CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: G3Q6

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART I - TO BE COMPLETED BY THE							ATE SURVEY AGENCY Facility ID: 00149				
MEDICARE/MEDICAID PROVIDER NO. (L1) 245223 2.STATE VENDOR OR MEDICAID NO. (L2) 955270700		3. NAME AND ADD (L3) RED WING I (L4) 1412 WEST F (L5) RED WING,	HEALTH CENT FOURTH STREE	ER		(L6) 55066	1. I 3. T	4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertificati 3. Termination 4. CHOW 5. Validation 6. Complaint				
5. EFFECTIVE DATE CHANGE OF OWNERS (L9)		7. PROVIDER/SUP	05 HHA	09 ESRD	02 13 PTIP	(L7) 22 CLIA		7. On-Site Visit 9. Other 8. Full Survey After Complaint				
6. DATE OF SURVEY 07/09/2015 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPIG	CE	FISCAI	YEAR ENDING I	DATE: (L3.	5)		
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	IS CERTIFIED AS ace With quirements Based On: acceptable POC pliance with Programents and/or Applied	n	2. 3. 4.	pproved Waivers (Technical Personi 24 Hour RN 7-Day RN (Rural Life Safety Code	SNF)	Requirements: 6. Scope of Servic 7. Medical Directo 8. Patient Room Si 9. Beds/Room	or					
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 145 (L37) (L38)	19 SNF (L39)	ICF	IID (L43)		15. FACILIT 1861 (e) (Y MEETS 1) or 1861 (j) (1):		(L15)				
16. STATE SURVEY AGENCY REMARKS (IF Facility's request for a continuing waiver of the surveyor Signature Susanne Reuss, Unit			SURVEY AGENC		Specialist	Date: 08/05/2015	i					
		BE COMPLETEI	D BY HCFA R	(L19) EGIONAI						(L20)		
DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participat 2. Facility is not Eligible	e (L21)		IPLIANCE WITH C	CIVIL	21. 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above:							
22. ORIGINAL DATE 23 OF PARTICIPATION 11/01/1978 (L24)	LTC AGREEM BEGINNING (L41)		4. LTC AGREEMI ENDING DAT (L25)		VOLUNTAL 01-Merger, 0 02-Dissatisf		00 esement	INVOLUNTA	et Health/Safety			
25. LTC EXTENSION DATE: 27. (L27)	ALTERNATIV A. Suspension B. Rescind Sus	of Admissions:	(L44) (L45)			ason for Withdrawa		OTHER 07-Provider S 00-Active	Status Change			
28. TERMINATION DATE:	29 (L28)	. INTERMEDIARY/C.	ARRIER NO.	(L31)	30. REMAR	RKS						
31. RO RECEIPT OF CMS-1539	32 L32)	. DETERMINATION C 07/06/2015	OF APPROVAL DA	(L33)	DETERM	IINATION AP	PROVAL					



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



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.

Red Wing Health Center August 5, 2015 Page 2

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

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245223	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 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
•	F0165 483.10(f)(1)		Correction Completed 06/30/2015		ID Prefix Reg. # LSC	483.13(c)(1)((ii)-(iii), (c)(2) -				F0226 483.13(c)		Correction Completed 06/30/2015
ID Prefix Reg. # LSC	483.15(c)(6)		Correction Completed 06/30/2015		ID Prefix Reg. # LSC	F0248 483.15(f)(1)		Correction Completed 06/30/2015			F0253 483.15(h)(2)		Correction Completed 06/30/2015
ID Prefix Reg. # LSC	F0254 483.15(h)(3)		Correction Completed 06/30/2015		ID Prefix Reg. # LSC	F0279 483.20(d), 48	33.20(k)(1)	Correction Completed 06/30/2015			F0280 483.20(d)(3), 483		Correction Completed 06/30/2015
	F0282 483.20(k)(3)(ii)					483.25(a)(3)		Correction Completed 06/30/2015		Reg. #	F0318 483.25(e)(2)		Correction Completed 06/30/2015
	F0323 483.25(h)		Correction Completed 06/30/2015		ID Prefix Reg. #	F0328 483.25(k)		Correction Completed 06/30/2015		ID Prefix Reg. #			Correction Completed 06/30/2015
Reviewed By	, F	Reviewed E	Зу	Dat 08/		Sign	ature of Surve	yor:	5022			Date: 07/09	9/2015
Reviewed By	, F	Reviewed E	Зу	Dat	te:	Sign	ature of Surve	yor:				Date:	

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245223	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 7/9/2015
Name	of Facility		Street Address, City, State, Zip Code	
RE	D 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
			Correction					Correction					Correction
ID Prefix	F0353		Completed 06/30/2015		ID Prefix	E0256		Completed 06/30/2015		ID Prefix	E0420		Completed 06/30/2015
			00/30/2013					00/30/2013					00/30/2013
Reg. # LSC	483.30(a)				Reg. #	483.30(e)				Reg. # LSC	483.60(c)		
									+-				_
			Correction					Correction					
			Completed					Completed					
ID Prefix	F0431		06/30/2015		ID Prefix			06/30/2015					
	483.60(b), (d), (e)			Reg. #	483.65							
LSC					LSC				_				
Reviewed By	'	Reviewed E		Da		Signature of	f Surve	_				Date:	
State Agency	/	SI	R/KJ	0	8/05/20	015		1	650	22		(07/09/2015
Reviewed By	· —	Reviewed B	Зу	Da	te:	Signature of	f Surve	yor:				Date:	
CMS RO													
Followup to	Survey Comple	ted on:		_							a Summary of		
	5/21/2015					Unco	orrecte	d Deficiencies	(CM	S-2567) Sent	to the Facility?	YES	NO

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245223	(Y2) Multiple Constr e A. Building B. Wing	N BUILDING 01	(Y3) Date of Revisit 7/6/2015
Name	of Facility		Street Address, City, State, Zip Code	
RE	D 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
			Correction					Correction					Correction
ID Deefin			Completed		ID Danfin			Completed		ID Danfin			Completed
ID Prefix			06/30/2015					06/30/2015					05/28/2015
•	NFPA 101 K0033				-	NFPA 101 K0076				•	NFPA 101 K0144		_
	K0033			-		K0070			+		<u>KU144</u>		_
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix					ID Prefix					ID Prefix			_
Reg. #					Reg. #					Reg. #			_
LSC					LSC					LSC			_
			Correction					Correction					Correction
ID Prefix			Completed		ID Prefix			Completed		ID Prefix			Completed
Reg.#													
					LSC					LSC			_
			Correction					Correction					Correction
ID Drofiv			Completed		ID Drofiv			Completed		ID Drofiv			Completed
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Reg. #					Reg. #					Reg. #			_
				-					+				_
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix					ID Prefix					ID Prefix			_
Reg. #					Reg.#					Reg. #			_
LSC					LSC					LSC			_
Reviewed By	Revi	iewed B	Ву	Da	te:	Signature of	Surve	yor:				Date:	
State Agency	PS	/KJ		08	3/05/20	15		2582	22			07/0	6/2015
Reviewed By	Revi	ewed B	Ву	Da	te:	Signature of	Surve	yor:				Date:	
CMS RO													
Followup to Survey Completed on:			Check for any Uncorrected Deficiencies. Was a Summary of					+					
	5/22/2015	5				Unco	rrecte	d Deficiencies	(CI	/IS-2567) Sent	to the Facility?	YES	NO

