direct residents care) indicated R87 had a right hand orthotic to be worn during the day. The medical record lacked any evidence of regular review of the accommodation. No documentation of refusal of wearing the orthotic was provided.

On 5/20/15 at 11:23 a.m. the occupational therapist (OT)-B verified R87 had a contracted right wrist and was to be using a hand pillow with finger separators and a right hand resting splint. OT-B indicated nursing staff had been provided with written information to apply the orthotic. When asked, OT-B indicated R87 could still use the orthotic while wearing the sling for the fractured humerus. OT-B added the facility would benefit from having a restorative nursing program.

On 5/20/15 at 2:15 p.m., the licensed practical nurse (LPN)-C indicated the resident didn't wear a splint, as he would refuse it.

On 5/20/15 at 2:32 p.m., nursing assistant (NA)-J reported not seeing anything for his hand since working on unit.

On 5/21/15 at 11:00 a.m., RN-B confirmed the

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F 318	Continued From page 47 findings and added R87 would refuse the finger separator and wrist/hand orthotic. RN-B agreed the care plan was not being followed and the team would have to review the use of the orthotic. On 5/17/15 at 5:43 p.m. during staff interview, the registered nurse (RN)-B reported R102 had a contracture of the left arm and wore a left elbow extension orthotic. During random observation on 5/18, and 5/19/ 2015, R102 did not wear a left elbow brace. On 5/18/15 at 2:40 p.m., R102 was sitting in Broda chair in room watching television and visiting with F-M. F-M reported R102 did not wear any splint on the left arm and he was not sure why. On 5/19/15 at 2:40 p.m., R102 was sitting in room in a Broda chair. F-N was visiting and R102 had a rectangular brown pillow under the left elbow and between the lower arm and chest wall. F-N was unsure where the elbow splint was. A review of the initial minimum data set (MDS) dated 11/20/14 indicated the resident had diagnoses that included quadriplegia and traumatic brain injury. The MDS also indicated R102 was totally dependent on staff for all personal hygiene/shaving and had functional limitations in range of motion in upper and lower sides bilaterally. Discharge summary for occupational therapy (OT), dated 4/30/15, was reviewed. The summary indicated R102 "requires maximum physical assistance to appropriately donn, doff bilateral hand and wrist orthotics and left elbow brace ..." and "... Mother and staff will carry over with elbow orthotic and all staff have been placing arm straps on per program already in place." A review of the most current care plan lacked evidence the information from OT had been added to the care plan. OT had provided a	F 318		

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F 318	Continued From page 48 summary and print out of pictures on how to apply the elbow orthotic correctly to the left arm of R102. This information was placed in an information book on the unit. There was no indication as to who may have read the information. The "care cards" used by the nursing assistants which provided information on how to care for the residents, lacked any information or update regarding the use of the elbow orthotic. On 5/20/15 at 9:40 a.m. the occupation therapist indicated a new elbow orthotic had just been obtained for him., it had been fitted to R102 specifically and would have been more comfortable. Staff had been trained to apply it. On 5/20/15 at approximately 10:30 a.m. the RN-B and Licensed practical nurse (LPN)-G searched room for the elbow extension orthotic and found it in a bottom dresser drawer. On 5/20/15 at 12:00 p.m. the RN-B verified it appeared the splint was not being used daily and it had not been added to the care plan or care cards for the nursing assistants. RN-B indicated it must have been missed. The RN manager indicated the care plan and care cards would be updated.	F 318		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 323	**F 323** **Immediate corrective action:** RN-C received re-education for failing to report the loose siderails in a timely manner. The siderails for resident (R58) were repaired on 5/20/2015.	6/30/15

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F 323	Continued From page 49 by: Based on observation, interview and document review, the facility failed to repair side rails in a timely manner for 1 of 1 resident (R58). Findings includes: On 5/18/15, at 11:45 a.m., two half side rails were observed on each side of R58's bed. Upon further inspection the side rails were noted to be firmly attached to the bed at the base of the side rail, but the upper portions of both side rails were noted to wiggle and lean outward away from the bed and were not perpendicular to the mattress. When asked at 11:45 a.m. why R58 had the side rails, R58 replied the rails were to prevent him from falling out of bed. When R58 was asked if afraid of falling out of bed, R58 replied "No." When asked if the side rails helped R58 move about in bed or to get in and out of bed, R58 stated he used the pole (which was placed beside the bed and extended to the ceiling.) At 11:53 a.m., the condition of the side rails was reported to registered nurse (RN)-C, who had no comment. On 5/20/15, at 10:00 a.m. the loose side rails were still observed on the bed. At 10:03 a.m. RN-C was interviewed regarding why the side rails had not been repaired or replaced. RN-C stated the maintenance department had been contacted yesterday about the side rails. RN-C stated the resident did not have a problem with falls, would hang onto the transfer pole and swing himself into and out of bed with staff assist. However, RN-C did not report to the maintenance department the loose side rails until 5/20/15. On 5/21/15, at 9:40 a.m. maintenance staff	F 323	**Corrective action as it applies to others:** The policy and procedure titled "Side Rail Use" was reviewed and remains current. Nursing staff will complete a physical device assessment for all residents with siderails according to facility policy and procedure any noted loose side rails will be repaired. Nursing and maintenance staff will be educated on the policy and procedure by 6/30/2015. **Recurrence will be prevented by:** 2 random weekly audits will be conducted on each unit to ensure side rails are in good repair. Audits will be conducted for 90 days and audit results will be shared with the QA committee for their input on the need for continued monitoring. **The correction will be monitored by:** Maintenance director and or designee	

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F 323	Continued From page 50 (MS-E) stated the side rail had been fixed the previous morning (5/20/15.) MS-E stated the request to fix the side rail had been received from the maintenance director. At 10:45 a.m. the maintenance director was interviewed and stated the request to fix R58's side rail had not been received verbally from RN-C until "yesterday" (5/20/15.) On 5/21/15, at 10:50 a.m., R58 stated during an interview, that since the side rails were replaced they felt "much better." When asked how safe R58 felt before with the old side rails, R58 stated "not very safe." R58's care plan updated 8/14/12, revealed R58 used a transfer pole when transferring. That if feeling weak or tired they were to ask for help. Another section of the care plan, updated 5/10/13, revealed R58 could offload when in bed and used one 1/2 side rail to do this for mobility and positioning. The care plan also indicated the following: staff were to ensure assistive devices were available and in good repair to assist in "highest level of function with bed mobility." A fall assessment completed in the electronic health record and dated 4/21/15, revealed R58 was at risk for falls because of unsteadiness, incontinence and impaired mobility. A Brief Interview for Mental Status (BIMS) found in the eHR and completed on 4/21/15, revealed R58 scored 14/15, indicating R58 was cognitively intact.	F 323		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS	F 328		

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F 328	Continued From page 51 The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide appropriate hand hygiene, per facility policy, when providing tracheotomy care to 1 of 2 ventilator dependent residents (R163) during tracheostomy care. Findings include: Appropriate hand hygiene was not followed during observation of a tracheotomy dressing change for R163. On 5/19/15, starting at 9:44 a.m., licensed practical nurse (LPN-B) was observed to wash hands and don gloves. LPN-B then proceeded to complete a gastrostomy tube (GT) dressing change for R163. However, LPN-B did not complete the GT dressing change before beginning the tracheotomy dressing change for the resident. Still wearing the same soiled gloves, LPN-B removed the old gauze pad from around the tracheotomy tube, soaked a new gauze pad with	F 328	**F 328** **Immediate corrective action:** LPN – B received re-education for failing to change gloves and perform hand hygiene per policy and procedure. **Corrective action as it applies to others:** The policy and procedure titled "Hand Hygiene" was reviewed and remains current. Nursing staff will be re-educated on the policy and procedure by 6/30/2015 **Recurrence will be prevented by:** 2 random weekly audits will be conducted on each unit to ensure staff remain complaint with the policy and procedure. Audits will be conducted for 90 days and audit results will be shared with the QA committee for their input on the need for continued monitoring.	6/30/15

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F 328	Continued From page 52 normal saline and cleansed around the tracheotomy tube. LPN-B then removed the soiled gloves and washed their hands before donning new gloves and placing a new gauze pad around R163's GT site. Then without removing their gloves and washing their hands, LPN-B proceeded to open a new gauze package and place a new gauze pad around the tracheotomy tube. LPN-B stated R163 had been admitted with a sore around the neck and upon observation a dime size open area was noted to the right of the tracheotomy, with no drainage present. On 5/20/15, at 10:46 a.m., LPN-B was interviewed regarding the lack of hand hygiene between dressing changes for R163. LPN-B stated they thought "you always went from dirty to clean" and since the treatment was for dressing removals, the dirty part was done first. The facility's Gastrostomy/Jejunostomy Site Care policy dated 2/2014, revealed glove removal and hand washing was to occur after GT cleansing. The facility's Tracheotomy Care policy dated 3/2014, revealed that after the old tracheotomy dressing was removed, gloves were to be removed and hands washed. The policy further indicated that gloves were to be worn when placing a new gauze pad around the stoma site, then removed and hands washed.	F 328	**The correction will be monitored by:** Director of Nursing and/or designee.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any	F 329		

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F 329	Continued From page 53 drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure medications were administered with respect to potential excessive dosages for 1 of 5 residents (87) reviewed for unnecessary medications. Findings include: According to the current physician orders, R87 had the potential to receive an excessive amount of acetaminophen. The current physician order sheets revealed R87	F 329	**F 329** **Immediate corrective action:** The primary MD was notified regarding the excessive dose of acetaminophen and the acetaminophen was discontinued. **Corrective action as it applies to others:** Licensed nursing staff will review residents who receive regularly scheduled acetaminophen and PRN acetaminophen to ensure they have not exceeded the maximum recommended dose as ordered by their MD. The policy and procedure for medication administration was reviewed and remains current. Licensed nursing staff and Trained Medication Aides will be re-educated on the policy and procedure by 6/30/2015,	6/30/15

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F 329	Continued From page 54 was admitted to the facility on 4/15/13, with diagnoses of cerebral artery occlusion, contracture of joints at many sites, and pain in joint, hand. The current physician orders indicate read: Acetaminophen Tablet 1000 mg (milligram) oral three times a day. R87 also had a standing house order that read: Tylenol (Acetaminophen) give 650 mg by mouth every 4 hours as needed for pain. Give 650 mg orally every 4 hours prn (as needed) for minor pain or temp (temperature) or greater than 100.5. Do not exceed 3000 mg of Tylenol in a 24 hr period." The scheduled Tylenol amount equals 3000 mg. On dose of the 650 mg every 4 hours as needed for pain would exceed the limit of 3 grams in 24 hours. A review of the April 2015 medication administration record indicated R87 received an as needed 650 mg dose of Tylenol on 2 separate occasions. R87 received medication which exceeded the 3000 mg Tylenol amount on 4/27 and 4/28/15, when he received as as needed dose. On 5/20/15 at approximately 2:00 p.m., the registered nurse (RN)-B verified the physician orders and that the two as needed doses in April exceeded the 3000 mg recommended dose. RN-B reported she would talk to the nurse practioner regarding the Tylenol orders. A policy was requested but not received.	F 329	**Recurrence will be prevented by:** 2 random weekly audits will be conducted on each unit to ensure residents with acetaminophen orders do not receive a dose in excess of the MD prescribed dose. Audits will be conducted for 90 days and audit results will be shared with the QA committee for their input on the need for continued monitoring. **The correction will be monitored by:** Director of Nursing and/or designee	

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F 329	Continued From page 55	F 329		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assure enough staff were available to meet the needs for residents residing on the 2nd floor. This affected 2 of 7 residents (R17 and R117) residents on the unit and had the potential to affect all 43 residents on the unit of the 111 residents that resided in the facility.	F 353	**F 353** **Immediate corrective action:** An immediate review of staffing levels for all Units was completed and while the ratio of caregiver to resident meets or exceeds the industry standards with current census and acuity, some opportunities for improvement were identified. **Corrective action as it applies to others:** A float NAR will be added during peak times based upon census and acuity. Additional staff will be hired to fill vacant positions. A new position personal care attendant will be added to assist the NAR's by performing other duties on the unit that are non-care assignments. All residents who are interviewable will be interviewed to assure their needs are being met satisfactorily. Families will be interviewed when resident is unable.	6/30/15

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F 353	Continued From page 56 Findings includes: R17 was observed to have several facial hairs the evening of 5/17/15, and during subsequent days of the survey on 5/18/15 and 5/19/15. On 5/17/2015 at 5:48 p.m. during an attempt to interview R17, was observed to have several gray/white facial hairs to the upper lip and the chin area approximately one half inch long. Resident was unable to communicate her needs when queried. On 5/18/15 at 8:51 a.m. and 11:45 a.m. observed R17 in her room lying in bed covered with a white sheet observed to still have numerous facial hairs. On 5/19/2015 at 7:39 a.m. noted R17 lying in bed with facial hair or unshaven during continuous observations while nursing assistant (NA)-F gave peri-care: -At 7:55 a.m. was left in bed without been shaven by NA-F. -At 10:04 a.m. observed NA-F repositioned R17 in bed then NA-F left the room. R117 was witnessed to have several facial hairs the evening of 5/17/15, and during subsequent days of the survey on 5/18/15 and 5/19/15. On 5/17/2015 at 5:48 p.m. during an effort to interview R117, was detected to have quite a lot of gray/white facial hairs to the upper lip and the chin area. Resident was unable to communicate his needs when queried. On 5/18/15 at 9:01 a.m. and 11:43 a.m. observed R117 in his room sitting up in his wheelchair by the bed unshaven. On 5/19/2015 at 7:39 a.m. noted R117 lying in bed with facial hair and while sitting in his wheelchair at 10:27 a.m. unshaven. During an interview with family member (F)-Z for R117 on 5/18/15 at 2:42 p.m. stated, on one occasion her husband had to wait for	F 353	Staffing will continue to be discussed each day by the DON, Administrator, Supervisor, Scheduler and Nurse Managers and adjustments made where needed. Staff will be re-educated on the attendance policy and procedure. **Recurrence will be prevented by:** Ongoing interviews of residents and families will occur daily using the Abaqis program and evaluated quarterly. Included in these interviews are questions regarding needs of residents being met and satisfaction with assistance. **The correction will be monitored by:** Director of Nursing and/or designee	

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F 353	Continued From page 57 approximately 15 to 20 minutes for assistant with changing wet diaper. During an interview on 5/19/15 at 10:24 a.m. with licensed practical nurse (LPN)-B verified R17 and R117 were unshaven and stated, there was no reason why R17 and R117 were unshaven and they should have been shaven. Nursing assistants are busy and we had many call-ins and I should not use that as an excuse. We don't have enough staff here, but I will tell the nurse assistants to shave them." During interview with NA-F on 5/19/15 at 10:37 a.m. verified that R17 and R117 were unshaven because she was busy due to insufficient nursing assistant staffing and they are always short of nursing assistant. Further stated, "It is very difficult to complete the resident ADLs as required and at times I do not take lunch breaks." NA-F was in tears and point out, she always emotional when talking about this residents because they need help and deserve better. Will go ahead shave R17 and will try to shave R117 because at times R117 would not let them shave him. In addition, NA-F indicated, "I will not bring my family member here because they don't have enough staff." During interview with NA-G on 5/20/15 at 11:48 a.m. stated, "Staffing is troubling, the care cards are not updated with resident's activities of daily living (ADL) such as Hoyer lift. I do not feel they have sufficient staffing in the building. I feel like they have potential to have more staff but we have no call no show and they still work here and the policy is not been followed that is why staff who does no call no show continue to do what they are doing."	F 353		

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F 353	Continued From page 58 During an interview with NA-H on 5/20/15 at 2:29 p.m. stated was worried and uncomfortable as a student nursing assistant who gets pulled and assigned for 1 on 1 with resident without being supervised. In addition, indicated, "There is not enough staff here to care for the residents or give quality of care." On 5/17/15, at 2:00 p.m. a resident's family member approached the surveyor and stated there was not enough staff on during the meal times. The family member stated her relative was not always being fed, despite sitting at a feeding table. The family member stated staff would walk past the resident give the resident a bite to eat, but did not sit down to feed. On 5/20/15, at 10:01 a.m. registered nurse (RN-C) stated once in awhile, but not recently, there may not be enough staff, so supervisors would pull staff from either the memory care unit or RN-C would help out on the floor. On 5/20/15, at 10:30 a.m. nursing assistant (NA-D) stated they can "barely" get all their work done. Stated "to be honest with you, these people don't get checked and changed every two hours. It's impossible to do it." NA-D stated they had worked at the facility for a number of years and this is the "worst" staffing has been. On 5/21/15, at 11:30 a.m. the staffing coordinator stated they were well aware that some of the newly hired nursing assistants, who had not taken their nursing assistant test, were not allowed to work on a unit by themselves. The staff coordinator stated they made sure the newly hired nursing assistants were working with	F 353		

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another nursing assistant. The staffing coordinator stated they did not know what the supervisor did if there were sick calls, but "Hope they follow my schedule."

At 11:40 a.m. the staffing coordinator stated "we are short staffed." When asked about contacting a temporary agency for assistance the staffing coordinator stated "Corporate won't allow it."

On 5/21/15, at 12:44 p.m. housekeeper (HK-A) stated there had been times when nursing assistants had not been observed to take a break so they could get all of their work done.

On 5/18/15 at approximately 10:00 a.m. family member (F)-B reported the staff seem short and overworked; everyone looks tired. During the winter it was worse, they didn't seem to have a plan for when people called in or when they couldn't get in to work.

On 5/19/15 at 8:12 a.m., LPN-G indicated the unit she was working on was pretty busy and would prefer to work with three nursing assistants. Some days there are only two. It was also pretty rough during the winter; there were a lot of changes going on, the facility was hiring but not very many applications.

On 5/19/15 at 12:12 p.m. NA-I reported the unit she was working on was heaven compared to the other units. This unit use to have two nursing assistants, but now it just has one. I get all my work done to the best I can, NA-I reported the shaves on the unit did not get done today as, "I just didn't have time." NA-I also stated another

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F 353	Continued From page 60 resident had just gotten out of bed because of not having enough time earlier and that resident required two staff people The nursing assistant indicated she took a break but not a lunch break, "there is just too much to do" On 5/19/15 at 12:46 p.m. LPN-I indicated the morale at the facility was poor. LPN-I added that she cuts her breaks short so she can get her work done and added she stays late often. LPN reported she doesn't feel she can give the care she knows she can give and added it was hard to get everything done. On 5/20/15 at 3:30 p.m. LPN-D reported working a recent weekend and the unit was so short. The whole building was short so you couldn't pull from any where. LPN-D said "that evening I could not get all my treatments done, and I worked over into midnight to get my charting done." When LPN-D informed the director of nursing she was told "corporate would rather get a tag from the health department then get pool in here". LPN-D added some of the medication passes on units were so heavy it cannot be completed within the 2 hour window of time. When asked if this information was passed on to administration, the LPN-D reported no one complains because they won't do anything about it. On 5/20/15 at 9:10 a.m. the staffing coordinator (SC) indicated she has to be creative with the staffing. She implied if there is no one slotted for the open shift (Holes) staff will pick up for a few hours and then get someone to come in early. For sick calls, the staffing coordinator indicated she will reposition some staff or call the other shift person to come in early or contact those who may have signed up to pick up. The SC verified the	F 353		

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facility does not use pool and they do not mandate staff to work. The SC indicated people were working a lot of extra hours and added the whole community is short. The upcoming weekend had at least 17 holes in the schedule at this time. The SC indicated the upcoming weekend was the hardest to fill. If I cant get all shifts covered, I inform the director of nursing and she works her magic.

On 5/21/15 at 9:58 a.m. the director of nursing (DON) was interviewed regarding staffing. The DON reported she will hear from families regarding staffing concerns, but indicated not having any for awhile. The DON explained she recently went to a family care plan because of some of the concerns expressed by the family. The DON added she wants to look into a position that would do certain activities such as pass water, talk to the residents, get people to activities and free up nursing staff. When asked about how did nursing ensure residents were getting the needed care, the DON replied there is a supervisor on the evenings and nights, and the units have nurse managers. The nurses on the unit are responsible for care card updates. The DON indicated there was no system or audit system in place to ensure all work is getting completed. The nurses on the units should inform the managers. The don was unaware of results from any family/customer satisfaction surveys. The don was unaware of any further grievances regarding the staffing and to contact the facility social worker.

On 5/21/15 at 10:32 a.m., the social worker reviewed recent grievances received with the surveyor. 1. Family member (F)-D filed a concern form on 4/30/15. The report indicated

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F 353	Continued From page 62 F-D for R147 reported R147 had called home as he wanted the bed pan. The call light had been on for over an hour. When F-D called the nursing station, the phone rang 12-14 times with no answer. When F-D arrived at the unit, only 1 staff member was available. F-D other comments included R147's call light is frequently on for 1 hr plus before a call is answered. 2. Family member (F-E) for R126 filed a grievance concern on 12/1/14. F-E had multiple complaints and concerns about care for R126 including care for "halo" care, positioning, oral care and working equipment. R126 moved from facility before a meeting could be scheduled to reconcile. 3. A visitor for R147 filed a concern on 5/8/15. The visitor was concerned as family member (F)-D upset as unit had lots of call lights on and R147 had to wait 45 minutes again for call light to be answered and a new ordered medication was not available for R147. Staffing policy was requested but not provided. A review of the Daily Staffing hours posted for 5/9/15 indicated resident census was 112. The posting indicated on the day shift from 6 a.m. to 2 p.m the total number of nursing assistants (NA's) was 14 for a total number of hours worked. A review of the actual working day schedule revealed three call ins of nursing assistants. The allocation sheet indicated there were 11 NA's working a total of 88 hours.	F 353		
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.	F 356		

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F 356	Continued From page 63 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 post the actual hours worked for nursing staff directly responsible for resident care per shift. This had the potential to affect 111 residents in the facility. Findings include: The posted hours and the actual working schedule was reviewed from 5/1/15 - 5/21/15	F 356	**F356** **Immediate Corrective Action:** The template for posting total number of hours was reconciled on 05/29/2015 from 05/01/2015 to 05/21/2015. **Corrective Action as it applies to others:** Policy and procedure for staffing was reviewed and remains current. Supervisor, Nurse Managers and Staffing Coordinator were re-educated on correcting the actual hours posting to reflect changes to staffing that have occurred that shift by 6/30/2015. **Reoccurrence will be prevented by:** Random weekly audits will be conducted on each unit for 90 days to ensure nursing hours are posted in accordance to facility policy. Audit results will be shared with the monthly QA committee for their input and recommendations for continued monitoring.	6/30/15

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F 356	Continued From page 64 during which it was noted the posted hours were not reconciled to reflect the actual staffing for all shifts. The following issues were identified with the hours posted. A review of the posted nursing hours for 5/20/15, revealed five registered nurses, for a total of 40 hours, were included in the day shifts registered nurse total hours. However, a review of the staffing schedule for 5/20/15, revealed only two registered nurses were documented on the schedule. On 5/21/15, at 11:35 a.m., the staffing coordinator stated the posted nursing hours for 5/20/15, included the assistant director of nurses, two nurse managers and two minimum data set (MDS) nurses. When asked if the MDS nurses did hands on care for residents on a daily basis, the staffing coordinator stated "No." The staff coordinator reported to fill shifts sometimes the shifts were pieced together. For example if two people each worked half of an 8 hour shift, it was counted as one person on the daily staffing hours. The facility did not have regular short shifts. A review of the daily staffing hours posted for 5/9/15 indicated on the day shift from 6 a.m. to 2 p.m. the total number of nursing assistants (NA's) was 14 for a total number of hours worked of 105 hours. A review of the actual working day schedule revealed three call ins of nursing assistants. The allocation sheet indicated there were 11 NA's working a total of 88 hours. On 5/21/15 at 9:50 a.m., the director of nursing reported the MDS coordinators should not be	F 356	**Correction will be monitored by:** Director of Nursing and/or designee	

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 _____	05/21/2015

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 65 counted in the daily hours actually worked by registered nurses (RN). The DON verified the posted hours should be updated on a daily bases of changes. The facility's policy of Posting of Daily Nursing hours, last revised 12/13 indicated the facility will post the actual hours of RN's LPN's NA's and trained medication assistants per shift. The policy reads: "Changes will be made each shift on the form should an employee call off work is not replaced.	F 356		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the pharmacist failed to identify and report to the physician drug irregularities for 1 of 5 (R87) residents in the sample reviewed for the use of unnecessary medications. Findings include: According to the current physician orders, R87	F 428	**F428** **Immediate Corrective Action:** Resident R87 Tylenol 650mg PRN was discontinued on 5/20/2015. **Corrective Action as it applies to others:** All resident Tylenol orders will be reviewed to make sure that they do not exceed the parameters set forth by the provider. All staff will be re-educated on parameters of medications set forth by provider by 06/30/2015.	6/30/15

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F 428	Continued From page 66 had the potential to receive an excessive amount of acetaminophen. The current physician order sheets revealed R87 was admitted to the facility on 4/15/13 with diagnoses of cerebral artery occlusion, contracture of joints at many sites, and pain in joint, hand. The current physician orders indicate R87 had a physician order that read: Acetaminophen Tablet 1000 mg (milligram) oral three times a day. R87 also had a standing house order that read: Tylenol (Acetaminophen) give 650 mg by mouth every 4 hours as needed for pain. Give 650 mg orally every 4 hours prn (as needed) for minor pain or temp (temperature) or greater than 100.5. Do not exceed 3000 mg of Tylenol in a 24 hr period." The scheduled Tylenol amount equals 3000 mg. On dose of the 650 mg every 4 hours as needed for pain would exceed the limit of 3 grams in 24 hours. A review of the April 2015 medication administration record indicated R87 received an as needed 650 mg dose of Tylenol on 2 separate occasions. R87 exceed the 3000 mg Tylenol amount on 4/27 and 4/28/15 when he received as as needed dose. On 5/20/15 at approximately 2:00 p.m. the registered nurse (RN)-B verified the physician orders and that the two as needed doses in April exceeded the 3000 mg recommended dose. RN-B reported she would talk to the nurse practioner regarding the Tylenol orders. On 5/21/15 at 12:38 the pharmacist was updated on the extra doses of Tylenol received and asked	F 428	**Reoccurrence will be prevented by:** 2 random weekly audits will be conducted on each unit to ensure residents with acetaminophen orders do not receive a dose in excess of the MD prescribed dose. Audits will be conducted for 90 days and audit results will be shared with the QA committee for their input on the need for continued monitoring. **Correction will be monitored by:** Director of Nursing and/or designee	

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F 428	Continued From page 67 about continuing with the standing house order. The pharmacist reported that clinically it was okay, however it was too bad the standing house orders were not discontinued with some of resident's other pain medication.	F 428		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can	F 431	**F 431** **Immediate Corrective Action:** Medications that were found to not have an open date were removed from the medication cart. **Corrective Action as it applies to others:** The policy and procedure for storing medications/biologicals was reviewed and remains current. All other medication carts/rooms will be audited to ensure medications are stored according to facility policy and procedure. All staff will be re-educated on the policy by 6/30/2015.	6/30/15

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F 431	Continued From page 68 be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation document review and interview, the facility failed to ensure medications were dated when opened, labeled correctly and removed if expired for 2 of 5 units that affected 7 residents (R76, R32, R15, R156, R83, R136 and R132). Findings include: On 5/17/15 at 1:15 pm., during the medication storage tour with licensed practical nurse (LPN)-F on the 3 East unit medication carts, medication was observed to be opened and not dated. R76's Humalog insulin pen was opened and not dated. On 5/17/15 at 1:35 p.m., during the medication storage tour with the licensed practical nurse on 2 East unit medication cart, medications were observed to be in use but not dated when opened or without identification labels. During the tour, the following concerns were identified. - R32's Novolog insulin was opened, dispensed 4/11/15, and not dated when opened. - R15's Novolog insulin pen was opened, dispensed 4/4/25 and not dated when opened. - R156's Novolog flex pen was opened, and remained in cart for use. The pen had been dispensed on 3/25/14 and opened same day.	F 431	**Reoccurrence will be prevented by:** 2 random weekly medication cart audits will be conducted on each unit for 90 days to ensure medications are dated appropriately. Audit results will be shared with the monthly QA committee for their input and recommendations for continued monitoring. **The correction will be monitored by:** Director of Nursing and/or designee	

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F 431	Continued From page 69 - A Lantus insulin pen with no label remained in the medication cart. It was opened and not dated. - R83's two bottle of heparin sodium solution were opened and not dated. - R136's sodium chloride ophthalmic ointment was opened and not dated. Two Symbicort inhalers without any identification labels were in the medication cart. In black marker the names of R132 and R156 were written on the sides of the inhalers. LPN-E confirmed these findings and indicated she would removed the items. On 5/20/15 at 2:53 the director of nursing was informed about the findings and verified items should be labeled and dated when opened. Expired medications should be removed from the drawers. The facility's policy, Storage and Expiration of Medications, Biologicals, Syringes and Needles, last revised 1/1/13 indicated Facility should ensure that medications and biologicals have an expiration date on the label., and have not been retained longer than recommended by the manufacturer...Also, the policy reads: "Once any medication or biological package is opened, facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened." The facility's policy, Medication: Storage of , last revised 7/2013 read: "Drug containers having soiled illegible, worn, makeshift, incomplete,	F 431		

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F 431	Continued From page 70 damaged, or missing labels are returned to the pharmacy for proper labeling before storing.	F 431	**F 441** **Immediate corrective action:** LPN-B was educated on when to change and wash hands when doing Tracheostomy and Gastrostomy tube dressing changes according to the policy. **Corrective Action as it applies to others:** The Policy and Procedure for Tracheostomy care and Gastrostomy site care was reviewed and remains current. All staff will be re-educated on the policy by 06/30/2015. **Reoccurrence will be prevented by:** 2 random weekly treatment audits will be conducted on each unit for 90 days to ensure each resident is receiving proper tracheostomy and gastrostomy dressing changes to prevent the spread of infection. Audit results will be shared with the monthly QA committee for their input and recommendations for continued monitoring.	6/30/15
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of	F 441		

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F 441	Continued From page 71 infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper hand hygiene during a dressing change for 1 of 1 resident (R163); and between 3 of 3 residents (R37, R32 and R138) during use of a point of care device. Findings include: Appropriate hand hygiene was not followed during observation of a gastrostomy tube (GT) and tracheotomy dressing change for R163. On 5/19/15, starting at 9:44 a.m. licensed practical nurse (LPN-B) was observed to wash their hands and don gloves. LPN-B then proceeded to check the GT site for redness by removing a gauze pad. Wearing the same gloves, LPN-B took a clean gauze pad soaked in normal saline, and cleansed around the GT site. Without changing gloves or washing their hands, LPN-B then removed a gauze pad from around the tracheotomy area. Still wearing the same soiled gloves, LPN-B wet another gauze pad with normal saline and cleansed around the tracheotomy. LPN-B stated R163 had been admitted with a sore around the neck and upon observation a dime size open area was noted to the right of the tracheotomy, with no drainage present. Then with the same gloves on LPN-B took two Q-tips and cleansed closer around the tracheotomy area. LPN-B removed the soiled gloves and washed their hands before donning a	F 441	**The correction will be monitored by:** Director of Nursing and/or designee	

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F 441	Continued From page 72 new pair of gloves. With the new gloves on LPN-B placed a new gauze pad around the G-tube and taped the pad down. Without removing the gloves and washing their hands, LPN-B proceeded to open a new gauze pad package and place the new pad around the tracheotomy tube. The gloves were then removed and LPN-B washed hands. On 5/20/15, at 10:46 a.m. LPN-B was interviewed regarding the lack of hand hygiene between dressing changes for R163. LPN-B stated they thought "you always went from dirty to clean" and since the treatment was for dressing removals, the dirty part was done first. The facility's Gastrostomy/Jejunostomy Site Care policy dated 2/2014, revealed glove removal and hand washing was to occur after GT cleansing. The facility's Tracheotomy Care policy dated 3/2014, revealed that after the old tracheotomy dressing was removed gloves were to be removed and hands washed. The policy further indicated that gloves were to be worn when placing a new gauze pad around the stoma site, then removed and hands washed. The facility's Hand Hygiene In the Healthcare Setting Guidelines, dated 5/2014, revealed hand hygiene was to be performed before and after change "a dressing" and after handling soiled equipment. During observation of glucose monitoring on three residents, the licensed practical nurse (LPN)-B did not wash hands in between each resident	F 441		

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F 441	Continued From page 73 On 5/20/15 at 11:15 a.m., LPN-B entered R37's room, applied gloves and obtained a blood sample from the resident's finger to check for blood glucose from a personal glucometer. When LPN-B had completed the task, she removed the gloves, and picked up the tote, and exited the room. LPN-B then entered R32's room at approximately 11:20 a.m., applied gloves and obtained a blood sample from the resident's finger and obtained a reading from the personal glucometer. When the task was completed, LPN-B removed and disposed of the gloves and left the room. LPN-B went down the hall and entered R138's room. At approximately 11:25 a.m., LPN-B applied gloves and obtained a blood sample from R138, When done, the gloves were removed and LPN-B left the room. LPN-B indicated she was done obtaining blood glucose's. When asked why she did not wash hands in between residents, she indicated she should have and did not. On 5/20/15 at 9:30 a.m., the director of nursing verified the nurse should have washed her hands in between residents when performing an invasive procedure. Policy revised 5/2014 titled Hand Hygiene in the Healthcare Settings indicated "Hand washing with soap and water or alcohol based hand rub (ABHR) will always be performed at the following times: Before and after performing any invasive procedure (e.g. fingerstick blood sampling).	F 441		

Red Wing
HEALTHCARE
COMMUNITY
by Welcov Healthcare

June 19, 2015

CERTIFIED MAIL # 7008 1830 0003 6000 3582

Susanne Reuss, Unit Supervisor
Licensing and Certification Program
Minnesota Department of Health
Health Regulations Division
P.O. Box 64900
St. Paul, MN 55164-0900

Dear Susanne:

Our plan of correction on form CMS 2567 is enclosed. Alicia Peterson, RN, DON has also emailed the contents of this mailing to your email address of susanne.reuss@state.mn.us. If you have any questions please do not hesitate to call. Our phone number is (651) 385-4800.