Form CMS - 2567B (9-92) Page 1 of 1 Event ID: G3Q622

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: G3Q6

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART	I - TO BE COM	PLETED BY T	THE STAT	E SURVEY A	AGENCY		Facility ID: 00149
MEDICARE/MEDICAID PROVIDER (L1) 245223 2.STATE VENDOR OR MEDICAID NO (L2) 955270700		3. NAME AND AD (L3) RED WING (L4) 1412 WEST (L5) RED WING ,	HEALTH CENT FOURTH STREI	ER	(L	.6) 55066	4. TYPE OF ACTION 1. Initial 3. Termination 5. Validation	2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OV (L9)		7. PROVIDER/SUI	05 HHA	Y 09 ESRD	<u>02</u> (L7) 22 CLIA	7. On-Site Visit 8. Full Survey After	9. Other Complaint
6. DATE OF SURVEY 05/2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	1/2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	Ξ	FISCAL YEAR ENDIN	G DATE: (L35)
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	145 (L18) 145 (L17)	A. In Compliar Program Re Compliance1. A X B. Not in Com	equirements	n	2. T 3. 2 4. 7	proved Waivers Of Th Technical Personnel 14 Hour RN 1-Day RN (Rural SNF) Life Safety Code B*	e Following Requirements: 6. Scope of Ser 7. Medical Dir) 8. Patient Roon 9. Beds/Room (L12)	vices Limit ector
14. LTC CERTIFIED BED BREAKDOW	N				15. FACILITY	MEETS		
18 SNF 18/19 SNF 145	19 SNF	ICF	IID		1861 (e) (1)	or 1861 (j) (1):	(L15)	
(L37) (L38) 16. STATE SURVEY AGENCY REMAR Facility's request for a continuing was a contin			(L43) LATION DATE):					
17. SURVEYOR SIGNATURE Momodou Fa	tty, HFE NE	Date :	06/24/2015	(L19)		urvey agency as hnsTon, Pro	ogram Specialis	Date: 07/02/2015 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA RI	EGIONAI	OFFICE O	R SINGLE STAT	TE AGENCY	,
DETERMINATION OF ELIGIBILIT			MPLIANCE WITH C	CIVIL			cial Solvency (HCFA-2572) Interest Disclosure Stmt (HC	FA-1513)
22. ORIGINAL DATE OF PARTICIPATION 11/01/1978	23. LTC AGREEM BEGINNING		24. LTC AGREEMI ENDING DAT		VOLUNTARY 01-Merger, Cl		05-Fail to	(L30) NTARY Meet Health/Safety Meet Agreement
(L24) 25. LTC EXTENSION DATE:	(L41) 27. ALTERNATIV A. Suspension		(L25) (L44)		03-Risk of Inv	oluntary Termination on for Withdrawal	<u>OTHER</u>	er Status Change
(L27)	B. Rescind Sus	pension Date:	(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/C	CARRIER NO.		30. REMARK	XS .		
		03001						
31. RO RECEIPT OF CMS-1539	(L28)	. DETERMINATION (OF APPROVAL DA	(L31) TE		67 sent to Rocl 07/06/2015 Co	hi 07/06/2015 Co.	
	(L32)			(L33)		NATION APPRO		



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:

<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

Red Wing Health Center June 15, 2015 Page 2

at the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

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

Fax: 651-215-9697

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

Red Wing Health Center June 15, 2015 Page 4

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:

Red Wing Health Center June 15, 2015 Page 5

> 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



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:

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6

Red Wing Health Center June 10, 2015 Page 2

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

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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.

Red Wing Health Center June 10, 2015 Page 4

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 Red Wing Health Center June 10, 2015 Page 5

> 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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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)

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

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	j ,	IPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		245223	B. WING_			5/21/2015
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1412 WEST FOURTH STREET RED WING, MN 55066		ST2 1720 13
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		FC	000		
	as your allegation of of Department's accepts bottom of the first page be used as verification. Upon receipt of an accepts of your facility of your facility of the page 1.	ance. Your signature at the ge of the CMS-2567 form will n of compliance. ceptable POC an on-site will be conducted to validate liance with the regulations	6/24/15 SEX	JUN 2 COMPLIANCE MON LICENSE AND	4 2015	ISION
F 165 SS=E		O VOICE GRIEVANCES -	F1	65 <u>F 165</u>		
	discrimination or repri include those with res been furnished as we furnished. This REQUIREMENT by: Based on document if facility failed to ensure grievances without fea	pect to treatment which has as that which has not been is not met as evidenced review and interview, the eresident rights to voice ar of reprisal was honored		Immediate corrective Interviews for residen R16, R18, R 32, R52 ar were conducted as sor facility became aware grievances. Grievance were completed and s to the IDT for review a up. LPN (A), NA (A) and NA	ts (R 13, and R124) on as the of the forms ubmitted and follow-	w(30/15
	R124) in the sample w Findings include: R13, R16, R18, R32, I	13, R16, R18, R32, R52, tho expressed grievances. R52 and R124 expressed as at the resident council solution to the conserve.		members received imm education on 5/19/15 of facility became aware of residents' concerns.	once the	
	expressed. A review of the resider		E	TITLE		(X6) DATE

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.