Sincerely,

Tony Linn
Administrator

Enclosure

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

F5223023

PRINTED: 06/10/2015
FORM APPROVED
OMB NO. 0938-0391

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	245223	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/22/2015**

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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 6-25-15 RECEIVED JUN 22 2015 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

EXIT: 5-21-15 DC: 6-30-15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Administrator

(X6) DATE: 6/19/2015

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

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K 000	Continued From page 1 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@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	K 000		

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K 000	Continued From page 2 census of 114 at the time of the survey.	K 000		
K 033 SS=D	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain a fire resistance rating of at least one hour in the exit component accordance with the following requirements of 2000 NFPA 101, Section 19.3.1.1, 8.2.5.2. This could effect 40 out of 114 residents. Findings include: On facility tour between 11:00 AM and 2:00 PM on 05/22/2015, observation revealed that the following was found: 3rd floor - 1. West stairwell above lay in ceiling - open penetrations around sprinkler piping and not seal at head of wall 2. Center stairwell - open penetrations around	K 033	**K 033** Open penetrations above the West stairwell and the center stairwell were sealed with flame stopper 5000 by members of the maintenance team. To prevent a re-occurrence the Plant Operations Director will inspect maintenance and outside vendors work after it is completed, making sure penetrations are properly sealed. Completed 5/22/2015 All stairwells ~~were~~ will be inspected and corrected as needed by 6/30/2015. The Plant Operations Director will be responsible for this correction	

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	05/22/2015

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 033	Continued From page 3 cables Check all stairwells for this deficiency These deficient practices were confirmed by the Plant Operations Director (DP) at the time of discovery.	K 033		
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 114 residents. Findings include: On facility tour between 11:00 AM and 2:00 PM on 05/22/2015, observations revealed that the 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. There was no balancing report available. This deficient practice was confirmed by the Plant	K 067	K067 AW 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. b. The building has automatic shutdown of all ventilation fans upon detection of smoke or activation of the building fire alarm system.	

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 _____	05/22/2015

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

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K 067		K 067	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.	

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 _____	05/22/2015

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

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K 067		K 067	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 loss of $172,774.17 shown on our most recent cost report which is from 2014 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 one year 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.	

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 _____	05/22/2015

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

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K 067		K 067	e. The lease on the building runs out in about one year making the remaining useful life of the building after the 6 month project about 6 months.	

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 _____	05/22/2015

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RED WING HEALTH CENTER	1412 WEST FOURTH STREET RED WING, MN 55066

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K 067	Continued From page 4 Operations Director (DP) at the time of discovery.	K 067		
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation, the facility was storing medical gas cylinders in a manner not in conformance with NFPA 99 (1999 edition) Chapter 4, Sections 4-3.1.1.2 (3) and 4-3.5.2.2 (2). This deficient practice could all 15 out of 114 residents FINDINGS INCLUDE: On facility tour between 11:00 AM and 2:00 PM on 05/22/2015, observation revealed that in oxygen storage room on 2nd floor east the following was found: 1. (1) unsecured "E" cylinders 2. Empty and full "E" cylinders were not segregated from each other	K 076	**K 076** Unsecured "E" cylinder was place in the "E" cylinder rack 5/22/2015 by the Plant Operations Director. New racks were ordered one for full cylinders and one for empty cylinders. Signage will be stenciled on the wall over each rack to designate whether it is for full "E" cylinders or empty ones. To be completed by the Maintenance team by 6/30/2015. Nursing staff will be re-educated on proper placement of "E" cylinders in either the empty or full rack by Nursing Management.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 076	Continued From page 5 These deficient practices were confirmed by the Plant Operations Director (DP) at the time of discovery.	K 076	The Plant Operations Director and the DON will be responsible for monitoring of the oxygen storage to prevent re-occurrence. Audits of the oxygen storage room will be completed at random times once weekly for four weeks then monthly for two months. Results will be reported to the Quality Assurance Committee for further review. To be corrected by 6/30/2015.	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to inspect the emergency generator in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 Chapter 6-4.1 and 6.4.2. The deficient practice could affect all 114 residents. Findings include: On facility tour between 9:15 AM and 12:30 PM on 05/12/2015, documentation review of the emergency generator revealed that the facility did not have a letter for the reliable fuel source for the natural gas emergency generator. The letter needs to contain all five points as required below: a. A statement of reasonable reliability of the natural gas delivery b. A brief description that supports the statement	K 144	K 144 The Plan Operations Director obtained the specified letter from Excel energy 5/28/2015 and placed it on file.	

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K 144	Continued From page 6 regarding the reliability c. A statement that there is a low probability of interruption of the natural gas d. A brief description that supports the statement regarding the low probability of interruption e. The signature of technical personnel from the natural gas vendor. This deficient practice was confirmed by the Plant Operations Director (DP) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 144		

Sheehan, Pat (DPS)

From: Sheehan, Pat (DPS)
Sent: Thursday, June 25, 2015 12:56 PM
To: rochi_lsc@cms.hhs.gov
Cc: gary.schroeder@state.mn.us; 'tony.linn@welcov.com'; Dehler, Robert; Dietrich, Shellae (MDH); 'Fiske-Downing, Kamala'; Henderson, Mary (MDH); 'Johnston, Kate'; Leach, Colleen (MDH); marian.whitney@state.mn.us; Meath, Mark (MDH)
Subject: Red Wing Health Center (235223) K67 Annual Waiver Request - Previously Approved - No changes

This is to inform you that Red Wing CC is again requesting an annual waiver for K67, corridors as a plenum. The exit date was 5-21-15.

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	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	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 6-25-15

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 loss of $172,774.17 shown on our most recent cost report which is from 2014 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 one year 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 one year making the remaining useful life of the building after the 6 month project about 6 months.

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title	Office	Date

WHV INC.

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

		Current Year			Prior Year		
		SNF	HH	Total	SNF	HH	Total
730-82000:89999	Information Technology-Other Expenses	72,840.82		72,840.82	87,021.67		87,021.67
740-82000:89999	Marketing-Other Expenses	6,161.42		6,161.42	4,244.79		4,244.79
750-84020	Property & Related-Bed Tax/Surcharge	441,640.10		441,640.10	408,174.86		408,174.86
750-84030	Property & Related-Nursing Home License	14,253.00		14,253.00	34,232.96		34,232.96
	TOTAL ADMIN & GENERAL - OTHER	1,403,520.08	0.00	1,403,520.08	1,266,532.78	0.00	1,266,532.78
	EMPLOYEE BENEFITS						
	GROUP 03-2						
800-89100	Benefits-Life	5,170.00		5,170.00	6,790.54		6,790.54
800-89110	Benefits-Health	307,220.58		307,220.58	497,380.58		497,380.58
800-89120	Benefits-Dental	16,735.04		16,735.04	17,728.94		17,728.94
800-89130	Benefits-Disability	3,288.31		3,288.31	3,696.08		3,696.08
800-89135	Benefits-Other Employee Insurances				1,503.64		1,503.64
800-89140	Benefits-FICA & Medicare	326,327.30		326,327.30	338,744.91		338,744.91
800-89150	Benefits-Unemployment	44,187.22		44,187.22	63,055.11		63,055.11
800-89160	Benefits-401K	19,619.07		19,619.07	17,762.92		17,762.92
800-89170	Benefits-Deferred Comp	6,468.98		6,468.98	6,781.18		6,781.18
800-89180	Benefits-Flex	418.50		418.50	471.50		471.50
800-89190	Benefits-Worker's Comp	181,190.93		181,190.93	229,493.11		229,493.11
800-89200	Benefits-Tuition Reimbursement	1,914.08		1,914.08	7,604.03		7,604.03
800-89210	Benefits-Uniform Allowance	5,601.38		5,601.38	5,100.01		5,100.01
800-89220	Benefits-Employee Appreciation	9,118.82		9,118.82	4,280.95		4,280.95
800-89240	Benefits-Drug Test/Background Checks	645.32		645.32	1,427.83		1,427.83
800-89250	Benefits-Employee Vaccinations				189.95		189.95
	TOTAL BENEFITS	927,905.53	0.00	927,905.53	1,202,011.28	0.00	1,202,011.28
	CAPITAL RELATED COSTS - BUILDING						
	GROUP 01-2						
810-89500	Depreciation & Amortization-Land Improvements	17,291.88		17,291.88	34,321.76		34,321.76
810-89510	Depreciation & Amortization-Building	212,671.10		212,671.10	428,867.15		428,867.15
810-89520	Depreciation & Amortization-Leasehold Improvements	674,512.42		674,512.42	769,313.43		769,313.43
820-89600	Interest-Capital Lease	17,791.81		17,791.81	98,929.50		98,929.50
820-89605	Interest-Lease Contract	326,862.80		326,862.80			
750-84010	Property & Related-Property Taxes	45,722.76		45,722.76	55,210.82		55,210.82
750-84040	Property & Related-Insurance MIP	21,209.76		21,209.76	21,536.01		21,536.01
	TOTAL CAPITAL RELATED COSTS-BUILDING	1,316,062.53	0.00	1,316,062.53	1,408,178.67	0.00	1,408,178.67
	CAPITAL RELATED COSTS - MOVABLE EQUIPMENT						
	GROUP 03-2						
820-89620	Interest-Working Line of Credit	1,190.47		1,190.47	3,743.03		3,743.03
820-89630	Interest-Other	792.90		792.90	502.81		502.81
810-89530	Depreciation & Amortization-Equipment	246,537.68		246,537.68	236,199.83		236,199.83
810-89550	Depreciation & Amortization-Financing Costs	7,657.20		7,657.20			
	TOTAL CAPITAL RELATED COSTS- MOVABLE	256,178.25	0.00	256,178.25	240,445.67	0.00	240,445.67
	TOTAL EXPENSES	11,652,465.18	0.00	11,652,465.18	12,048,543.05	0.00	12,048,543.05
	TOTAL NET (INCOME) LOSS	172,774.17	0.00	172,774.17	1,131,803.29	0.00	1,131,803.29

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 0470 0000 5262 1758
June 10, 2015

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5223024

Dear Mr. Linn:

The above facility was surveyed on May 17, 2015 through May 21, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Susanne Reuss, Unit Supervisor at (651) 201-3793.

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

Please 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.

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00149	A. BUILDING: _____ B. WING _____	05/21/2015

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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On May 17 - May 21, 2015, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Health Regulation Division, Licensing and	2 000 6/24/15 SER	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Alicia Peterson — RN / DON — 6/24/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00149	A. BUILDING: _____ B. WING _____	05/21/2015

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2 000	Continued From page 1 Certification Program, P.O. Box 64900 St. Paul, MN 55164-0900.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 540	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive	2 540		

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2 540	Continued From page 2 resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care as defined in part 4658.0405. Subp. 2. Information gathered. The comprehensive resident assessment must include at least the following information: A. medically defined conditions and prior medical history; B. medical status measurement; C. physical and mental functional status; D. sensory and physical impairments; E. nutritional status and requirements; F. special treatments or procedures; G. mental and psychosocial status; H. discharge potential; I. dental condition; J. activities potential; K. rehabilitation potential; L. cognitive status; M. drug therapy; and N. resident preferences. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to repair side rails in a timely manner for 1 of 1 resident (R58). Findings includes: On 5/18/15, at 11:45 a.m. two half side rails were observed on each side of R58's bed. Upon further inspection the side rails were noted to be firmly attached to the bed at the base of the side rail, but the upper portion of both side rails were noted to wiggle and lean outward away from the bed and were not perpendicular to the mattress. When asked at 11:45 a.m. why R58 had the side	2 540		

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2 540	Continued From page 3 rails R58 replied the rails were to prevent him from falling out of bed. When R58 was asked if they were afraid they would fall out of bed, R58 replied "No." When asked if the side rails helped R58 move about in bed or to get in and out of bed, R58 stated he used the pole (which was placed beside the bed and extended to the ceiling.) At 11:53 a.m. the condition of the side rails was reported to registered nurse (RN)--C, who had no comment. On 5/20/15, at 10:00 a.m. the loose side rails were still observed on the bed. At 10:03 a.m. RN-C was interviewed regarding why the side rails had not been repaired or replaced. RN-C stated the maintenance department had been contacted yesterday about the side rails. RN-C stated the resident did not have a problem with falls, would hang onto the transfer pole and swing himself into and out of bed with staff assist. However, RN-C did not report to the maintenance department the loose side rails until 5/20/15. On 5/21/15, at 9:40 a.m. maintenance staff (MS-E) stated the side rail had been fixed the previous morning (5/20/15.) MS-E stated the request to fix the side rail had been received from the maintenance director. At 10:45 a.m. the maintenance director was interviewed and stated the request to fix R58's side rail had not been received verbally from RN-C until "yesterday" (5/20/15.) On 5/21/15, at 10:50 a.m. R58 stated during an interview that since the side rails were replaced they felt "much better." When asked how safe R58 felt before with the old side rails, R58 stated "not very safe."	2 540		

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2 540	Continued From page 4 R58's care plan updated 8/14/12, revealed R58 used a transfer pole when transferring. That if feeling weak or tired they were to ask for help. Another section of the care plan, updated 5/10/13, revealed R58 could offload when in bed and used one 1/2 side rail to do this for mobility and positioning. The care plan also indicated the following: staff were to ensure assistive devices were available and in good repair to assist in "highest level of function with bed mobility." A fall assessment completed in the electronic health record and dated 4/21/15, revealed R58 was at risk for falls because of unsteadiness, incontinence and impaired mobility. A Brief Interview for Mental Status (BIMS) found in the eHR and completed on 4/21/15, revealed R58 scored 14/15, indicating R58 was cognitively intact. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review policy and procedures, train staff, assess the system, monitor and evaluate to assure that comprehensive assessments are conducted, completed to assure the needs of all residents are identified and met. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 540		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The	2 560		

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2 560	Continued From page 5 comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, document review and interview, the facility did not develop a comprehensive plan of care regarding shaving or facial hair removal for 3 of 4 residents (R17, R117, R102) reviewed for personal cares. Findings include: R17 was observed to have several facial hairs the evening of 5/17/15, and during subsequent days of the survey on 5/18/15 and 5/19/15. The Care Area Assessment (CAA) for Activities of Daily Living (ADL's) functional/Rehabilitation Potential dated 3/9/15, indicated, "Resident is dependent on staff for all ADL's and cares .... Staff will proceed to care plan residents (resident's) dependence on staff and to maintain dignity and cleanliness." The care plan dated 3/18/15, identified R17 had alteration in hygiene/ADL's/shower/bath and directed staff, "I receive a partial bath and a hair wash once a week I am dependent on staff for all hygiene needs. Goals: I would like to be clean and odor-free daily. Interventions ... Staff monitor residents' skin during bath and cares for signs of irritation or breakdown and further evaluates ..." however the care plan did not address shaving facial hair for resident.	2 560		

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2 560	Continued From page 6 R117 care plan lacked interventions regarding shaving. R117 was observed to have several facial hairs the evening of 5/17/15, and during subsequent days of the survey on 5/18/15 and 5/19/15. The CAA dated 2/20/15 indicated, " ... Resident is dependent on staff for all ADL's and is incontinent of bowl and bladder. Staff monitor skin during ADL's and peri-care with any changes reported for further eval (evaluation). Staff will proceed to care plan residents risk for skin break down and to maintain skin integrity." The care plan dated 3/4/15 focused, "Cognition: I am cognitively impaired due to: DX of intra-cerebral hemmorage (hemorrhage) and being vent dependent unable to express my needs much of the time. I can nod to yes or no questions. My memory is difficult to assess due to my communication deficits. My abilities are knowing my family, where I am and time of year. Interventions: Staff will assist in decision making as instructed by the family or resident. Please anticipate my needs". However the care plan did not address shaving facial hair for resident. During an interview on 5/19/15 at 10:24 a.m., licensed practical nurse (LPN)-B verified R17 and R117 were unshaven and stated, there was no reason why R17 and R117 were unshaven and they should have been shaven. LPN-B acknowledged the care plan did not address shaving facial hair for R17 and R117.	2 560		

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2 560	Continued From page 7 On 5/20/15 at 2:22 p.m., registered nurse (RN)-A verified, the care plan did not address shaving for R17 and R117. Policy and procedure titled care planning process, dated revision March 2013, indicated, "1. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment (the MDS of the RAI). ..... 4. Care plans include problems/strengths, long and short-term goals, objectives and expected outcomes, as well as planned interventions, and specific disciplines responsible. This prevents a plan from becoming merely a list of tasks. It provides rationale for planned intervention and the basis for evaluation....." R102's plan of care did not address shaving. R102 was observed on 5/18/15 at 2:38 p.m.,with darker colored facial hair on his cheeks, upper lip,chin and upper neck. R102 indicated he doesn't mind being shaved. A family member (F)-M in the room indicated R102 liked to be clean shaven however, was usually not shaved when visiting. The visitor added another family member visits frequently and always would shave R102 when visiting. On 5/19/15 at 2:00 p.m., a random observation was made and R102's face continued to have long facial hair on entire face. At this time, F-B was visiting and confirmed R102 had not been shaved for a few days and that she would do it. F-C verified R102 is not usually clean shaven when she visits, and frequently shaves R102. R102's care plan, last revised 5/17/15, indicated R102 would like to be clean, neat and well	2 560		