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MUL ⁻ A. BUILDI		(X3)	(X3) DATE SURVEY COMPLETED	
		245223	B. WING				05/21/2015
	ROVIDER OR SUPPLIER G HEALTH CENTER			1412	EET ADDRESS, CITY, STATE, ZIP CODE WEST FOURTH STREET WING, MN 55066		03/21/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	2/2/15, under the section of the problems being comfort to the staff vill push and take care of me and the problems being comfort the problems being comfort the problems pushed.	tion marked Nursing, read, son 2E need to be think they should've been ne section titled Social to respect. 2E doesn't feel met. 2E Lights aren't being /2 hour to an hour. Talked ring to be helpful but nt to hear it." Residents who neeting were R13, R32 and 2015 and April 2015 es lacked mention of the pary 2015 resident council 5/18/15, at 9:20 a.m., R16 rait long periods of time for ares and position changes. The people that live here try to when the staff get mad at at longer, I don't want to be R16 stated, "If I complain, pull on me more when they at hurts. I already have retable in this chair and I am the wait longer for help." ity management was aware sident council which R16 h [R13, R52 and R124] eople who watch out for	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		
	Review of R16's medical record indicated an annual minimum data set (MDS) completed 3/18/15, which assessed R16 as cognitively intact						

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245223	B. WING			0	5/21/2015	
	ROVIDER OR SUPPLIER	,	•	1412	EET ADDRESS, CITY, STATE, ZIP CODE 2 WEST FOURTH STREET D WING, MN 55066		37 <u>2172</u> 013	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N BE RIATE	(X5) COMPLETION DATE		
	p.m., a concern was ecomplain the staff will want to complain. We was done about it." Reresident council meeting R52 expressed concellong periods of time for chair is very uncomfor constant pain from a keto see better custome staff but does not wanterly MDS complet was assessed as cognimate decisions about During an interview or R32 validated the confebruary 2, 2015 reside confirmed the resident about the lack of resoll were afraid of retaliation stated, "Be sure to talk because they are seried staff being mean to the Review of R32's medic quarterly MDS complet was assessed as cognimate decisions about When interviewed on SR124 talked about lice	isions about care. ith R52 on 5/18/15, at 3:15 expressed about, "If I get back at me so I don't complained and nothing 52 made reference to the ng in February 2015 when rns about having to wait or assistance, that the wheel table, and she is in the injury. R52 would like or service training for the tothem to, "Get back at me." cal record indicated a sted 4/30/15, which R52 initively intact and able to care. in 5/19/15, at 10:32 a.m., cerns addressed at the dent council meeting and its continued to be upset aution and that the residents on from the staff. R32 its (R13) and [R124] busly concerned about the em." cal record indicated a ted 2/18/15, which R32 initively intact and able to care. in 5/19/15, at 10:37 a.m., insed practical nurse LPN-A] is always so mad	F	165				

PRINTED: 06/10/2015 FORM APPROVED

OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ 245223 B. WING 05/21/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1412 WEST FOURTH STREET RED WING HEALTH CENTER RED WING, MN 55066 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 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

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ı	TIPLE CONSTR		(X3) DATE SURVEY COMPLETED		
		245223	B. WING				05/21/2015	
RED WIN	ROVIDER OR SUPPLIER G HEALTH CENTER			1412 WEST	DRESS, CITY, STATE, ZIP CODE T FOURTH STREET G, MN 55066		03/21/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON O BE 'RIATE	BE COMPLETION		
	worth anything. It was laughed at." R13 feels against him by not tall time and this is "to get complained about her Review of R13's mediannual MDS complete assessed as cognitive decisions about care. During an interview with p.m., a concern was expeased to be a long time the unit." R18 stated, "something wrong to the way." R18 validated her management because they will get back at metal Review of R18's medic annual MDS completed assessed as cognitively decisions about care. During an interview with services (DSS), the direct assessed as cognitively decisions about care. During an interview with services (DSS), the direct assessed as cognitively decisions about care. During an interview with services (DSS), the direct assessed as cognitively decisions about care. RN-A, validated there we will be concerns expressed Resident Council meeting resident council	like being a kid and being the NA-A has retaliated king to him for a period of a back at me because I " cal record indicated an d 3/11/15, which R13 was ly intact and able to make the R18 on 5/19/15, at 2:00 expressed that the staff are they push him around in a sn't want to complain for use "these people have and are the usual staff in Maybe I have done em so they treat me this edid not report to he stated, "I am afraid e." al record indicated an d 4/8/15, which R18 was y intact and able to make the director of social ector of nursing (DON) and A on 5/19/15, at 10:45 e February Resident The DSS, DON and was no investigation into d at the February 2015 ng. There were no	F	165				

		L & WEDICAID SERVICES			OMB	OMB NO. 0938-039		
STATEMENT OF DEFICIENCIES (X1) P AND PLAN OF CORRECTION ID		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	PROVIDER/SUPPLIER/CLIA (X2) MUL IDENTIFICATION NUMBER: A. BUILDI		(X3) DA	(X3) DATE SURVEY COMPLETED		
		245223	B. WING			05/04/0045		
NAME OF PROVIDER OR SUPPLIER RED WING HEALTH CENTER			1	STREET ADDRESS, CITY, STATE, ZIP 1412 WEST FOURTH STREET RED WING, MN 55066	CODE	05/21/2015		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	(TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
F 165 F 225 SS=D	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. 483.13(c)(1)(ii)-(iii), (c)(2) - (4)		F 2	<u>F 225</u>				
	been found guilty of ab mistreating residents bhad a finding entered in registry concerning about of residents or misappresidents for second of law against an indicate unfitness for second or licensing authorities. The facility must ensured involving mistreatment, including injuries of unk misappropriation of resimmediately to the admitto other officials in account of the stablished prosidents of the survey and certification. The facility must have experience in the stablish of the survey and certifications.	y a court of law; or have not the State nurse aide use, neglect, mistreatment opriation of their property; dige it has of actions by a employee, which would ervice as a nurse aide or State nurse aide registry e that all alleged violations neglect, or abuse, nown source and dent property are reported inistrator of the facility and rdance with State law cedures (including to the cation agency). vidence that all alleged y investigated, and must abuse while the		An internal investigation conducted for residus 5/20/15 RN-B and RN-C received education on abuse Corrective action as others: The policy and proce Abuse Prevention was on 6/11/15 and remains and the policy educated on the policy procedure for Abuse by 6/30/2015.	etion was ent (R58) on ved re- reporting. it applies to dure for as reviewed ains current. f will be re- cy and	w/3e/15		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245223	B. WING			0	5/21/2015
	PROVIDER OR SUPPLIER G HEALTH CENTER		•	141	REET ADDRESS, CITY, STATE, ZIP CODE 2 WEST FOURTH STREET D WING, MN 55066	1 0	3/21/2015
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	The results of all investo the administrator or representative and to with State law (includicertification agency) wincident, and if the alleappropriate corrective This REQUIREMENT by: Based on interview arfacility failed to investig mistreatment for 1 of 2 reported to facility staff. Findings include: A review of R58's elect revealed a Brief Intervi (BIMS) had been comp. R58 scored 14/15, indiintact. The eHR care prevealed R58 was ableed angerous situation", but to safety in a dangerou staff to assist me to saf quarterly minimum data revealed R58 was alware quired the extensive agrooming, and toileting. On 5/18/15, at 11:37 and individual interview, the nursing assistant (NA)-lanswering the call light,	estigations must be reported this designated other officials in accordance ing to the State survey and within 5 working days of the eged violation is verified action must be taken. It is not met as evidenced action must be taken. It is not met as evidenced action must be taken. It is not met as evidenced action for the eget allegations of potential aresidents (R58) who had are possible neglect of care. It is not met as evidenced actions of potential aresidents (R58) who had are possible neglect of care. It is not met as evidenced actions of potential aresidents (R58) who had actions act	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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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 245223 B. WING 05/21/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1412 WEST FOURTH STREET RED WING HEALTH CENTER RED WING, MN 55066 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ 245223 B WING 05/21/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1412 WEST FOURTH STREET **RED WING HEALTH CENTER** RED WING, MN 55066 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 225 Continued From page 8 F 225 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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245223	B. WING _		05	/21/2015	
NAME OF PROVIDER OR SUPPLIER RED WING HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1412 WEST FOURTH STREET RED WING, MN 55066			
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F 225 F 226 SS=D	R58, but another residence 483.13(c) DEVELOP/ABUSE/NEGLECT, EThe facility must dever policies and procedur mistreatment, neglect and misappropriation This REQUIREMENT by: Based on interview a facility failed to investimistreatment, per facility facility is policy titl. The facility's policy titl. Abuse & Neglect Previousled all incidents suspected mistreatme immediately and upor nursing supervisor on investigating the situal physical assessment all staff involved in the findings. Based or from R58, the facility fand procedure. A review of R58's electrovealed a Brief Interview.	dent residing in the facility. IMPLMENT TC POLICIES Ilop and implement written es that prohibit , and abuse of residents of resident property. is not met as evidenced and document review, the gate allegations of potential lity policy, for 1 of 2 reported to facility staff re. ed Vulnerable Adult & rention and dated 5/12, of mistreatment or ent were to be reported a receipt of the report the duty was to begin tion by conducting a of the resident, speaking to e situation and document a the information received ailed to follow the policy etronic health record (eHR), iew for Mental Status	F 2	225	o d nt. s	id 30 15	
		pleted on 4/21/15, which 14/15, indicating R58 was					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245223	B. WING_			05/24/2045	
	PROVIDER OR SUPPLIER G HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP 1412 WEST FOURTH STREET RED WING, MN 55066	CODE	05/21/2015	
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	cognitively intact. The 8/12/13, revealed R58 recognize a dangerou remove myself to safe I would need staff to a was also identified as urine and required sta recent quarterly minim 4/21/15, revealed R58 urine and required the one staff for grooming On 5/18/15, at 11:37 a individual interview, the ignored R58 by not an assisting the resident a incontinent product. R8 registered nurse (RN)-no longer worked at the 11:00 a.m., R58 was in NA-F and how R58 felt and R58 stated not fee explained that NA-F had NA-F had an "attitude" others. On 5/20/15, at 10:23 a. one and a half months NA-D and NA-C, there [NA-F] who ignored R58, and was not caring on 5/20/15, at 11:20 a. werbally told RN-C what had provided RN-B with NA-C stated the informatifier R58 made the reparts of the safet R58	eHR care plan dated a was able to "reliably s situation", but "cannot ty in a dangerous situation, ssist me to safety." R58 frequently incontinent of ff assistance. The most um data set (MDS) dated was always incontinent of extensive assistance of and toileting. .m., R58 stated during an ere were times when NA-F swering the call light, not and not changing R58's sated reporting NA-F to C. R58 also stated NA-F er facility. On 5/20/15, at terviewed again about when cared for by NA-F ling very good and d not treated him well and that NA-F was better than m., NA-D stated that about ago, R58 reported to was a nursing assistant 8, did not do anything for g for the resident properly. m., NA-C stated to have a R58 had verbalized and a the written information. Action was brought to RN-B bort. NA-C stated that R58's langed whenever NA-F	F 2	All alleged occurrence suspected abuse or repetition of the investigative reported and/or Social Service ensure the investigative through and completion of the investigative relevant dates and tis summary of all investinterviews with all string the incident, identification of the rinterventions implemented alleged staff member identification of the rinterventions implemented alleged abuse and will reviewed by the QA comonthly for IDT input recommendations. The an ongoing practice. The correction will be monitored by: Administrator and/or	res of neglect will igated by ng and /or oce with to the vestigation, ort will be diministrator Director to ion is e including: mes, tigative aff involved iffication of oce including iffication of oce including iffication of oce including includ		

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OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING _ COMPLETED 245223 B. WING 05/21/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1412 WEST FOURTH STREET RED WING HEALTH CENTER RED WING, MN 55066 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLÉTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) 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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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING CON	E SURVEY IPLETED 5/21/2015
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1412 WEST FOURTH STREET	5/21/2015
RED WING HEALTH CENTER 1412 WEST FOURTH STREET	
ILLD WING, WIN 35000	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 244 "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, "If complain, the staff will push and puil 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 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.	

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		245223	B. WING _			F/04/004 =
NAME OF PROVIDER OR SUPPLIER RED WING HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1412 WEST FOURTH STREET RED WING, MN 55066	1 0	5/21/2015
(X4) PREF TAC	IX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F2	p.m., a concern was a complain the staff will want to complain. We was done about it." R resident council meet R52 expressed conce long periods of time for chair is very uncomfor constant pain from a ket to see better custome staff but does not wan Review of R52's medit quarterly MDS complet was assessed as cognimate decisions about During an interview on R32 validated the concert february 2, 2015 reside confirmed the resident about the lack of resolution were afraid of retaliation stated, "Be sure to talk because they are serior staff being mean to the Review of R32's medic quarterly MDS complet was assessed as cognimate decisions about when interviewed on 5 R124 talked about licer (LPN)-A and stated, "[I at me, One day she call	ith R52 on 5/18/15, at 3:15 expressed about, "If I get back at me so I don't complained and nothing 52 made reference to the ing in February 2015 when in about having to wait or assistance, that the wheel table, and she is in the inguiry. R52 would like in service training for the it them to, "Get back at me." cal record indicated a sted 4/30/15, which R52 initively intact and able to care. 5/19/15, at 10:32 a.m., beens addressed at the lent council meeting and is continued to be upset button and that the residents on from the staff. R32 ito [R13] and [R124] is always concerned about the indicated a seed 2/18/15, which R32 itively intact and able to care.	F2	monthly meeting until each grievance is resolved. Resident council minutes will be shared with the monthly QA committed for their input and recommendations for continue monitoring. This will be an ongoing process. The correction will be monitored by: Social Service Director and/or designee	ee	