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2 560	Continued From page 8 groomed daily. However the current care plan does not identify personal grooming/shaving needs for R102. On 5/20/15 at 12:00 p.m. the RN-B verified the care plan did not identify personal grooming/shaving needs for R102 and it would be updated as soon as possible. RN-B verified it was the expectation to be shaved daily. Reed, Sheryl Based on observation, document review and interview, the facility did not develop a comprehensive plan of care regarding shaving or facial hair removal for 3 of 4 residents (R17, R117, R102) reviewed for personal cares. Findings include: R17 was observed to have several facial hairs the evening of 5/17/15, and during subsequent days of the survey on 5/18/15 and 5/19/15. The Care Area Assessment (CAA) for Activities of Daily Living (ADL's) functional/Rehabilitation	2 560		

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2 560	Continued From page 9 Potential dated 3/9/15, indicated, "Resident is dependent on staff for all ADL's and cares .... Staff will proceed to care plan residents (resident's) dependence on staff and to maintain dignity and cleanliness." The care plan dated 3/18/15, identified R17 had alteration in hygiene/ADL's/shower/bath and directed staff, "I receive a partial bath and a hair wash once a week I am dependent on staff for all hygiene needs. Goals: I would like to be clean and odor-free daily. Interventions ... Staff monitor residents' skin during bath and cares for signs of irritation or breakdown and further evaluates ..." however the care plan did not address shaving facial hair for resident. R117 care plan lacked interventions regarding shaving. R117 was observed to have several facial hairs the evening of 5/17/15, and during subsequent days of the survey on 5/18/15 and 5/19/15. The CAA dated 2/20/15 indicated, " ... Resident is dependent on staff for all ADL's and is incontinent of bowl and bladder. Staff monitor skin during ADL's and peri-care with any changes reported for further eval (evaluation). Staff will proceed to care plan residents risk for skin break down and to maintain skin integrity." The care plan dated 3/4/15 focused, "Cognition: I am cognitively impaired due to: DX of intra-cerebral hemmorage (hemorrhage) and being vent dependent unable to express my needs much of the time. I can nod to yes or no questions. My memory is difficult to assess due to my communication deficits. My abilities are	2 560		

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2 560	Continued From page 10 knowing my family, where I am and time of year. Interventions: Staff will assist in decision making as instructed by the family or resident. Please anticipate my needs". However the care plan did not address shaving facial hair for resident. During an interview on 5/19/15 at 10:24 a.m., licensed practical nurse (LPN)-B verified R17 and R117 were unshaven and stated, there was no reason why R17 and R117 were unshaven and they should have been shaven. LPN-B acknowledged the care plan did not address shaving facial hair for R17 and R117. On 5/20/15 at 2:22 p.m., registered nurse (RN)-A verified, the care plan did not address shaving for R17 and R117. Policy and procedure titled care planning process, dated revision March 2013, indicated, "1. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment (the MDS of the RAI). ..... 4. Care plans include problems/strengths, long and short-term goals, objectives and expected outcomes, as well as planned interventions, and specific disciplines responsible. This prevents a plan from becoming merely a list of tasks. It provides rationale for planned intervention and the basis for evaluation....." R102's plan of care did not address shaving. R102 was observed on 5/18/15 at 2:38 p.m.,with darker colored facial hair on his cheeks, upper	2 560		

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2 560	Continued From page 11 lip,chin and upper neck. R102 indicated he doesn't mind being shaved. A family member (F)-M in the room indicated R102 liked to be clean shaven however, was usually not shaved when visiting. The visitor added another family member visits frequently and always would shave R102 when visiting. On 5/19/15 at 2:00 p.m., a random observation was made and R102's face continued to have long facial hair on entire face. At this time, F-B was visiting and confirmed R102 had not been shaved for a few days and that she would do it. F-C verified R102 is not usually clean shaven when she visits, and frequently shaves R102. R102's care plan, last revised 5/17/15, indicated R102 would like to be clean, neat and well groomed daily. However the current care plan does not identify personal grooming/shaving needs for R102. On 5/20/15 at 12:00 p.m. the RN-B verified the care plan did not identify personal grooming/shaving needs for R102 and it would be updated as soon as possible. RN-B verified it was the expectation to be shaved daily. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could assure the policy and procedures are reviewed, revised as needed, staff trained and systems assessed, monitored and evaluated to assure the comprehensive plan of care is developed and lists measurable objectives and timetables to meet each residents individual needs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use	2 565		

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2 565	Continued From page 12 Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Citation Text for Tag 0282, Regulation FF09 Reed, Sheryl Based on observation, interview and document review, the facility failed to provide services in accordance with the residents written plan of care for 2 of 2 residents (R87, R83) for assist with shaving and for not receiving activities. Findings include: R87's care plan, dated 4/15/15 indicated R87 could no longer complete grooming tasks on his own and wanted his grooming needs to be anticipated and met for me by staff. Interventions included staff assist/maintain electric razor cleaning after each use and weekly per protocol. R87 was observed on 5/17/15 at 7:12 p.m. with approximately 5/8 inch long dark and light facial hairs on his checks, chin, upper lip and upper neck area. The following day 5/18/15, at 2:30 p.m., the facial hair remained on R87's face. On 5/19/15 during random observations from 7:10 a.m. to 10:30 a.m., the facial hair remained on R87's face. On 5/19/15 at 12:30 p.m., nursing assistant (NA)-I verified she did not get to shave R87 during the shift.	2 565		

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2 565	Continued From page 13 On 5/19/15 at 2:45 p.m., the registered nurse coordinator (RN)-B was informed R87 had not been shaved since 5/17/15. The care plan was reviewed with RN-B who explained that the nursing assistant should have incorporated the shave during the day as it was the expectation residents are shaved daily. R83 did not receive activities as directed by the plan of care. Document review of the activity plan of care, dated 4/10/14, Directed staff: Quality of Life: Continuing these activities I did prior to admission are important to me; I like this type of music:Rap, I like these types of TV programs; Sitcom, Movies; Action, like the pirates of the Caribbean. During an observation on 5/17/15, at 3:00 p.m. at 7:00 p.m., R83 was laying in bed on the right side. Eyes were open but there was no response to verbal communication. There was no radio, no television, no CD and no books on tape playing. During an observation on 5/18/15, at 9:00 a.m., 10:48 a.m. and 1:00 p.m., R83 was laying in bed on the right side. Eyes were open but there was no response to verbal communication. There was no radio, no television, no CD and no books on tape playing. When interviewed on 5/18/15, at 11:32 a.m. Family member (F)-A expressed being "upset and discouraged" because R83 is not involved in activities as much as possible and F-A would like to see R83 "more involved." F-A expressed R83 being so young and involved with music, movies, and videos, which were a big part of R83's life, which should still be a part of his life. F-A verified	2 565		

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2 565	Continued From page 14 the facility was aware and F-A talked about activities in the March 2015 care conference. F-A has several family members who visit frequently and have expressed concern because they are not seeing activity involvement. During observation on 5/18/15, at approximately 1:30-2:30 p.m. movie Happy Gilmore was showing in the dining room. R83 did not attend the movie. During an interview with the activity aide (AA)-A on 5/19/15 at 9:42 a.m. revealed R83 has a volunteer visitor who comes every two weeks for hand massage but AA-A is not sure of the sensory stimulation for R83 and exactly what he would benefit from because stated, "I am not sure what [R83] can comprehend." Furthermore AA-A expressed not being sure about R83 being in a crowded group setting and stated, "We do not know if [R83] can see anything or what the brain is doing." AA-A verified R83 was not brought to group setting activities and that the nursing staff should be turning on the television and music for R83. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one	2 565		

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2 565	Continued From page 15 (21) days.	2 565		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Citation Text for Tag 0280, Regulation FF09 Based on interview and record review, the facility failed to update the care plan for 1 of 3 residents (R163) with a pressure ulcer, 1 of 3 residents (R102) with falls and1 of 3 residents (R87) with therapy recommendations. Findings include: A Comprehensive Evaluation of Skin Inspection and Risk Factors was completed in R163's electronic health record (eHR) on 5/14/15. The assessment revealed R163 had been admitted to the facility with a scar on the coccyx, which measured 2.5 x 3.5 centimeters and which was the result of previous pressure ulcers. An eHR progress note dated 5/14/15, at 9:38 a.m., noted	2 570		

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2 570	Continued From page 16 R163 was admitted with Mepilex in the coccyx area "over a fragile area. Area is closed." Another eHR progress note dated 5/15/15, at 11:11 p.m. revealed there was an "excoriated skin on coccyx." The undated temporary care plan indicated R163 was to be turned and repositioned by one to two staff every two hours and when necessary. However, the temporary care plan was not updated after identification of a new pressure ulcer in the coccyx area which was noted on 5/18/15. On 5/18/15, at 2:45 p.m. R163 was observed receiving perineal care by nursing assistants (NA)-A and NA-H. R163 was noted to be incontinent of stool and an open area was noted on the coccyx area. NA-A and NA-H verified the open area on the resident's coccyx. At 2:50 p.m. the assistant director of nurses (ADON) was informed and verified the presence of the open area on the coccyx. The resident's physician was also present at the time and the ADON reported the open area to the physician, who ordered a Mepilex sponge dressing to the area. On 5/19/15, at 10:55 a.m. the ADON stated the temporary care plan had been updated to reflect R163's new coccyx pressure ulcer. However, upon review of the temporary care plan the coccyx pressure ulcer was not identified. At 11:00 a.m. the ADON reviewed the temporary care plan and had no comment regarding the temporary care plan not having been updated. R102's plan of care was not updated with a	2 570		

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2 570	Continued From page 17 therapy recommendation. On 5/17/15 at 5:43 p.m., during staff interview, the registered nurse (RN)-B reported R102 had a contracture of the left arm and wore a left elbow extension orthotic. During random observation on 5/18, and 5/19/ 2015, R102 did not wear a left elbow brace. On 5/18/15 at 2:40 p.m. R102 was sitting in Broda chair in room watching television and visiting with a family member (F)-M. F-M reported R102 did not wear any splint on the left arm and he was not sure why. On 5/19/15 at 2:40 p.m., R102 was sitting in room in Broda chair. Another family member (F)-N was visiting and R102 had a rectangular brown pillow under the left elbow and between the lower arm and chest wall. F-N was unsure where the elbow splint was. Discharge summary for occupational therapy (OT), dated 4/30/15, was reviewed. The summary indicated R102 "requires maximum physical assistance to appropriately donn, doff bilateral hand and wrist orthotics and left elbow brace ... " and " ... Mother and staff will carry over with elbow orthotic and all staff have been placing arm straps on per program already in place. " A review of the most current care plan lacked evidence the information from OT had been added to the care plan. The care card used by the nursing assistants to direct resident care, lacked any information or update regarding the use of the elbow orthotic. On 5/20/15 at 12:00 p.m. the RN-B verified it appeared the splint was not being used daily and it had not been added to the care plan or care cards for the nursing assistants. RN-B indicated it must have been missed. The RN-B indicated it would also be added. Resident 87 did not have an updated care plan	2 570		

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2 570	Continued From page 18 for a fall with an injury. On 5/17/15 at 7:13 p.m., RN-B reported R87 currently had a fractured right humerus and was wearing a sling for the right arm. R87 had a fall on 5/3/15 at 1:30 a.m. in his room which resulted in a fracture of the right humerus. R87 had another fall on 5/10/15 from the bed to the floor. No injury was reported A review of the facility's Unusual Occurrence Report was completed. The form was dated 5/3/15 and indicated the resident was found on the floor in the resident's room. R87 was sent to the hospital for evaluation and treatment of a fractured right humerus. A post fall assessment was completed and other interventions were developed. They included: therapy to evaluate the use of a transfer pole, and place bed in a low position. A review of the current care plan indicated the transfer pole was being reevaluated and on 5/17/15 the following intervention was added: to keep bedroom door racked open at night and try to keep surrounding area quiet to assist with sleeping. The care plan was not updated to include the injury of the fractured right humerus, or other interventions to direct staff care. The care plan did not include care for the sling, when it was to be worn or removed etc. On 5/20/15 at 2:50 p.m. RN-B reviewed the interventions and the care plan and agreed it had not been updated to include the injury and care and services needed. In addition, a review of the current care plan lacked evidence of R87 having a contracted right arm and wrist. A 5/8/2013 entry identified R87 had a "Special Accommodation" request indicating he was aware of the risks and benefits to not follow normal facility protocol regarding the right upper arm brace and wrist splint. An	2 570		

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2 570	Continued From page 19 intervention indicated the accommodation agreement would be reviewed at least quarterly, upon return from hospital or change in condition. The nursing assistant care card (used to direct residents care) directed statt that R87 had a right hand orthotic to be worn during the day. The medical record lacked any evidence of regular review of the accommodation. No documentation of refusal of wearing the orthotic or specific interventions for the contracted areas. During interview, on 5/17/15 at 7:13 p.m., the registered nurse (RN)-B indicated R87 had a contracture on right arm, however the splint was not being worn. RN-B reported R87 currently had a fractured right humerus and was wearing a sling for the right arm. During random observations on 5/17/15 and on 5/19/15 from 7:10 a.m. to 10:20 a.m., R87 sat in the wheelchair in the dining room during the breakfast meal and then in the hallway. R87 would self propel wheelchair short distance such as back into dining room, but would then return to hallway by the nursing station. There was no evidence of a right hand/wrist orthotic being worn. On 5/20/15 at 1:00-2:30 p.m., R 87 was not wearing a right wrist orthotic. On 5/20/15 at 11:23 a.m. the occupational therapist (OT)-B verified R87 has a contracted right wrist and was to be using a hand pillow with finger separators and a right hand resting splint. When asked, OT-B indicated R87 could still use the orthotic while wearing the sling for the fractured humerus. On 5/20/15 at 2:15 p.m. the licensed practical nurse (LPN)-C indicated the resident didn't wear a splint, as he would refuse it. On 5/20/15 at 2:32 p.m. nursing assistant (NA)-J reported not seeing anything for his hand since working on unit. On 5/21/15 at 11:00 a.m. RN-B confirmed the	2 570		

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2 570	Continued From page 20 findings and added R87 would refuse the finger separator and wrist/hand orthotic. RN-B agreed the care plan had not been revised or updated to identify interventions. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to care plan revisions. The DON or designee, could provide training for all nursing staff related to the timeliness of care plan revisions. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to assure enough staff were available to meet the needs for residents	2 800		

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2 800	Continued From page 21 residing on the 2nd floor. This affected 2 of 7 residents (R17 and R117) residents on the unit and had the potential to affect all residents on the unit of the 111 residents that resided in the facility. Findings includes: R17 was observed to have several facial hairs the evening of 5/17/15, and during subsequent days of the survey on 5/18/15 and 5/19/15. On 5/17/2015 at 5:48 p.m. during an attempt to interview R17, was observed to have several gray/white facial hairs to the upper lip and the chin area approximately one half inch long. Resident was unable to communicate her needs when queried. On 5/18/15 at 8:51 a.m. and 11:45 a.m. observed R17 in her room lying in bed covered with a white sheet observed to still have numerous facial hairs. On 5/19/2015 at 7:39 a.m. noted R17 lying in bed with facial hair or unshaven during continuous observations while nursing assistant (NA)-F gave peri-care: -At 7:55 a.m. was left in bed without been shaven by NA-F. -At 10:04 a.m. observed NA-F repositioned R17 in bed then NA-F left the room. R117 was witnessed to have several facial hairs the evening of 5/17/15, and during subsequent days of the survey on 5/18/15 and 5/19/15. On 5/17/2015 at 5:48 p.m. during an effort to interview R117, was detected to have quite a lot of gray/white facial hairs to the upper lip and the chin area. Resident was unable to communicate his needs when queried. On 5/18/15 at 9:01 a.m. and 11:43 a.m. observed R117 in his room sitting up in his wheelchair by the bed unshaven. On 5/19/2015 at 7:39 a.m. noted R117 lying in bed with facial hair and while sitting in his wheelchair at 10:27 a.m. unshaven.	2 800		

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2 800	Continued From page 22 During an interview with family member (F)-Z for R117 on 5/18/15 at 2:42 p.m. stated, on one occasion her husband had to wait for approximately 15 to 20 minutes for assistant with changing wet diaper. During an interview on 5/19/15 at 10:24 a.m. with licensed practical nurse (LPN)-B verified R17 and R117 were unshaven and stated, there was no reason why R17 and R117 were unshaven and they should have been shaven. Nursing assistants are busy and we had many call-ins and I should not use that as an excuse. We don't have enough staff here, but I will tell the nurse assistants to shave them. I don't know if the nursing assistant don't need money or not" During interview with NA-F on 5/19/15 at 10:37 a.m. verified that R17 and R117 were unshaven because she was busy due to insufficient nursing assistant staffing and they are always short of nursing assistant. Further stated, "It is very difficult to complete the resident ADLs as required and at times I do not take lunch breaks." NA-F was in tears and point out, she always emotional when talking about this residents because they need help and deserve better. Will go ahead shave R17 and will try to shave R117 because at times R117 would not let them shave him. In addition, NA-F indicated, "I will not bring my family member here because they don't have enough staff." During interview with NA-G on 5/20/15 at 11:48 a.m. stated, "Staffing is trebling, the care cards are not updated with resident's activities of daily living (ADL) such as Hoyer lift. I do not feel they have sufficient staffing in the building. I feel like they have potential to have more staff but we have no call no show and they still work here and	2 800		

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2 800	Continued From page 23 the policy is not been followed that is why staff who does no call no show continue to do what they are doing." During an interview with NA-H on 5/20/15 at 2:29 p.m. stated was worried and uncomfortable as a student nursing assistant who get pull and assigned for 1 on 1 with resident without being supervised and sometimes does not take her half an hour breaks. In addition, indicated, "There is not enough staff here to care for the resident or give quality of care." Miller, Sue On 5/17/15, at 2:00 p.m. a resident's family member approached the surveyor and stated there was not enough staff on during the meal times. The family member stated her relative was not always being fed, despite sitting at a feeding table. The family member stated staff would walk past the resident give the resident a bite to eat, but did not sit down to feed. On 5/20/15, at 10:01 a.m. registered nurse (RN-C) stated once in awhile, but not recently, there may not be enough staff, so supervisors would pull staff from either the memory care unit or RN-C would help out on the floor. On 5/20/15, at 10:30 a.m. nursing assistant (NA-D) stated they can "barely" get all their work done. Stated "to be honest with you, these people don't get checked and changed every two hours. It's impossible to do it." NA-D stated they had worked at the facility for a number of years and this is the "worst" staffing has been. On 5/21/15, at 11:30 a.m. the staffing coordinator stated they were well aware that some of the newly hired nursing assistants, who had not taken	2 800		

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2 800	Continued From page 24 their nursing assistant test, were not allowed to work on a unit by themselves. The staff coordinator stated they made sure the newly hired nursing assistants were working with another nursing assistant. The staffing coordinator stated they did not know what the supervisor did if there were sick calls, but "Hope they follow my schedule." At 11:40 a.m. the staffing coordinator stated "we are short staffed." When asked about contacting a temporary agency for assistance the staffing coordinator stated "Corporate won't allow it." On 5/21/15, at 12:44 p.m. housekeeper (HK-A) stated there had been times when nursing assistants had not been observed to take a break so they could get all of their work done. Reed, Sheryl On 5/18/15 at approximately 10:00 a.m. family member (F)-B reported the staff seem short and overworked; everyone looks tired. During the winter it was worse, they didn't seem to have a plan for when people called in or when they couldn't get in to work. On 5/19/15 AT 8:12 A.M. LPN-G indicated the unit she was working on was pretty busy and would prefer to work with three nursing assistants. Some days there are only two. It was also pretty rough during the winter; there were a lot of changes going on, the facility was hiring but not very many applications. On 5/19/15 at 12:12 p.m. NA-I reported the unit she was working on was heaven compared to the other units. This unit use to have two nursing assistants, but now it just has one. I get all my work done to the best I can, NA-I reported the	2 800		

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2 800	Continued From page 25 shaves on the unit did not get done today as I just didn't have time. NA-I also stated another resident had just gotten out of bed because of not having enough time earlier and that resident required two staff people The nursing assistant indicated she took a break but not a lunch break, "there is just too much to do" On 5/19/15 at 12:46 p.m. LPN-I indicated the morale at the facility was poor. LPN-I added that she cuts her breaks short so she can get her work done and added she stays late often. LPN reported she doesn't feel she can give the care she knows she can give and added it was hard to get everything done. On 5/20/15 at 3:30 p.m. LPN-D reported working a recent weekend and the unit was so short. The whole building was short so you couldn't pull from any where. LPN-D said "that evening I could not get all my treatments done, and I worked over into midnights to get my charting done." When LPN-D informed the director of nursing she was told "corporate would rather get a tag from the health department then get pool in here". LPN-D added some of the medication passes on units were so heavy it cannot be completed within the 2 hour window of time. When asked if this information was passed on to administration, the LPN-D reported no one complains because they wont do anything about it. On 5/20/15 at 9:10 a.m. the staffing coordinator (SC) indicated she has to be creative with the staffing. She implied if there is no one slotted for the open shift (Holes) staff will pick up for a few hours and then get someone to come in early. For sick calls, the staffing coordinator indicated she will reposition some staff or call the other shift person to come in early or contact those who may	2 800		

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2 800	Continued From page 26 have signed up to pick up. The SC verified the facility does not use pool and they do not mandate staff to work. The SC indicated people were working a lot of extra hours and added the whole community is short. The upcoming weekend had at least 17 holes in the schedule at this time. The SC indicated the upcoming weekend was the hardest to fill. If I cant get all shifts covered, I inform the director of nursing and she works her magic. On 5/21/15 at 9:58 a.m. the director of nursing (DON) was interviewed regarding staffing. The DON reported she will hear from families regarding staffing concerns, but indicated not having any for awhile. The DON explained she recently went to a family care plan because of some of the concerns expressed by the family. The DON added she wants to look into a position that would do certain activities such as pass water, talk to the residents, get people to activities and free up nursing staff. When asked about how did nursing ensure residents were getting the needed care, the DON replied there is a supervisor on the evenings and nights, and the units have nurse managers. The nurses on the unit are responsible for care card updates. The DON indicated there was no system or audit system in place to ensure all work is getting completed. The nurses on the units should inform the managers. The don was unaware of results from any family/customer satisfaction surveys. The don was unaware of any further grievances regarding the staffing and to contact the facility social worker. On 5/21/15 at 10:32 a.m., the social worker reviewed recent grievances received with the surveyor. 1. Family member (F)-D filed a concern form on 4/30/15. The report indicated	2 800		

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2 800	Continued From page 27 F-D for R147 reported R147 had called home as he wanted the bed pan. The call light had been on for over an hour. When F-D called the nursing station, the phone rang 12-14 times with no answer. When F-D arrived at the unit, only 1 staff member was available. F-D other comments included R147's call light is frequently on for 1 hr plus before a call is answered. 2. Family member (F-E) for R126 filed a grievance concern on 12/1/14. F-E had multiple complaints and concerns about care for R126 including care for "halo" care, positioning, oral care and working equipment. R126 moved from facility before a meeting could be scheduled to reconcile. 3. A visitor for R147 filed a concern on 5/8/15. The visitor was concerned as family member (F)-D upset as unit had lots of call lights on and R147 had to wait 45 minutes again for call light to be answered and a new ordered medication was not available for R147. Staffing policy was requested but not provided. A review of the Daily Staffing hours posted for 5/9/15 indicated resident census was 112. The posting indicated on the day shift from 6 a.m. to 2 p.m the total number of nursing assistants (NA's) was 14 for a total number of hours worked. A review of the actual working day schedule revealed three call ins of nursing assistants. The allocation sheet indicated there were 11 NA's working a total of 88 hours. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could monitor, assess and evaluate to assure necessary staffing is provided to assure the	2 800		

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2 800	Continued From page 28 needs of residents are met. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 800		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide the appropriate tracheotomy care to 1 of 2 ventilator dependent residents (R163) during tracheostomy care. Findings include: Appropriate hand hygiene was not followed during observation of a tracheotomy dressing change for R163. On 5/19/15, starting at 9:44 a.m. licensed practical nurse (LPN-B) was observed to wash	2 830		

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2 830	Continued From page 29 their hands and don gloves. LPN-B then proceeded to complete a gastrostomy tube (GT) dressing change for R163. However, LPN-B did not complete the GT dressing change before beginning the tracheotomy dressing change for the resident. Still wearing the same soiled gloves, LPN-B removed the old gauze pad from around the tracheotomy tube, soaked a new gauze pad with normal saline and cleanse around the tracheotomy tube. LPN-B then removed the soiled gloves and washed their hands before donning new gloves and placing a new gauze pad around R163's GT site. Then without removing their gloves and washing their hands, LPN-B proceeded to open a new gauze package and place a new gauze pad around the tracheotomy tube. LPN-B stated R163 had been admitted with a sore around the neck and upon observation a dime size open area was noted to the right of the tracheotomy, with no drainage present. On 5/20/15, at 10:46 a.m. LPN-B was interviewed regarding the lack of hand hygiene between dressing changes for R163. LPN-B stated they thought "you always went from dirty to clean" and since the treatment was for dressing removals, the dirty part was done first. The facility's Gastrostomy/Jejunostomy Site Care policy dated 2/2014, revealed glove removal and hand washing was to occur after GT cleansing. The facility's Tracheotomy Care policy dated 3/2014, revealed that after the old tracheotomy dressing was removed, gloves were to be removed and hands washed. The policy further	2 830		

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2 830	Continued From page 30 indicated that gloves were to be worn when placing a new gauze pad around the stoma site, then removed and hands washed. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and revice policies and procedures related to hand hygiene with vent residents, monitoring and care, and could provide staff education related to the care of resident related to hand hygiene with vent residents. The director of nursing or designee could develop an audit tool to ensure appropriate care is provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by:	2 895		

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2 895	Continued From page 31 Citation Text for Tag 0318, Regulation FF09 Lacina, Mary Beth Based on observation, interview and document review the facility failed to provide nursing rehabilitative services for 3 of 3 resident (R83, 87, R102) reviewed for rehabilitative services to maintain or increase range of motion (ROM) Findings include: The facility did not coordinate the plan of care between therapy and nursing to provide range of motion (ROM) for R83. During an observation on 5/19/15, at 7:20 a.m. R83 was receiving perineal cleansing from nursing assistants NA-F and NA-K who seemed to be struggling to separate R83's legs for the cares. Both NA's encouraged R83 to "relax your legs." When interviewed on 5/18/15, at 11:32 a.m. Family member (FM)-A expressed being "discouraged," because it did not seem like the range of motion was being completed for R83 and FM-A expressed thinking R83 was "stiffer and tighter" in the arms and legs. Furthermore, FM-A revealed expressing concerns about R83's ROM at the last care conference in March 2015. During interviews with nursing assistants NA-F and NA-K on 5/19/15, at 10:50 a.m. both thought that the therapy department was providing ROM for R83. During interviews with licensed practical nurse (LPN)-B and LPN-H both thought nursing did not do ROM for R83 because therapy provided the ROM program for R83. Document and electronic medical record (eMR)	2 895		

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2 895	Continued From page 32 review, revealed R83 was admitted to the facility on 11/21/13. The active diagnoses from R83's plan of care, dated 5/19/15, listed, but was not limited to tracheostomy, septicemia, endocarditis, and unspecified intracranial hemorrhage. The Minimum Data Set (MDS) assessment dated 4/29/15, indicated under section B Hearing , Speech and Vision, read; Comatose, Persistent vegetative state/no discernable consciousness. R83 was assessed on the quarterly Minimum Data Set (MDS) on 1/28/15, as severe cognition impairment and unable to answer questions. The document titled, PT-Therapist Progress and Discharge Summary read, End of Care 4/23/15, ROM [range of motion] ankle. Goal-The patient will tolerate PROM [passive range of motion] and stretching program in order to increase B [bilateral] LE [lower extremity] ext. [extension] to -15 degrees and hip ext PROM to neutral and maintain B ankle DF [dorsi-flexion] to effective and safe positioning in bed and prevent development of contracture's. Precautions, high risk for contracture's and skin breakdown due to complete dependence for mobility, Cardiac precautions. Wakeful Unresponsive state. Discharge plan and instructions D/C [discharge] to same SNF [skilled nursing facility] with staff management of positioning. The physical therapist (PT)-A responsible for the therapy discharge was interviewed on 5/19/15, at 11:30 a.m. and verified nursing should have been given a referral to continue with PROM and does not know if the facility form was completed. The facility form was asked for from medical records but not received. The director of nursing (DON) was interviewed on	2 895		

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2 895	Continued From page 33 5/20/15, at 8:50 a.m. and verified R83 should have received passive range of motion from the nursing staff and the ROM should be added to the plan of care. Reed, Sheryl On 5/17/15 at 7:13 p.m. the RN-B indicated R87 had a contracture on right arm, however the splint was not being worn and R87 had a right humerus fracture. During random observations on 5/17/15 and on 5/19/15 from 7:10 a.m. to 10:20 a.m. R87 sat in the wheelchair in the dining room during the breakfast meal and then in the hallway. R87 would self propel wheelchair short distance such as back into dining room, but would then return to hallway by the nursing station. There was no evidence of a right hand/wrist orthotic. On 5/20/15 at 1:00-2:30 p.m. R 87 was not wearing a right wrist orthotic. The annual minimum data set (MDS) dated 3/5/15 indicated R87 was admitted with diagnoses that included cerebral vascular accident, traumatic brain injury and dementia. The MDS indicated R87 had no impairment of upper/lower extremities and needed extensive assistance with activities of daily living. Current physician orders indicated a diagnoses of contracture of joint of multiple sites. R87 had an physician order for "right hand/wrist orthotic to be worn during the day 0800-2000 as tolerated. staff to apply during morning cares and removed at bedtime. Check skin each shift." A review of the current care plan lacked evidence of R87 having a contracted right arm and wrist. A 5/8/2013 entry identified R87 had a "Special Accommodation" request indicating he was aware of the risks and benefits to not follow normal facility protocol regarding the right upper arm brace and wrist	2 895		

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2 895	Continued From page 34 splint. An intervention indicated the accommodation agreement would be reviewed at least quarterly, upon return from hospital or change in condition. The nursing assistant care card (used to direct residents care) indicated R87 had a right hand orthotic to be worn during the day. The medical record lacked any evidence of regular review of the accommodation. No documentation of refusal of wearing the orthotic was provided. On 5/20/15 at 11:23 a.m. the occupational therapist (OT)-B verified R87 has a contracted right wrist and was to be using a hand pillow with finger separators and a right hand resting splint. OT-B indicated nursing staff had been provided with written information to apply the orthotic. When asked, OT-B indicated R87 could still use the orthotic while wearing the sling for the fractured humerus. OT-B added the facility would benefit from having a restorative nursing program. On 5/20/15 at 2:15 p.m. the licensed practical nurse (LPN)-C indicated the resident didn't wear a splint, as he would refuse it. On 5/20/15 at 2:32 p.m. nursing assistant (NA)-J reported not seeing anything for his hand since working on unit. On 5/21/15 at 11:00 a.m. RN-B confirmed the findings and added R87 would refuse the finger separator and wrist/hand orthotic. RN-B agreed the care plan was not being followed and the team would have to review the use of the orthotic. R 102 On 5/17/15 at 5:43 p.m. during staff interview, the registered nurse (RN)-B reported R102 had a contracture of the left arm and wore a left elbow extension orthotic. During random observation on 5/18, and 5/19/2015, R102 did not wear a left elbow brace. On 5/18/15 at 2:40 p.m. R102 was sitting in Broda	2 895		

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2 895	Continued From page 35 chair in room watching television and visiting with F-M. F-M reported R102 did not wear any splint on the left arm and he was not sure why. On 5/19/15 at 2:40 p.m., R102 was sitting in room in broad chair. F-N was visiting and R102 had a rectangular brown pillow under the left elbow and between the lower arm and chest wall. F-N was unsure where the elbow splint was. A review of the initial minimum data set (MDS) dated 11/20/14 indicated the resident had diagnoses that included quadriplegia and traumatic brain injury. The MDS also indicated R102 was totally dependent on staff for all personal hygiene/shaving and had functional limitations in range of motion in upper and lower sides bilaterally. Discharge summary for occupational therapy (OT), dated 4/30/15, was reviewed. The summary indicated R102 "requires maximum physical assistance to appropriately donn, doff bilateral hand and wrist orthotics and left elbow brace ..." and "... Mother and staff will carry over with elbow orthotic and all staff have been placing arm straps on per program already in place." A review of the most current care plan lacked evidence the information from OT had been added to the care plan. OT had provided a summary and print out of pictures on how to apply the elbow orthotic correctly to the left arm of R102. This information was placed in an information book on the unit. There was no indication as to who may have read the information. The "care cards" used by the nursing assistants too provided information on how to care for the residents, lacked any information or update regarding the use of the elbow orthotic. On 5/20/15 at 9:40 a.m. the occupation therapist indicated a new elbow orthotic had just been obtained for him., it had been fitted to R102 specifically and would have been more	2 895		

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2 895	Continued From page 36 comfortable. Staff had been trained to apply it. On 5/20/15 at approximately 10:30 a.m. the RN-B and Licensed practical nurse (LPN)-G searched room for the elbow extension orthotic and found it in a bottom dresser drawer. On 5/20/15 at 12:00 p.m. the RN-B verified it appeared the splint was not being used daily and it had not been added to the care plan or care cards for the nursing assistants. RN-B indicated it must have been missed. The RN manager indicated the care plan and care cards would be updated. SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review and revise the policies and procedures for range of motion programs, educate the appropriate personnel in any changes and appoint a designee to monitor the procedures to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by:	2 920		