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OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ 245223 B. WING 05/21/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1412 WEST FOURTH STREET RED WING HEALTH CENTER RED WING, MN 55066 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRFFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 244 Continued From page 17 F 244 the facility. When interviewed, the DSS, DON and RN-A validated the concerns should have been investigated. F 248 483.15(f)(1) ACTIVITIES MEET F 248 SS=D INTERESTS/NEEDS OF EACH RES F248 The facility must provide for an ongoing program Immediate corrective action: 6/30/15 of activities designed to meet, in accordance with the comprehensive assessment, the interests and Recreation staff will coordinate the physical, mental, and psychosocial well-being of each resident. with nursing to have Resident (R83) brought out to movies, Bible study, and reading group This REQUIREMENT is not met as evidenced on a weekly basis, and provide 1:1 visits throughout the week by by: recreation staff and volunteers. Based on observation, interview and document review, the facility failed to provide an individualized program of activities to meet the Corrective action as it applies to psychosocial wellbeing of each resident for 1 of 3 others: residents (R83) reviewed for activities. Recreation will provide for all Findings include: residents in persistive vegative state, one to one visits by the recreation staff and/or R83 did not receive activities as directed by the volunteers throughout the week. plan of care. Recreation staff will highlight During observations on 5/17/15, at 3:00 p.m. and activities on the resident's activity preference and needs at 7:00 p.m., R83 was laying in bed on the right worksheet and, place this in the side. Eyes were open but there was no response resident's room next to their to verbal communication. There was no radio, no monthly activities schedule. 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER SUPPLIER 245223 NAME OF PROVIDER OR SUPPLIER RED WING HEALTH CENTER (X2) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) FREFX TAG 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. (X2) MULTIPLE CONSTRUCTION A. BUILDING STREET ADDRESS, CITY, STATE, ZIP CODE 1412 WEST FOURTH STREET RED WING, MN 55066 PREFIX CROSS-REFERENCED TO THE APPROPRIATE OEFICIENCY A. BUILDING STREET ADDRESS, CITY, STATE, ZIP CODE 1412 WEST FOURTH STREET RED WING, MN 55066 PREFIX CROSS-REFERENCED TO THE APPROPRIATE OEFICIENCY A. BUILDING STREET ADDRESS, CITY, STATE, ZIP CODE 1412 WEST FOURTH STREET RED WING, MN 55066 PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECT	OLIVIEI	TO FOR MEDICANE &	MEDICAID SERVICES				OMRIM). 0938-0391
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Table Continued From page 18 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 kexpressed [R83] being so young and involved with music, and videos, which were a big part of fis 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. Summary staff will per reductive for seeing activity involvement. 1412 WEST FOURTH STREET RED WING, MN 55086 REQ WING, MN 55086 Commet ReD 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 Commet Red Will will be re-educated by 6/30/2015 Commet Red Will Red CROSS-REFERNOED To THE APPROPRIATE (CACHOR CORRECTIVE ACTION ACTI			245223	B. WING			05/	/21/2015
RED WING, MN 55066 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. PREV WING, MN 55066 RED WING, MN 55066 PREFIX CACH CORRECTION (EACH CORRECTION (EACH CORRECTION (EACH CORRECTION THE ACTION SHOULD BE COMPLE CORNECTIVE ACTION SHOULD BE COMPLE CORNECTIVE ACTION SHOULD BE CACH CORRECTIVE	NAME OF P	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE		
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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;	F 248	no radio, no television the room. When interviewed on Family member (F)-A discouraged" because activities as much as to see R83 "more involved being so young and in and videos, which we which should still be a the facility was aware activities in the March stated several family r frequently and have e they are not seeing activities in the control of the control o	5/18/15, at 11:32 a.m. expressed being "upset and possible and F-A would like bloved." F-A expressed [R83] avolved with music, movies, are a big part of [R83's] life, apart of his life. F-A verified and F-A talked about 2015 care conference. F-A members who visit expressed concern because stivity involvement. In the medical record (eMR) was admitted to the facility are diagnoses from R83's 19/15, listed, but was not y, septicemia, endocarditis, ranial hemorrhage. The DS) assessment dated be section B Hearing, and; Comatose, Persistent scernable consciousness. The quarterly Minimum 1/28/15, as severe and unable to answer the activity plan of care, availity of Life: Continuing for to admission are this type of music: Rap, I	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		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	1 ' '	E SURVEY MPLETED
		245223	B. WING		0:	5/21/2015
	ROVIDER OR SUPPLIER G HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1412 WEST FOURTH STREET RED WING, MN 55066	•	
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F 248	1:302:30 p.m. movi showing in the dining the movie. During an interview won 5/19/15, at 9:42 a. volunteer visitor who hand massage but AA sensory stimulation for would benefit from be what [R83] can compressed not being scrowded group setting know if [R83] can see is doing." AA-A verifier group setting activities	ith the activity aide (AA)-A m., revealed R83 has a comes every two weeks for A-A is not sure of the or R83 and exactly what he cause stated, "I am not sure rehend." Furthermore AA-A sure about R83 being in a g and stated, "We do not anything or what the brain d R83 was not brought to s and that the nursing staff he television and music for	F 24	The correction will be monitored by: Director of activities and/or designee		
SS=E	MAINTENANCE SER The facility must provimaintenance services sanitary, orderly, and This REQUIREMENT by: Based on observation review, the facility faile orderly and comfortab west and 3 east) unit if urine odors. 2 of 10 (F window curtains were hemming. 6 of 8 resid	VICES de housekeeping and necessary to maintain a		Immediate corrective action: 2West and 3East unit hallway where cleaned. Resident (R13 and R18) had their window curtains replaced. Wheelchair where cleaned for residents (R16, R18, R28, R29, R40, and R52). Rooms of resident (R40 and R164) had touch up paint done in their rooms, and resident (R98) had the floor s removed.	s ng	6/30(15