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2 920	Continued From page 37 Based on observation, interview and document interview the facility failed to provide personal hygiene care for 4 of 4 residents (R17, R117, R87 and R102) who were dependent upon staff for personal cares. Findings Include: R17 was observed to have several facial hairs the evening of 5/17/15, and during subsequent days of the survey on 5/18/15 and 5/19/15. R17's clinical record noted R17 was admitted to facility on 3/3/11, and had diagnoses, which included respiratory ventilator, anoxic brain damage, cognitive impaired, urinary obstruction, and hypertension. Medication that included Paxil, oxycodone and phenytoin. R17's discharge Minimum Data Set (MDS) dated 3/13/15, identified R17 required total assist with bed mobility, transfers, dressing, toileting, bathing and personal hygiene needs. The Care Area Assessment (CAA) for Activities of Daily Living (ADL's) functional/Rehabilitation Potential dated 3/9/15, indicated, "Resident is dependent on staff for all ADL's and cares .... Staff will proceed to care plan residents (resident's) dependence on staff and to maintain dignity and cleanliness." The care plan dated 3/18/15, identified R17 had alteration in hygiene/ADL's/shower/bath and directed staff, "I receive a partial bath and a hair wash once a week I am dependent on staff for all hygiene needs. Goals: I would like to be clean and odor-free daily. Interventions ... Staff monitor residents' skin during bath and cares for signs of irritation or breakdown and further evaluates ..."	2 920		

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2 920	Continued From page 38 however the care plan did not address shaving facial hair for resident. On 5/17/2015 at 5:48 p.m., during an attempt to interview R17, she was observed to have several gray/white facial hairs to the upper lip and the chin area approximately one half inch long. Resident was unable to communicate her needs when queried. On 5/18/15 at 8:51 a.m. and 11:45 a.m. R17 was observed in her room laying in bed covered with a white sheet and was observed to still have numerous facial hairs. On 5/19/2015 at 7:39 a.m., nursing assistant (NA) -F was observed to complete R17's peri cares. At 7:55 a.m., R17 was left in bed without been shaven by NA-F. R117 was witnessed to have several facial hairs the evening of 5/17/15, and during subsequent days of the survey on 5/18/15 and 5/19/15. R117's clinical record noted R117 was admitted to facility on 2/11/15, and had diagnoses, which included respiratory failure, chronic airway obstruction, muscle weakness, hypertension, diabetes type II. Medication that included Lasix and insulins. R117's quarterly MDS dated 4/16/15 recited, "rarely/never understood, sometimes understands." Identified R117 required total assist with bed mobility, transfers, dressing, eating, toileting, personal hygiene and bathing activities. The CAA dated 2/20/15 indicated, "... Resident is dependent on staff for all ADL's and is incontinent of bowl and bladder. Staff monitor skin during	2 920		

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2 920	Continued From page 39 ADL's and peri-care with any changes reported for further eval (evaluation). Staff will proceed to care plan residents risk for skin break down and to maintain skin integrity." The care plan dated 3/4/15 focused, "Cognition: I am cognitively impaired due to: DX of intra-cerebral hemmorage (hemorrhage) and being vent dependent, unable to express my needs much of the time. I can nod to yes or no questions. My memory is difficult to assess due to my communication deficits. My abilities are knowing my family, where I am and time of year. On 2/18/15 my BIMS assessment indicates severely impaired as I am rarely able to express myself. Interventions: Staff will assist in decision making as instructed by the family or resident. Please anticipate my needs". On 5/17/2015 at 5:48 p.m. during an effort to interview R117, was detected to have quite a lot of gray/white facial hairs to the upper lip and the chin area. Resident was unable to communicate his needs when queried. On 5/18/15 at 9:01 a.m. and 11:43 a.m., R117 was observed in his room sitting up in his wheelchair by the bed unshaven. On 5/19/2015 at 7:39 a.m., R117 was laying in bed with facial hair. During an interview on 5/19/15 at 10:24 a.m., licensed practical nurse (LPN)-B verified R17 and R117 were unshaven and stated, there was no reason why R17 and R117 were unshaven and they should have been shaven. "Nursing assistants are busy and we had many call-ins and I should not use that as an excuse. We don't have enough staff here, but I will tell the nurse	2 920		

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2 920	Continued From page 40 assistants to shave them. I don't know if the nursing assistant don't need money or not" During interview on 5/19/15 at 10:37 a.m., NA-F verified that R17 and R117 were unshaven because she was busy due to insufficient nursing assistant staffing and they are always short of nursing assistants. Further stated, "It is very difficult to complete the resident ADLs as required and at times I do not take lunch breaks." NA-F was in tears and pointed out, she was always emotional when talking about residents because they need help and deserve better. "Will go ahead shave [R17] and will try to shave [R117] because at times [R117] would not let them shave him." In addition, NA-F indicated, "I will not bring my family member here because they don't have enough staff." During interview with registered nurse (RN)- A on 5/19/15 at 10:51 a.m., verified that R17 and R117 had facial hair or were unshaven and stated, "My expectation is, residents were supposed to be shaved daily." On 5/20/15 at 2:22 p.m. RN-A indicated, the care plan does not address shaving R17 and R117. Policy and procedure titled nursing care standards dated July 2013, reads, "Assistance with or supervision of shaving residents as necessary to keep them clean and well groomed. Each resident should have their own shaving equipment." Reed, Sheryl R87 needed assistance from staff for grooming/shaving and was not provided facial hair removal. R87 was observed on 5/17/15 at 7:12 p.m. with approximately 5/8 inch long dark and light facial	2 920		

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2 920	Continued From page 41 hairs on his checks, chin, upper lip and upper neck area. The following day 5/18/15, at 2:30 p.m. the facial hair remained on R87's face. On 5/19/15 during random observations, the facial hair remained on the resident's face. The annual MDS dated 3/5/15 identified diagnoses included cerebrovascular accident, dementia and traumatic brain injury and aphasia (inability to express and understand language). The MDS indicated R87 needed extensive assist with personal hygiene. R87's care plan, dated 4/15/15 indicated R87 could no longer complete grooming tasks on his own and wanted his grooming needs to be anticipated and met for me by staff. Interventions included Staff assist/maintain electric razor cleaning after each use and weekly per protocol. On 5/19/15 at 12:30 p.m. the nursing assistant (NA)-I verified she did not get to shave R 87 during the shift. The nursing assistant indicated R87 does like to get a shave so it should not be a problem the next day. On 5/19/15 at 2:45 p.m. the registered nurse coordinator (RN)-B was informed R87 had not been shaved since 5/17/15 and on what the care plan directed staff. RN-B Indicated the nursing assistant should have incorporated the shave during the day. RN-B also verified the care plan does not direct staff on grooming R87 daily, and added, it somehow was missed when care plan developed. R87 was not provided with toileting care and was incontinent of bowel. On 5/19/15 at 7:10 a.m,. R87 was sitting in a Broda wheelchair at the dining table waiting for breakfast to be served. R87 sat at the table throughout breakfast and until 8:45 a.m. when was moved to the hallway. R87 sat in the wheelchair in the hallway. Carpets were being cleaned so he would move from area to another	2 920		

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2 920	Continued From page 42 area by the assistance of staff. At approximately 10:30 a.m. the licensed practical nurse (LPN-C) took R87 to his room. With staff assistance, R87 was able to stand up using a transfer pole. R87 was incontinent of stool. LPN-C provided pericare and applied a clean brief to R87 while standing at the transfer pole. R87's skin was red with deep creases and wrinkles. The annual minimum data set (MDS) dated 3/5/15 identified diagnoses included cerebrovascular accident, dementia and traumatic brain injury and aphasia (inability to express and understand language). The MDS indicated R87 needed extensive assist with all activities of daily living including transfers and toileting. The MDS indicated the R87 was incontinent of bowel and bladder. The current care plan directed staff to toilet upon rising, before and after meals and at hour of sleep. On 5/19/15 at 10:35 a.m., LPN-C confirmed resident had been incontinent of stool and the skin on buttocks and thighs was red with multiple deep creases and wrinkles. On 5/19/15 at 12:00 p.m., NA-I verified getting R87 up before 7:00 a.m. and she had not been able to get back to R87. NA-I indicated she was so thankful LPN-C had helped her. On 5/19/15 at approximately 2:45 p.m., RN-B verified the findings and agreed R87 should have been repositioned and toileted sooner. R102 was dependent on staff for all personal hygiene/grooming and was not provided facial hair removal. R 102 was observed on 5/18/15 at 2:38 p.m. with darker colored facial hair on his cheeks, upper lip, chin and upper neck. R102 indicated he doesn't mind being shaved. A family member (F)-M in the room indicated R102 liked to be clean shaven however, was usually not shaved when visiting. The visitor added another family member visits	2 920		

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2 920	Continued From page 43 frequently and always would shave the R102 when visiting. On 5/19/15 at 2:00 p.m. a random observation was made and R102's face continued to have long facial hair on entire face. At this time F-B was visiting and confirmed R102 had not been shaved for a few days and that she would do it. F-C verified R102 is not usually clean shaven when she visits and frequently shaves R102. The initial MDS dated 11/20/14 identified diagnoses included quadriplegia, and traumatic brain injury. The MDS indicated R102 was totally dependent on staff for all personal hygiene. R102's care plan, last revised 5/17/15, indicated R102 would like to be clean, neat and well groomed daily. However the current care plan does not identify personal grooming/shaving needs for R102. On 5/20/15 at 12:00 p.m. the RN-B verified the care plan did not identify personal grooming/shaving needs for R102 and it would be updated as soon as possible. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could review and revise policy and procedures as needed, train staff, assess the system, monitor and evaluate to assure that residents receive the necessary care and services based on an indivdualized comprehensive assessment. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection	21390		

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21390	Continued From page 44 control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Citation Text for Tag 0441, Regulation FF09 Miller, Sue Based on observation, interview and document review, the facility failed to ensure proper hand hygiene during a dressing change for 1 of 1 residents (R163); and between 3 of 3 residents (R37, R32 and R138) during use of a point of care device. This had the potential to affect all	21390		

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21390	Continued From page 45 residents in the facility who used care device. Findings include: Appropriate hand hygiene was not followed during observation of a gastrostomy tube (GT) and tracheotomy dressing change for R163. On 5/19/15, starting at 9:44 a.m. licensed practical nurse (LPN-B) was observed to wash their hands and don gloves. LPN-B then proceeded to check the GT site for redness by removing a gauze pad. Wearing the same gloves, LPN-B took a clean gauze pad soaked in normal saline, and cleansed around the GT site. Without changing gloves or washing their hands, LPN-B then removed a gauze pad from around the tracheotomy area. Still wearing the same soiled gloves, LPN-B wet another gauze pad with normal saline and cleansed around the tracheotomy. LPN-B stated R163 had been admitted with a sore around the neck and upon observation a dime size open area was noted to the right of the tracheotomy, with no drainage present. Then with the same gloves on LPN-B took two Q-tips and cleansed closer around the tracheotomy area. LPN-B removed the soiled gloves and washed their hands before donning a new pair of gloves. With the new gloves on LPN-B placed a new gauze pad around the G-tube and taped the pad down. Without removing the gloves and washing their hands, LPN-B proceeded to open a new gauze pad package and place the new pad around the tracheotomy tube. The gloves were then removed and LPN-B washed their hands. On 5/20/15, at 10:46 a.m. LPN-B was interviewed regarding the lack of hand hygiene between dressing changes for R163. LPN-B stated they	21390		

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21390	Continued From page 46 thought "you always went from dirty to clean" and since the treatment was for dressing removals, the dirty part was done first. The facility's Gastrostomy/Jejunostomy Site Care policy dated 2/2014, revealed glove removal and hand washing was to occur after GT cleansing. The facility's Tracheotomy Care policy dated 3/2014, revealed that after the old tracheotomy dressing was removed gloves were to be removed and hands washed. The policy further indicated that gloves were to be worn when placing a new gauze pad around the stoma site, then removed and hands washed. The facility's Hand Hygiene In the Healthcare Setting Guidelines, dated 5/2014, revealed hand hygiene was to be performed before and after change "a dressing" and after handling soiled equipment. Reed, Sheryl During observation of glucose monitoring on three residents, the licensed practical nurse (LPN)-B did not wash her hands in between each resident On 5/20/15 at 11:15 a.m., LPN-B entered R37's room, applied gloves and obtained a blood sample from the resident 's finger to check for blood glucose from a personal glucometer. When LPN-B had completed the task, she removed the gloves, and picked up the tote, and exited the room. LPN-B then entered R32's room at approximately 11:20 a.m., applied gloves and obtained a blood sample from the resident's finger and obtained a reading from the personal glucometer. When the task was completed,	21390		

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21390	Continued From page 47 LPN-B removed and disposed of the gloves and left the room. LPN-B went down the hall and entered R138's room at approximately 11:25 a.m. LPN-B applied gloves and obtained a blood sample from R138, When done, the gloves were removed and LPN-B left the room. LPN-B indicated she was done obtaining blood glucose's. When asked why she did not wash hands in between residents, she indicated she should have and did not. On 5/20/15 at 9:30 a.m., the director of nursing verified the nurse should have washed her hands in between residents when performing an invasive procedure. Policy revised 5/2014 titled Hand Hygiene in the Healthcare Settings indicated "Hand washing with soap and water or alcohol based hand rub (ABHR) will always be performed at the following times: Before and after performing any invasive procedure (e.g. fingerstick blood sampling). SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could assure that infection control standards for hand washing of residents before vent, G-tube and between resident during blood sugar checks, that universal equipment is cleaned and that gloves are removed and hands washed when staff provide personal cares to residents. The director of nursing and/or designee could assure policy and procedures are current, that staff are trained and that the system for infection control practices is followed, monitored and evaluated to assure compliance. TIME PERIOD FOR CORRECTION: Twenty-one	21390		

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21390	Continued From page 48 (21) days.	21390		
21435	MN Rule 4658.0900 Subp. 1 Activity and Recreation Program; General Subpart 1. General requirements. A nursing home must provide an organized activity and recreation program. The program must be based on each individual resident's interests, strengths, and needs, and must be designed to meet the physical, mental, and psychological well-being of each resident, as determined by the comprehensive resident assessment and comprehensive plan of care required in parts 4658.0400 and 4658.0405. Residents must be provided opportunities to participate in the planning and development of the activity and recreation program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide an individualized program of activities to meet the psychosocial wellbeing of each resident for 1 of 3 residents (R83) reviewed for activities. Findings include: R83 did not receive activities as directed by the plan of care. During observations on 5/17/15, at 3:00 p.m. and at 7:00 p.m., R83 was laying in bed on the right side. Eyes were open but there was no response to verbal communication. There was no radio, no television, no CD or tape playing in the room.	21435		

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21435	Continued From page 49 During observations on 5/18/15, at 9:00 a.m., 10:48 a.m., and 1:00 p.m., R83 was laying in bed on the right side. Eyes were open but there was no response to verbal communication. There was no radio, no television, no CD or tape playing in the room. When interviewed on 5/18/15, at 11:32 a.m., Family member (F)-A expressed being "upset and discouraged" because R83 is not involved in activities as much as possible, and F-A would like to see R83 "more involved." F-A expressed [R83] being so young and involved with music, movies, and videos, which were a big part of [R83's] life, which should still be a part of his life. F-A verified the facility was aware and F-A talked about activities in the March 2015 care conference. F-A stated several family members who visit frequently and have expressed concern because they are not seeing activity involvement. Document and electronic medical record (eMR) review revealed R83 was admitted to the facility on 11/21/13. The active diagnoses from R83's plan of care, dated 5/19/15, listed, but was not limited to tracheostomy, septicemia, endocarditis, and unspecified intracranial hemorrhage. The Minimum Data Set (MDS) assessment dated 4/29/15, indicated under section B Hearing , Speech and Vision, read; Comatose, Persistent vegetative state/no discernable consciousness. R83 was assessed on the quarterly Minimum Data Set (MDS) on 1/28/15, as severe cognition impairment and unable to answer questions. Document review of the activity plan of care, dated 4/10/14, read, Quality of Life: Continuing these activities I did prior to admission are important to me; I like this type of music: Rap, I	21435		

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21435	Continued From page 50 like these types of TV programs: Sitcom, Movies; Action, like the pirates of the Caribbean. During observation on 5/18/15, at approximately 1:30 --2:30 p.m. movie Happy Gilmore was showing in the dining room. R83 did not attend the movie. During an interview with the activity aide (AA)-A on 5/19/15, at 9:42 a.m,. revealed R83 has a volunteer visitor who comes every two weeks for hand massage but AA-A is not sure of the sensory stimulation for R83 and exactly what he would benefit from because stated, "I am not sure what [R83] can comprehend." Furthermore AA-A expressed not being sure about R83 being in a crowded group setting and stated, "We do not know if [R83] can see anything or what the brain is doing." AA-A verified R83 was not brought to group setting activities and that the nursing staff should be turning on the television and music for R83. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could assure activity programs are based on each individual resident's interests, strengths and needs, and must be designed to meet the physical, mental, and psychological well-being of each resident, as determined by the comprehensive resident assessment and comprehensive plan of care. The director of nursing could assure that policy and procedures are reviewed, revised as needed, staff trained and system assessed, monitored and evaluated to assure individual activity needs of residents are met.	21435		

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21435	Continued From page 51 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21435		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required	21530		

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21530	Continued From page 52 by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on document review and staff interview, the pharmacist failed to identify and report to the physician drug irregularities for 1 of 5 (R87) residents in the sample reviewed for the use of unnecessary medications. Findings include: According to the current physician orders, R87 had the potential to receive an excessive amount of acetaminophen. The current physician order sheets revealed R87 was admitted to the facility on 4/15/13 with diagnoses of cerebral artery occlusion, contracture of joints at many sites, and pain in joint, hand. The current physician orders indicate R87 had a physician order that read: Acetaminophen Tablet 1000 mg (milligram) oral three times a day. R87 also had a standing house order that read: Tylenol (Acetaminophen) give 650 mg by mouth every 4 hours as needed for pain. Give 650 mg orally every 4 hours prn (as needed) for minor pain or temp (temperature) or greater than 100.5. Do not exceed 3000 mg of Tylenol in a 24 hr period." The scheduled Tylenol amount equals 3000 mg. On dose of the 650 mg every 4 hours as needed for pain would exceed the limit of 3 grams in 24 hours.	21530		

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21530	Continued From page 53 A review of the April 2015 medication administration record indicated R87 received an as needed 650 mg dose of Tylenol on 2 separate occasions. R87 exceed the 3000 mg Tylenol amount on 4/27 and 4/28/15 when he received as as needed dose. On 5/20/15 at approximately 2:00 p.m. the registered nurse (RN)-B verified the physician orders and that the two as needed doses in April exceeded the 3000 mg recommended dose. RN-B reported she would talk to the nurse practioner regarding the Tylenol orders. On 5/21/15 at 12:38 the pharmacist was updated on the extra doses of Tylenol received and asked about continuing with the standing house order. The pharmacist reported that clinically it was okay, however it was too bad the standing house orders were not discontinued with some of resident's other pain medication. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or desigee could work with the medical director and consultant pharmacist to ensure to inform the facilty medication irregularities. The DON could ensure the staff were educated on the importance of medication irregularities.The DON or designee could randomly audit resident records to ensure adequate monitoring, parameters and documentation was in place. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21530		

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21540	Continued From page 54	21540		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure medications were administered with respect to potential excessive dosages for 1 of 5 residents (87) reviewed for unnecessary medication. Findings include: According to the current physician orders, R87 had the potential to receive an excessive amount of acetaminophen.	21540		

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21540	Continued From page 55 The current physician order sheets revealed R87 was admitted to the facility on 4/15/13 with diagnoses of cerebral artery occlusion, contracture of joints at many sites, and pain in joint, hand. The current physician orders indicate R87 had a physician order that read: Acetaminophen Tablet 1000 mg (milligram) oral three times a day. R87 also had a standing house order that read: Tylenol (Acetaminophen) give 650 mg by mouth every 4 hours as needed for pain. Give 650 mg orally every 4 hours prn (as needed) for minor pain or temp (temperature) or greater than 100.5. Do not exceed 3000 mg of Tylenol in a 24 hr period." The scheduled Tylenol amount equals 3000 mg. On dose of the 650 mg every 4 hours as needed for pain would exceed the limit of 3 grams in 24 hours. A review of the April 2015 medication administration record indicated R87 received an as needed 650 mg dose of Tylenol on 2 separate occasions. R87 exceed the 3000 mg Tylenol amount on 4/27 and 4/28/15 when he received as as needed dose. On 5/20/15 at approximately 2:00 p.m. the registered nurse (RN)-B verified the physician orders and that the two as needed doses in April exceeded the 3000 mg recommended dose. RN-B reported she would talk to the nurse practioner regarding the Tylenol orders. A policy was requested but not received. SUGGESTED METHOD OF CORRECTION:	21540		

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21540	Continued From page 56 The Director of Nursing (DON) or desigee could work with the medical director and consultant pharmacist to ensure medications were reviewed for appropriate interventions, monitoring and parameters for use. The DON could ensure the staff were educated on the importance of monitoring for unnecessary medications.The DON or designee could randomly audit resident records to ensure adequate monitoring, parameters and documentation was in place. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21540		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation document review and interview, the facility failed to ensure medications were dated when opened, labeled correctly and removed if expired for 2 of 5 units that affect 7 residents (R76, R32, R15, R156, R83, R136 and R132). Findings include: On 5/17/15 at 1:15 pm. during the medication storage tour with licensed practical nurse (LPN)-F on the 3 East unit medication carts, medication was observed to be opened and not dated. R76's Humalog insulin pen was opened and not dated.	21620		

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21620	Continued From page 57 On 5/17/15 at 1:35 p.m. during the medication storage tour with the licensed practical nurse on 2 East unit medication cart, medications were observed to be in use but not dated when opened or without identification labels. During the tour, the following concerns were identified. - R32's Novolog insulin was opened, dispensed 4/11/15, and not dated when opened. - R15's Novolog insulin pen was opened, dispensed 4/4/25 and not dated when opened. - R156's Novolog flex pen was opened, and remained in cart for use. The pen had been dispensed on 3/25/14 and opened same day. - A Lantus insulin pen with no label remained in the medication cart. It was opened and not dated. - R83's two bottle of heparin sodium solution were opened and not dated. - R136's sodium chloride ophthalmic ointment was opened and not dated. Two Symbicort inhalers without any identification labels were in the medication cart. In black marker the names of R132 and R156 were written on the sides of the inhalers. LPN-E confirmed these findings and indicated she would removed the items. On 5/20/15 at 2:53 the director of nursing was informed about the findings and verified items should be labeled and dated when opened. Expired medications should be removed from the drawers. Medication: Storage of policy, last revised 7/2013 read: "Drug containers having soiled illegible, worn, makeshift, incomplete, damaged, or	21620		

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21620	Continued From page 58 missing labels are returned to the pharmacy for proper labeling before storing. The facility's policy, Storage and Expiration of Medications, Biologicals, Syringes and Needles, last revised 1/1/13 indicated Facility should ensure that medications and biologicals have an expiration date on the label., and have not been retained longer than recommended by the manufacturer...Also, the policy reads: "Once any medication or biological package is opened, facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened." SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper storage of medications. Nursing staff could be educated as necessary to the importance of labeling medications properly and discarding expired medications. The DON or designee, along with the pharmacist, could audit medications on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21620		
21670	MN Rule 4658.1405 A.B.C.D. Resident Units The following items must be provided for each resident:	21670		

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21670	Continued From page 59 A. A bed of proper size and height for the convenience of the resident, a clean, comfortable mattress, and clean bedding, appropriate for the weather and resident's comfort, that are in good condition. Each bed must have a clean bedspread. A moisture-proof mattress or mattress cover must be provided for all residents confined to bed and for other beds as necessary. Rollaway type beds, cots, or folding beds must not be used. B. A chair or place for the resident to sit other than the bed. C. A place adjacent or near the bed to store personal possessions, such as a bedside table with a drawer. D. Clean bath linens provided daily or more often as needed. E. A bed light conveniently located and of an intensity to meet the needs of the resident while in bed or in an adjacent chair This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide proper fitting linens for 2 of 2 residents (R83, R106) using APM-2 bariatric mattresses. Findings include: During observation of cares on 5/19/15, at 10:30 a.m. R83 was turned from side to side by nursing assistants (NA)-F and NA-K for urinary incontinence care. The bottom sheet was not a fitted bed linen and did not remain in place, which resulted in R83 having his skin on the bare mattress at some times during the incontinence cares. The nursing assistants were observed	21670		

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21670	Continued From page 60 struggling to keep bed linen under R83 with cares. There was friction and shearing as the nursing assistants pulled on the bed linens in an attempt to keep the linen under R83. When interviewed on 5/19/15, at 10:30 a.m. both NA-A and NA-K verified the facility did not have linen big enough to fit these type of beds. Both nursing assistants validated the frustration of trying to keep the linen under R83 and both expressed concern for the friction and shearing of R83's skin. Both nursing assistants said they have reported the difficulty with nursing management. The facility did not provide proper fitting linens for R106's bariatric mattress. According to NA-A and NA-K, R106's family supplied the linen to fit the bed because they were told the facility did not have linen to fit the APM-2 bariatric mattresses. During an interview with the director of laundry (DL) services on 5/19/15, at 3:00 p.m. the DL stated the facility only purchased the one size fits all sheets. The facility did not have a policy regarding proper fitting bed linen. SUGGESTED METHOD OF CORRECTION: The director of housekeeping and laundry could develop and implement policies and procedures to ensure linens to fit bariatric beds for residents. Audits could be conducted at various times of the day and the results of those audits could be brought to the quality committee for their review.	21670		

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21670	Continued From page 61 TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21670		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain a sanitary, orderly and comfortable environment. 2 of 3 (2 west and 3 east) unit hallways had noticeable urine odors. 2 of 10 (R13, R18) residents's room window curtains were visibly torn and had frayed hemming. 6 of 8 residents (R16, R18, R28, R29, R40, and R52) wheel chairs were dirty. 2 of 10 resident rooms (R40, R164) required paint and repair and 1 of 10 resident rooms (R98) had dark staining on the flooring. Findings include: Throughout various times, each day of the survey 5/17, 5/18, 5/19 and 5/20/15, there was a strong urine odor observed to be present in the 2 west and 3 east hallways. During a family member (F-A) interview on 5/18/15, at 11:32 a.m., F-A stated, "Everytime I come into this building it smells like piss, there	21685		

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21685	Continued From page 62 must be something they can do for that. I've been aware of it for months,and complaining, why can't they figure it out and get rid of the smell." F-A verified family member was not cognitively intact to complain about the odor but the family members have complained about the odor in the facility on behalf of the resident who cannot speak up and would not like the odor. During an observation on 5/19/15 at 12:00 p.m., housekeeper (H)-A was spraying a substance into the hallway and stated, "We are trying to cover up the smell." H-A validated there was a strong urine odor in the 3 east hallway and was not sure where the odor was coming from. The product being sprayed was called, Good Sense Odor Counteractant. During observation of room order on 5/18/15, at 1:30 p.m., on 2 east hallway, there were 2 of 10 resident (R13, R18) window curtains that had frayed, undone hemming along the entire length of the 24 to 36 inch edgings. When interviewed on 5/18/15 at 1:30 p.m., R18 said he could not see the frayed drapery because of blindness but validated his family would not appreciate seeing the frayed edges during visits and stated, "Maybe it will bother them, so I think they should be fixed." When interviewed on 5/19/15, at 2:30 p.m., R13 verified the unhemmed, frayed curtain was "irritating" because R13 expressed "taking pride" in his room and would like things to be in good repair. During observation of the curtains in R13 and R18's bedroom, with the director of laundry and housekeeping (DLH) on 5/19/15, at 2:30 p.m. the DLH verified the curtains needed to be taken	21685		

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21685	Continued From page 63 down and repaired and/or replaced. During various observations on 5/17, 5/18 and 5/19/15, the wheel chairs of R16, R18, R28, R29, R40, and R52, had a build up of grime and crumbs present on the sides of the wheel chair, under the cushions and in some instances on the foot plates of the wheel chair. During observation of the wheel chairs for R16, R18, R28, R29, R40, and R52, with the director of laundry and housekeeping (DLH) on 5/19/15, at 2:30 p.m. the DLH verified the wheel chairs needed to be cleaned and the DLH stated, "They will be taken care of today." The DLH verified there was not a system to monitor the cleaning of the wheel chairs and the housekeeping staff were to clean the wheel chairs once a month when the room is "deep cleaned." Document review of the facility housekeeping form titled, Deep Clean Checkoff List, revealed R18 had the wheel chair cleaned on 4/8/15, R28 had the wheel chair cleaned on 4/2/15 and R40 had the wheel chair cleaned 4/27/15. There were no other forms produced for review to indicate if wheel chair cleaning occurred in April or May for R16, R29 and R52. Further interview on 5/19/15, at 2:30 p.m. with the DLH revealed, wheel chairs are cleaned on the day shift, but if a resident is up in the wheel chair the housekeeping staff are unable to clean the wheel chair. The DLH stated, "The wheel chairs are done on the day shift if they can get to them, there is an evening housekeeper from six to ten, but they are busy doing the dining rooms." On 5/20/15, at 10:00 a.m., an environmental tour was conducted with the administrator,	21685		

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21685	Continued From page 64 maintenance director, housekeeping director and the corporate housekeeping director. During the environmental tour, R40 and R164's rooms were noted to have gouges, scratches, and black marks on the walls. The maintenance director did verify they were in need of repair and painting, and the facility did not have a system in place when a room is to be painted. In addition, R98's room was noted to have several light orange spots observed on the floor by the side of the room that was unoccupied at this time. The resident's wheelchair was placed over the orange spots. The corporate housekeeping director stated the orange marks on the floor are stains; however when he scraped the spot with his shoe, the orange spot did wipe off. The housekeeping director verified the floor needs to be cleaned. SUGGESTED METHOD OF CORRECTION: The director of nursing, director of maintenence and/or designee could assure the physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment is kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21685		
21870	MN St. Statute 144.651 Subd. 18 Patients & Residents of HC Fac.Bill of Rights Subd. 18. Responsive service. Patients and residents shall have the right to a prompt and	21870		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21870	Continued From page 65 reasonable response to their questions and requests. This MN Requirement is not met as evidenced by: Based on document review, and interview, the facility failed to act upon grievances from the resident council meeting for 6 of 6 residents (R13, R16, R18, R32, R52, R124) who voiced specific care and service issues on 2 east. Findings include: R13, R32 and R124 attended the February 2015 Resident Council meeting and expressed the concerns of a group of resident's from the second floor regarding staff education and treatment. R16, R18, and R52 further corroborated resident concerns but were not at the meeting. A review of the resident council minutes for 2/2/15, under the section marked Nursing, read, "Tell nursing the aides on 2E need to be shadowed. (residents think they should've been fired on day one.)" The section titled Social Service read, "*Right to respect. 2E doesn't feel their needs are being met. 2E Lights aren't being answered, can take 1/2 hour to an hour. Talked back to, resident is trying to be helpful but nurses/aides don't want to hear it." Residents who were present at this meeting were R13, R32 and R124. A review of the March 2015 and April 2015 resident council minutes lacked mention of the resolution to the February 2015 resident council concerns. When interviewed on 5/18/15, at 9:20 a.m., R16	21870		

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	00149	A. BUILDING: _____ B. WING _____	05/21/2015

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21870	Continued From page 66 expressed having to wait long periods of time for the staff to help with cares and position changes. R16 referred to, "other people that live here try to watch out for me, but when the staff get mad at me they make me wait longer, I don't want to complain." Furthermore, R16 stated, "some of the regular day staff are sticks in the mud, I don't want them mad at me." R16 stated, "If I complain, the staff will push and pull on me more when they take care of me and that hurts. I already have problems being comfortable in this chair and I am afraid they will make me wait longer for help." R16 validated the facility management was aware of the problem from resident council which R16 validated attending with [R13,R52 and R124] whom she considers people who watch out for her. Review of R16's medical record indicated an annual minimum data set (MDS) completed 3/18/15,which assessed R16 as cognitively intact and able to make decisions about care. During an interview with R52 on 5/18/15, at 3:15 p.m., a concern was expressed about , "If I complain the staff will get back at me so I don't want to complain. We complained and nothing was done about it." R52 made reference to the resident council meeting in February 2015 when R52 expressed concerns about having to wait long periods of time for assistance, that the wheel chair is very uncomfortable, and she is in constant pain from a knee injury. R52 would like to see better customer service training for the staff but does not want them to, "Get back at me." Review of R52's medical record indicated a quarterly MDS completed 4/30/15, which R52 was assessed as cognitively intact and able to make decisions about care.	21870		

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21870	Continued From page 67 During an interview on 5/19/15, at 10:32 a.m., R32 validated the concerns addressed at the February 2, 2015 resident council meeting and confirmed the residents continued to be upset about the lack of resolution and that the residents were afraid of retaliation from the staff. R32 stated, "Be sure to talk to [R13] and [R124] because they are seriously concerned about the staff being mean to them." Review of R32's medical record indicated a quarterly MDS completed 2/18/15, which R32 was assessed as cognitively intact and able to make decisions about care. When interviewed on 5/19/15, at 10:37 a.m., R124 talked about licensed practical nurse (LPN)-A and stated, "[LPN-A] is always so mad at me, One day she came into my room screaming at me for reporting her to the director of nursing (DON). They know [LPN-A] is a problem but because she has been here for so long they won't do anything about her retaliation to us." R124 continued to talk about the February resident council meeting when the residents told the staff that nursing assistants (NA)-A and NA-B try to control the residents. "These nursing assistants do not allow choices, you better do it their way or expect to wait a long time if you should need something." Furthermore, R124 explained the residents on this end of the building talk and watch out for each other. R124 said to interview [R13], [R16], and [R52] because they also expressed concerns about [LPN-A] and [NA-A] and [NA-B]. Review of R124's medical record indicated a quarterly MDS completed 3/18/15, which R124 was assessed as cognitively intact and able to	21870		