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE S	
		245223	B. WING _			05/2	1/2015
	ROVIDER OR SUPPLIER G HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZI 1412 WEST FOURTH STREET RED WING, MN 55066	IP CODE	, 00,2	
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	repair and 1 of 10 res staining on the floorin Findings include: Throughout various ti survey 5/17, 5/18, 5/1 strong urine odor obsewest and 3 east hallw During a family memb 5/18/15, at 11:32 a.m. come into this building must be something the aware of it for months they figure it out and giverified family member to complain about the members have complain about the members have complained facility on behalf of the speak up and would not buring an observation housekeeper (H)-A was the hallway and stated the smell." H-A validate odor in the 3 east hall where the odor was calcounteractant. During observation of 1:30 p.m., on 2 east haresident (R13, R18) wifrayed, undone hemmin of the 24 to 36 inch ed on 5/18/15 at 1:30 p.m.	R164) required paint and ident rooms (R98) had dark g. mes, each day of the 9 and 5/20/15, there was a erved to be present in the 2 ays. er (F-A) interview on F-A stated, "Everytime I g it smells like piss, there ey can do for that. I've been and complaining, why can't get rid of the smell." F-A r was not cognitively intact odor but the family ained about the odor in the eresident who cannot of like the odor. on 5/19/15 at 12:00 p.m., as spraying a substance into I, "We are trying to cover up ed there was a strong urine	F 2	Corrective action as others: Carpets will be deep eliminate odors once will be spot scrubbed urine odor removed Housekeeping staff veducated on placing in the Tels maintenance communication systerepairs needed in restormation on all distressidents to insure the repairs needed to the be addressed. Wheel scheduled for deep to be announced in the nursing can assist how to coordinate wheeld cleaning. Dirty wheele being wiped down by housekeeping and nure daily basis after meals. Housekeeping and nure will be re-educated by Recurrence will be proby: 2 random weekly audic conducted on each undays to ensure hallware.	o cleaned to e a week and d daily with as needed. will be re- information nce em for sident's will receive scharging hat any at room can lchairs cleaning will morning so usekeeping chair lchairs are v ursing on a s. ursing staff y 6/30/2015 revented its will be nit for 90		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		i	TIPLE CONSTRUCTION ING	(X3) DA	TE SURVEY MPLETED	
		245223	B. WING_			F 104 1004 F
	ROVIDER OR SUPPLIER G HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP C 1412 WEST FOURTH STREET RED WING, MN 55066	CODE	5/21/2015
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	validated his family we the frayed edges during the will bother them, so fixed." When interviewed on verified the unhemmer "irritating" because Resign his room and would repair. During observation of R18's bedroom, with the housekeeping (DLH) of DLH verified the curtar down and repaired and During various observes 5/19/15, the wheel charmal R40, and R52, had a the crumbs present on the under the cushions and foot plates of the wheel charmal plants of the whole will be taken care of to the wheel chairs and the wheel chairs and the common is "deep cleaned."	ould not appreciate seeing ng visits and stated, "Maybe I think they should be 5/19/15, at 2:30 p.m., R13 d, frayed curtain was 13 expressed "taking pride" like things to be in good the curtains in R13 and he director of laundry and on 5/19/15, at 2:30 p.m. the ins needed to be taken d/or replaced. ations on 5/17, 5/18 and airs of R16, R18, R28, R29, ouild up of grime and exides of the wheel chair, d in some instances on the elechair. the wheel chairs for R16, and R52, with the director of ping (DLH) on 5/19/15, at fied the wheel chairs and the DLH stated, "They day." The DLH verified in to monitor the cleaning of the housekeeping staff were irs once a month when the "	F2	of odor and resident wheelchairs are clea good repair. Audit r be shared with the m committee for their i recommendations fo monitoring. The correction will be monitored by: Director of Laundry at Housekeeping and/or	n and in results will nonthly QA input and or continued e	
	form titled, Deep Clean R18 had the wheel cha	Checkoff List, revealed ir cleaned on 4/8/15, R28 aned on 4/2/15 and R40				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245223	B. WING			05	/21/2015
	ROVIDER OR SUPPLIER G HEALTH CENTER			1	TREET ADDRESS, CITY, STATE, ZIP CODE 412 WEST FOURTH STREET RED WING, MN 55066		
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F 253	had the wheel chair of no other forms produce wheel chair cleaning R16, R29 and R52. Further interview on 5 DLH revealed, wheel day shift, but if a residence the housekeeping state wheel chair. The DLH are done on the day sthere is an evening he but they are busy doir on 5/20/15, at 10:00 awas conducted with the maintenance director, the corporate housekeen environmental tour, R noted to have gouges marks on the walls. The verify they were in near and the facility did not when a room is to be and the side of the roor this time. The residence over the orange spots housekeeping directors.	ced for review to indicate if occurred in April or May for 5/19/15, at 2:30 p.m. with the chairs are cleaned on the dent is up in the wheel chair ff are unable to clean the stated, "The wheel chairs shift if they can get to them, busekeeper from six to ten, and the dining rooms." a.m., an environmental tour the administrator, housekeeping director and the dining rooms were and the maintenance director did the dof repair and painting, whave a system in place painted. The was noted to have pots observed on the floor on that was unoccupied at the corporate or stated the orange marks	F:	253			
F 254 SS=D	the spot with his shoe	; however when he scraped , the orange spot did wipe g director verified the floor BED/BATH LINENS IN	F 2	254			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245223	B. WING			0.5	/21/2015
	ROVIDER OR SUPPLIER G HEALTH CENTER			14	TREET ADDRESS, CITY, STATE, ZIP CODE 112 WEST FOURTH STREET ED WING, MN 55066	1 00	121/2010
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F 254	Continued From page	: 23	F	254	F 254		
		de clean bed and bath			Immediate corrective action:		
		is not met as evidenced			Bariatric fitted sheets were provided for residents (83 and R106) on 5/19/2015.		6/36/15
		n, interview and document ed to provide proper fitting ents (R83, R106) using			Corrective action as it applies to others:		
	APM-2 bariatric mattre				Bariatric fitted sheets have been ordered and will be used for all bariatric sized beds.		
	a.m. R83 was turned tassistants (NA)-F and	cares on 5/19/15, at 10:30 from side to side by nursing NA-K for urinary e bottom sheet was not a			Staff will be educated on the need to place fitted sheets on all bariatric beds.		
	resulted in R83 having	s during the incontinence			Recurrence will be prevented by:		
	struggling to keep bed cares. There was fricti	linen under R83 with on and shearing as the ed on the bed linens in an			3 weekly random audits will be completed for 90 days to ensure bariatric fitted sheets are available and in use for each		
	NA-A and NA-K verifie				resident who requires them. Audit results will be shared with the QA committee for their input on the need for continued monitoring.		
		the friction and shearing of ng assistants said they			The correction will be monitored by:		
	J	vide proper fitting linens for ss.			Director of nursing and/or designee		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		ONSTRUCTION		E SURVEY MPLETED
		245223	B. WING _			0,	5/21/2015
	ROVIDER OR SUPPLIER G HEALTH CENTER			1412	EET ADDRESS, CITY, STATE, ZIP CODE 2 WEST FOURTH STREET D WING, MN 55066	1	
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F 279	This REQUIREMENT by: Based on observation interview, the facility of comprehensive plant of facial hair removal for R117, R102) reviewed Findings include: R17 was observed to evening of 5/17/15, and of the survey on 5/18/ The Care Area Assess Daily Living (ADL's) for Potential dated 3/9/15 dependent on staff for Staff will proceed to concesident's) dependent dignity and cleanlines The care plant dated 3/alteration in hygiene/Addirected staff, "I receive wash once a week I and hygiene needs. Goals and odor-free daily. In residents' skin during irritation or breakdown however the care plant facial hair for residents. R117 care plant lacked shaving.	is not met as evidenced n, document review and did not develop a of care regarding shaving or 3 of 4 residents (R17, d for personal cares. have several facial hairs the nd during subsequent days 15 and 5/19/15. sment (CAA) for Activities of unctional/Rehabilitation is, indicated, "Resident is all ADL's and cares are plan residents are plan residents are on staff and to maintain s." 6/18/15, identified R17 had ADL's/shower/bath and are a partial bath and a hair m dependent on staff for all it I would like to be clean atterventions Staff monitor bath and cares for signs of and further evaluates" a did not address shaving the have several facial hairs and during subsequent	F 2	79	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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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING_ 245223 B. WING 05/21/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1412 WEST FOURTH STREET RED WING HEALTH CENTER RED WING, MN 55066 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 279 | Continued From page 26 F 279 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

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	objectives and timetal medical, nursing, mer that are identified in the assessment (the MDS Care plans include proshort-term goals, objectives and timetal proshort-term goals, objectives, as well as a specific disciplines resplan from becoming merovides rationale for a the basis for evaluation R102's plan of care did R102 was observed or darker colored facial halip, chin and upper neck doesn't mind being shad (F)-M in the room indiciclean shaven however, when visiting. The visiting member visits frequent R102 when visiting. On 5/19/15 at 2:00 p.m was made and R102's along facial hair on entire was visiting and confirm shaved for a few days as F-C verified R102 is not when she visits, and fre R102's care plan, last re R102 would like to be conformed daily. However does not identify personneeds for R102. On 5/20/15 at 12:00 p.m care plan did not identify grooming/shaving needs	coles to meet a resident's and and psychosocial needs are comprehensive of the RAI)	F	279			

STAT	EMENT	OF DEFICIENCIES					OMP	NO. 0938-039
AND	PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) E	DATE SURVEY OMPLETED
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1		PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE 1412 WEST FOURTH STREET RED WING, MN 55066		05/21/2015
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	= 280 SS=D	PARTICIPATE PLANN The resident has the ri	ING CARE-REVISE CP	F:	280	<u>F 280</u> Immediate corrective action:		
		incompetent or otherw incapacitated under the participate in planning changes in care and tre	e laws of the State, to care and treatment or eatment.			The temporary care plan for resident R 163 was updated on 5/19/2015.		4(30/15
		comprehensive assess interdisciplinary team, to physician, a registered for the resident, and oth disciplines as determined and, to the extent pract the resident, the resident legal representative; and	ment; prepared by an hat includes the attending nurse with responsibility her appropriate staff in ed by the resident's needs, icable, the participation of ht's family or the resident's			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.		
	1	This REQUIREMENT is by: Based on interview and failed to update the care (R163) with a pressure to (R102) with falls and 1 on therapy recommendation	record review, the facility plan for 1 of 3 residents alcer, 1 of 3 residents f 3 residents (R87) with			On 5/20/2015, the ADON and RN-B received immediate reeducation regarding updating resident care plans upon the discovery of any new pressure ulcer, therapy recommendations and fall interventions.		
	A e e	Findings include: A Comprehensive Evalua and Risk Factors was co electronic health record (assessment revealed R1 he facility with a scar on	mpleted in R163's eHR) on 5/14/15. The 63 had been admitted to					

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ 245223 B. WING 05/21/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1412 WEST FOURTH STREET RED WING HEALTH CENTER RED WING, MN 55066 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLÉTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) F 280 | Continued From page 29 F 280 Corrective action as it applies to measured 2.5 x 3.5 centimeters and which was others. the result of previous pressure ulcers. An eHR progress note dated 5/14/15, at 9:38 a.m., noted The policy and procedure titled R163 was admitted with Mepilex in the coccvx "Care Planning, IDT" was area "over a fragile area. Area is closed." Another reviewed and remains current. eHR progress note dated 5/15/15, at 11:11 p.m. revealed there was an "excoriated skin on Licensed staff will be reсоссух." educated on the policy and procedure by 6/30/2015. The undated temporary care plan indicated R163 was to be turned and repositioned by one to two The individual care plans for staff every two hours and when necessary. residents with current wounds. However, the temporary care plan was not falls within the last 12 months or updated after identification of a new pressure those who currently use orthotic ulcer in the coccyx area which was noted on devices will be reviewed by 5/18/15. 6/30/2015 to ensure the care plans are current including On 5/18/15, at 2:45 p.m. R163 was observed current interventions. 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 coccvx. 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 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

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F 280	care plan not having to R102's plan of care we therapy recommendate On 5/17/15 at 5:43 p.r. the registered nurse (contracture of the left extension orthotic. During random observacions of the left extension orthotic. During random observacions a family member (F)-Northodom of the left extension orthotic. During random observacions a family member (F)-Northodom of the lower and sure why. On 5/19/15 sitting in room in Brod member (F)-Northodom of the lower arm unsure where the elbodom of the lower than arm straps on per program of the most of evidence the informatic added to the care plan the nursing assistants lacked any information use of the elbow orthodom of 5/20/15 at 12:00 p. appeared the splint wait had not been added	as not updated with a tion. m., during staff interview, RN)-B reported R102 had a arm and wore a left elbow vation on 5/18, and 5/19/ear a left elbow brace. On R102 was sitting in Broda g television and visiting with M. F-M reported R102 did the left arm and he was not at 2:40 p.m., R102 was a chair. Another family siting and R102 had a low under the left elbow and an and chest wall. F-N was low splint was. Or occupational therapy vas reviewed. The 102 "requires maximum appropriately donn, doff st orthotics and left elbow ther and staff will carry over diall staff have been placing gram already in place." urrent care plan lacked on from OT had been in The care card used by to direct resident care, in or update regarding the	F	2280	Recurrence will be prevented by: 2 random weekly care plan audits will be conducted on eac 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		