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21870	Continued From page 68 make decisions about care. During an interview on 5/19/15, at 2:30 p.m., R13 discussed being very concerned about retaliation from LPN-A and referred to a situation a while back where a culture of a wound site was required. R13 said "[LPN-A] came into the room early in the morning, took off the appliances, did the culture and then left me, she did not put it back together again. R13 felt it was "in spite" because he has complained about her." R13 stated, "The residents watch out for each other here." R13 referred to [R124], [R16], [R52] as residents who discussed the concerns on the nursing unit. R13 shared another situation that R13 considered "bullying like in grade school" was one day in April when LPN-A laughed at R13 after an incident that was upsetting. R13 stated, "I felt angry, that I was not worth anything. It was like being a kid and being laughed at." R13 feels the NA-A has retaliated against him by not talking to him for a period of time and this is "to get back at me because I complained about her." Review of R13's medical record indicated an annual MDS completed 3/11/15, which R13 was assessed as cognitively intact and able to make decisions about care. During an interview with R18 on 5/19/15, at 2:00 p.m., a concern was expressed that the staff are mean to him because they push him around in a rough way, but he doesn't want to complain for fear of retaliation because "these people have been here a long time and are the usual staff in the unit." R18 stated, "Maybe I have done something wrong to them so they treat me this way." R18 validated he did not report to management because he stated, "I am afraid they will get back at me."	21870		

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21870	Continued From page 69 Review of R18's medical record indicated an annual MDS completed 4/8/15, which R18 was assessed as cognitively intact and able to make decisions about care. During an interview with the director of social services (DSS), the director of nursing (DON) and registered nurse (RN)-A on 5/19/15, at 10:45 a.m., the minutes of the February Resident Council were reviewed. The DSS, DON and RN-A, validated there was no investigation into the concerns expressed at the February 2015 Resident Council meeting. There were no resident or staff interviews conducted from the resident council meeting or on the 2E unit addressed in the resident council minutes. According to the DSS, the person who recorded the resident council minutes no longer works at the facility. When interviewed, the DSS, DON and RN-A validated the concerns should have been investigated. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could assure that residents concerns are listened to and acted upon timely. The director of nursing or designee could review policy and procedures, train staff, monitor systems, interview residents and evaluate the process to assure the facility acts upon resident council grievances, specifically related to food concerns. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21870		

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21880	Continued From page 70	21880		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section	21880		

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21880	Continued From page 71 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to ensure resident rights to voice grievances without fear of reprisal was honored for 6 of 6 residents (R13, R16, R18, R32, R52, R124) in the sample who expressed grievances. Findings include: R13, R16, R18, R32, R52 and R124 expressed staff retaliation concerns at the resident council meeting without a resolution to the concerns expressed. A review of the resident council minutes for 2/2/15, under the section marked Nursing, read, "Tell nursing the aides on 2E need to be shadowed. (residents think they should've been fired on day one.)" The section titled Social Service read, "*Right to respect. 2E doesn't feel their needs are being met. 2E Lights aren't being answered, can take 1/2 hour to an hour. Talked back to, resident is trying to be helpful but nurses/aides don't want to hear it." Residents who were present at this meeting were R13, R32 and R124. A review of the March 2015 and April 2015 resident council minutes lacked mention of the resolution to the February 2015 resident council concerns.	21880		

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21880	Continued From page 72 When interviewed on 5/18/15, at 9:20 a.m., R16 expressed having to wait long periods of time for the staff to help with cares and position changes. R16 referred to, "other people that live here try to watch out for me, but when the staff get mad at me they make me wait longer, I don't want to complain." Furthermore, R16 stated, "some of the regular day staff are sticks in the mud, I don't want them mad at me." R16 stated, "If I complain, the staff will push and pull on me more when they take care of me and that hurts. I already have problems being comfortable in this chair and I am afraid they will make me wait longer for help." R16 validated the facility management was aware of the problem from resident council which R16 validated attending with [R13,R52 and R124] whom she considers people who watch out for her. Review of R16's medical record indicated an annual minimum data set (MDS) completed 3/18/15,which assessed R16 as cognitively intact and able to make decisions about care. During an interview with R52 on 5/18/15, at 3:15 p.m., a concern was expressed about , "If I complain the staff will get back at me so I don't want to complain. We complained and nothing was done about it." R52 made reference to the resident council meeting in February 2015 when R52 expressed concerns about having to wait long periods of time for assistance, that the wheel chair is very uncomfortable, and she is in constant pain from a knee injury. R52 would like to see better customer service training for the staff but does not want them to, "Get back at me." Review of R52's medical record indicated a quarterly MDS completed 4/30/15, which R52 was assessed as cognitively intact and able to	21880		

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21880	Continued From page 73 make decisions about care. During an interview on 5/19/15, at 10:32 a.m., R32 validated the concerns addressed at the February 2, 2015 resident council meeting and confirmed the residents continued to be upset about the lack of resolution and that the residents were afraid of retaliation from the staff. R32 stated, "Be sure to talk to [R13] and [R124] because they are seriously concerned about the staff being mean to them." Review of R32's medical record indicated a quarterly MDS completed 2/18/15, which R32 was assessed as cognitively intact and able to make decisions about care. When interviewed on 5/19/15, at 10:37 a.m., R124 talked about licensed practical nurse (LPN)-A and stated, "[LPN-A] is always so mad at me, One day she came into my room screaming at me for reporting her to the director of nursing (DON). They know [LPN-A] is a problem but because she has been here for so long they won't do anything about her retaliation to us." R124 continued to talk about the February resident council meeting when the residents told the staff that nursing assistants (NA)-A and NA-B try to control the residents. "These nursing assistants do not allow choices, you better do it their way or expect to wait a long time if you should need something." Furthermore, R124 explained the residents on this end of the building talk and watch out for each other. R124 said to interview [R13], [R16], and [R52] because they also expressed concerns about [LPN-A] and [NA-A] and [NA-B]. Review of R124's medical record indicated a quarterly MDS completed 3/18/15, which R124	21880		

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21880	Continued From page 74 was assessed as cognitively intact and able to make decisions about care. During an interview on 5/19/15, at 2:30 p.m., R13 discussed being very concerned about retaliation from LPN-A and referred to a situation a while back where a culture of a wound site was required. R13 said "[LPN-A] came into the room early in the morning, took off the appliances, did the culture and then left me, she did not put it back together again. R13 felt it was "in spite" because he has complained about her." R13 stated, "The residents watch out for each other here." R13 referred to [R124], [R16], [R52] as residents who discussed the concerns on the nursing unit. R13 shared another situation that R13 considered "bullying like in grade school" was one day in April when LPN-A laughed at R13 after an incident that was upsetting. R13 stated, "I felt angry, that I was not worth anything. It was like being a kid and being laughed at." R13 feels the NA-A has retaliated against him by not talking to him for a period of time and this is "to get back at me because I complained about her." Review of R13's medical record indicated an annual MDS completed 3/11/15, which R13 was assessed as cognitively intact and able to make decisions about care. During an interview with R18 on 5/19/15, at 2:00 p.m., a concern was expressed that the staff are mean to him because they push him around in a rough way, but he doesn't want to complain for fear of retaliation because "these people have been here a long time and are the usual staff in the unit." R18 stated, "Maybe I have done something wrong to them so they treat me this way." R18 validated he did not report to management because he stated, "I am afraid	21880		

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21880	Continued From page 75 they will get back at me." Review of R18's medical record indicated an annual MDS completed 4/8/15, which R18 was assessed as cognitively intact and able to make decisions about care. During an interview with the director of social services (DSS), the director of nursing (DON) and registered nurse (RN)-A on 5/19/15, at 10:45 a.m., the minutes of the February Resident Council were reviewed. The DSS, DON and RN-A, validated there was no investigation into the concerns expressed at the February 2015 Resident Council meeting. There were no resident or staff interviews conducted from the resident council meeting or on the 2E unit addressed in the resident council minutes. According to the DSS, the person who recorded the resident council minutes no longer works at the facility. When interviewed, the DSS, DON and RN-A validated the concerns should have been investigated and the residents should have been reassured and protected from any form of retaliation. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee of the facility could ensure that policies and procedures are current, staff are trained and that a monitoring system is in place to ensure resident rights to voice grievances are communicated without fear of reprisal. TIME PERIOD FOR CORRECTION: Twenty-one	21880		

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21880	Continued From page 76 (21) days.	21880		
21995	MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to investigate allegations of potential mistreatment for 1 of 2 residents (R58) who had reported to facility staff possible neglect of care. Findings include: A review of R58's electronic health record (eHR) revealed a Brief Interview for Mental Status (BIMS) had been completed on 4/21/15, revealed R58 scored 14/15, indicating R58 was cognitively intact. The eHR care plan dated 8/12/13, revealed R58 was able to "reliably recognize a dangerous situation", but "cannot remove myself to safety in a dangerous situation, I would need staff to assist me to safety." The most recent quarterly minimum data set (MDS) dated 4/21/15, revealed R58 was always incontinent of urine and required the extensive assistance of one staff for grooming, and toileting.	21995		

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21995	Continued From page 77 On 5/18/15, at 11:37 a.m., R58 stated during an individual interview, there were times when nursing assistant (NA)-F ignored R58 by not answering the call light, not assisting the resident and not changing R58's incontinent product. R58 stated reporting NA-F to registered nurse (RN)-C, and also stated NA-F no longer worked at the facility. On 5/20/15, at 11:00 a.m., R58 was interviewed again about NA-F and how R58 felt when cared for by NA-F and R58 stated not feeling very good and explained that NA-F had not treated him well and NA-F had an "attitude" that NA-F was better than others. On 5/20/15, at 9:50 a.m.,. the director of nurses (DON) was interviewed regarding R58's report of alleged neglect. The DON reported never hearing of the incident. On 5/20/15, at 9:58 a.m., RN-C reported not recalling speaking with R58 regarding NA-F not providing cares to R58. On 5/20/15, at 10:23 a.m., NA-D stated that about one and a half months ago, R58 reported to NA-D and NA-C there was a nursing assistant [NA-F] who ignored R58, did not do anything for R58 and was not caring for the resident properly. NA-D stated that NA-D and NA-C, immediately wrote everything down that R58 had told them and presented the information to RN-C and RN-B. NA-D stated R58 seemed happier now and was not mentioning any more "bad information." On 5/20/15, at 11:04 a.m. R58's alleged neglect issue was discussed with RN-B, who stated "I guess I don't recall that", and denied having received any written information of the alleged	21995		

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21995	Continued From page 78 neglect incident. On 5/20/15, at 11:20 a.m., NA-C stated, had verbally told RN-C what R58 had verbalized and had provided RN-B with the written information. NA-C stated the information was brought to RN-B after R58 made the report. NA-C stated R58 verbalized wanting to die. NA-C stated that R58's behavior and attitude changed whenever NA-F cared for R58 and explained that R58 would report not having a good evening because of having to do things without help, such as self-transferring into bed. On 5/20/15, at 11:25 a.m., social worker(SW)-A stated not being aware of any possible neglect of care for R58. SW-A stated R58 had recently seen a psychologist as R58 had been complaining about a new resident in the next room being noisy at night. SW-A stated staff felt R58 did not do well with changes and that seeing the psychologist would be good for the resident, and R58 was doing better since having seen the psychologist. On 5/20/15, at 11:33 a.m., the DON stated she had spoken to RN-C, and RN-C did not recall receiving information from either NA-C or NA-D regarding R58's alleged neglect incident. On 5/20/15 at 1:20 p.m. NA-D stated NA-D and NA-C had written the information down on a large piece of paper and that NA-C who had delivered the written information to RN-B and RN-C. NA-D stated NA-D and NA-C felt, "very frustrated" that RN-B or RN-C stated they had not received the information. On 5/20/15, at 2:00 p.m. the DON was interviewed regarding NA-F. The DON stated	21995		

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	00149	A. BUILDING: _____ B. WING _____	05/21/2015

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21995	Continued From page 79 NA-F had been terminated because of a vulnerable adult (VA) incident with a resident. A review of NA-F's personnel file revealed the VA incident the DON was referring to did not involve R58, but another resident residing in the facility. SUGGESTED METHOD OF CORRECTION: The facility could assure that all allegations of potential abuse are thoroughly investigated and immediately reported to the state agency and that residents are protected from potential retaliation while an investigation is pending. The Administrator, director of nursing and/or designee could assure policies are reviewed, up to date, implemented and and that staff training has been completed. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21995		
22000	MN St. Statute 626.557 Subd. 14 (a)-(c) Reporting - Maltreatment of Vulnerable Adults Subd. 14. Abuse prevention plans. (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency. (b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse	22000		

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22000	Continued From page 80 prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse. (c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to investigate allegations of potential mistreatment, per facility policy, for 1 of 2 residents (R58), who reported to facility staff	22000		

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22000	Continued From page 81 possible neglect of care. Findings include: The facility's policy titled Vulnerable Adult & Abuse & Neglect Prevention and dated 5/12, revealed all incidents of mistreatment or suspected mistreatment were to be reported immediately and upon receipt of the report the nursing supervisor on duty was to begin investigating the situation by conducting a physical assessment of the resident, speaking to all staff involved in the situation and document the findings. Based on the information received from R58, the facility failed to follow the policy and procedure. A review of R58's electronic health record (eHR), revealed a Brief Interview for Mental Status (BIMS) had been completed on 4/21/15, which revealed R58 scored 14/15, indicating R58 was cognitively intact. The eHR care plan dated 8/12/13, revealed R58 was able to "reliably recognize a dangerous situation", but "cannot remove myself to safety in a dangerous situation, I would need staff to assist me to safety." R58 was also identified as frequently incontinent of urine and required staff assistance. The most recent quarterly minimum data set (MDS) dated 4/21/15, revealed R58 was always incontinent of urine and required the extensive assistance of one staff for grooming, and toileting. On 5/18/15, at 11:37 a.m., R58 stated during an individual interview, there were times when NA-F ignored R58 by not answering the call light, not assisting the resident and not changing R58's incontinent product. R58 stated reporting NA-F to registered nurse (RN)-C. R58 also stated NA-F no longer worked at the facility. On 5/20/15, at	22000		

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22000	Continued From page 82 11:00 a.m., R58 was interviewed again about NA-F and how R58 felt when cared for by NA-F and R58 stated not feeling very good and explained that NA-F had not treated him well and NA-F had an "attitude" that NA-F was better than others. On 5/20/15, at 10:23 a.m., NA-D stated that about one and a half months ago, R58 reported to NA-D and NA-C, there was a nursing assistant [NA-F] who ignored R58, did not do anything for R58, and was not caring for the resident properly. On 5/20/15, at 11:20 a.m., NA-C stated to have verbally told RN-C what R58 had verbalized and had provided RN-B with the written information. NA-C stated the information was brought to RN-B after R58 made the report. NA-C stated R58 verbalized wanting to die. NA-C stated that R58's behavior and attitude changed whenever NA-F cared for R58 and explained that R58 would report not having a good evening because of having to do things without help, such as self-transferring into bed. NA-D stated that NA-D and NA-C, immediately wrote everything down that R58 had told them and presented the information to RN-C and RN- B. NA-D stated R58 seemed happier now and was not mentioning any more "bad information." On 5/20/15, at 11:04 a.m. R58's alleged neglect issue was discussed with RN-B, who stated "I guess I don't recall that", and denied having received any written information of the alleged neglect incident. On 5/20/15, at 11:25 a.m., social worker(SW)-A stated not being aware of any possible neglect of care for R58. SW-A stated R58 had recently seen a psychologist, as R58 had been complaining about a new resident in the next room being noisy	22000		

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22000	Continued From page 83 at night. SW-A stated staff felt R58 did not do well with changes and that seeing the psychologist would be good for the resident and R58 was doing better since having seen the psychologist. On 5/20/15, at 11:33 a.m., the director of nursing (DON) stated she had spoken to RN-C and RN-C did not recall receiving information from either NA-C or NA-D regarding R58's alleged neglect incident. On 5/20/15 at 1:20 p.m., NA-D stated NA-D and NA-C had written the information down on a large piece of paper and that NA-C who had delivered the written information to RN-B and RN-C. NA-D stated NA-D and NA-C felt, "very frustrated" that RN-B or RN-C stated they had not received the information. On 5/20/15, at 2:00 p.m., the DON was interviewed regarding NA-F. The DON stated NA-F had been terminated because of a vulnerable adult (VA) incident with a resident. A review of NA-F's personnel file revealed the VA incident the DON was referring to did not involve R58, but another resident residing in the facility. SUGGESTED METHOD OF CORRECTION: The facility could assure established policies and procedures for abuse prevention plan are implemented, enforced and that allegations of potential abuse are thoroughly investigated. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	22000		