STATEMENT	T OF DEFICIENCIES	(VA) PROVIDED ON THE PROVIDED	- 1			OMB	NO. 0938-0391
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	it must have been mis would also be added. Resident 87 did not he for a fall with an injury. On 5/17/15 at 7:13 p.r. currently had a fractur wearing a sling for the on 5/3/15 at 1:30 a.m. in a fracture of the right another fall on 5/10/15. No injury was reported A review of the facility! Report was completed 5/3/15 and indicated the floor in the residen the hospital for evalual fractured right humerus was completed and oth developed. They incluithe use of a transfer poposition. A review of the current transfer pole was being 5/17/15 the following in keep bedroom door racto keep surrounding are sleeping. The care plan include the injury of the or other interventions to care plan did not includit was to be worn or rem On 5/20/15 at 2:50 p.m. interventions and the canot been updated to income and services needed. In addition, a review of the care in the state of the care of the car	ave an updated care plan m., RN-B reported R87 ed right humerus and was right arm. R87 had a fall in his room which resulted in humerus. R87 had is from the bed to the floor. Is Unusual Occurrence The form was dated he resident was found on it's room. R87 was sent to ition and treatment of a is. A post fall assessment her interventions were ded: therapy to evaluate ble, and place bed in a low care plan indicated the in reevaluated and on tervention was added: to eked open at night and try and quiet to assist with in was not updated to fractured right humerus, of direct staff care. The in e care for the sling, when invoved etc. RN-B reviewed the are plan and agreed it had lude the injury and care	F	280			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i	TIPLE CONSTRUCTION	(>	(3) DATE SURVEY COMPLETED
		245223	B. WING			05/21/2015
	ROVIDER OR SUPPLIER G HEALTH CENTER		•	STREET ADDRESS, CITY, STAT 1412 WEST FOURTH STREET RED WING, MN 55066		03/21/2013
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	had a "Special Accordindicating he was award to not follow normal right upper arm brace intervention indicated agreement would be upon return from hos The nursing assistant residents care) direct hand orthotic to be was medical record lacker review of the accommon frefusal of wearing interventions for the During interview, on registered nurse (RN contracture on right anot being worn. RN-Ea fractured right hum sling for the right arm During random obsers 5/19/15 from 7:10 a.r. the wheelchair in the breakfast meal and the would self propel wheels as back into dining rohallway by the nursin evidence of a right had On 5/20/15 at 1:00-2: wearing a right wrist on 5/20/15 at 11:23 at the rapist (OT)-B verifing reparators and When asked, OT-B in the orthotic while weaf fractured humerus.	and was wearing a my attention on the orthotic or specific contracted areas. Shirt, 15 at 7:13 p.m., the object of the splint was warrend was wearing a moduling the splint was a reported R87 currently had erus and was wearing a wations on 5/17/15 and on the hallway. R87 seelchair short distance such om, but would then return to g station. There was no and/wrist orthotic. a.m. the occupational ided R87 has a contracted be using a hand pillow with a right hand resting splint. dicated R87 could still use	F	280		

F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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OVIDER OR SUPPLIER HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIF 1412 WEST FOURTH STREET RED WING, MN 55066	CODE		
(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO	CTION SHOULD BI O THE APPROPRIA		
nurse (LPN)-C indicated a splint, as he would reference on 5/20/15 at 2:32 p.reported not seeing as working on unit. On 5/21/15 at 11:00 a findings and added Reseparator and wrist/has the care plan had not identify interventions. 483.20(k)(3)(ii) SERV	red the resident didn't wear refuse it. m. nursing assistant (NA)-J nything for his hand since m. RN-B confirmed the refuse the finger and orthotic. RN-B agreed been revised or updated to		82			
The services provided must be provided by accordance with each care.	d or arranged by the facility qualified persons in resident's written plan of		Immediate corrective Resident (R87) was s	shaven on	@ 30/15	
by: Based on observation review, the facility failed accordance with the refor 2 of 2 residents (Rishaving and for not refindings include: R87's care plan, dated could no longer complown and wanted his guanticipated and met for included staff assist/m cleaning after each us R87 was observed on	n, interview and document ed to provide services in esidents written plan of care 87, R83) for assist with ceiving activities. d 4/15/15 indicated R87 lete grooming tasks on his rooming needs to be or me by staff. Interventions naintain electric razor lete and weekly per protocol. 5/17/15 at 7:12 p.m. with		failing to follow the for resident (R87). Activity aid (AA-A) reeducation regarding	plan of care eceived re- following		
	OVIDER OR SUPPLIER HEALTH CENTER SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From page nurse (LPN)-C indicat a splint, as he would r On 5/20/15 at 2:32 p.r reported not seeing an working on unit. On 5/21/15 at 11:00 a findings and added Re separator and wrist/ha the care plan had not identify interventions. 483.20(k)(3)(ii) SERV PERSONS/PER CAR The services provided must be provided by co accordance with each care. This REQUIREMENT by: Based on observation review, the facility faile accordance with the re for 2 of 2 residents (Re shaving and for not re Findings include: R87's care plan, dated could no longer compl own and wanted his g anticipated and met fo included staff assist/m cleaning after each us R87 was observed on approximately 5/8 inch	OVIDER OR SUPPLIER HEALTH CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. 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.	OVIDER OR SUPPLIER HEALTH CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. 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	OVIDER OR SUPPLIER ##ALTH CENTER ##ALTH CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSG IDENTIFYING INFORMATION) Continued From page 33 Continued From page 33 Continued From page 33 Continued From page 33 Continued From page 37 Continued From page 38 Continued From page 39 F 280 Continued From page 39 F 280 Continued From page 39 F 280 Continued From page 39 F 280 Continued From page 39 F 280 F 280 F 280 F 280 F 280 F 281 F 282 F	A SULLDING 245223 BY STREET ADDRESS, CITY, STATE, ZIP CODE 1412 WEST FOURTH STREET RED WING, MI S506E SUMMARY STATEMENT OF DEFICIENCES SUMMARY STATEMENT OF DEFICIENCES RED WING, MI S506E RED WING, MI S506E RED WING, MI S506E PREPTX RED WING, MI S506E PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL RESOLATORY OR LSC DEMINYMO INFORMATION) 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. 483.20(K)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: This REQUIREMENT	

CENTERS FOR MEDICARE & MEDICAID SERVICES

	XTEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245223	B. WING_			05/	21/2015
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F 282	neck area. The follow p.m., the facial hair re 5/19/15 during randor a.m. to 10:30 a.m., the R87's face. On 5/19/15 at 12:30 p (NA)-I verified she did during the shift. On 5/19/15 at 2:45 p. coordinator (RN)-B was been shaved since 5/reviewed with RN-B was nursing assistant show shave during the day residents are shaved. R83 did not receive as plan of care. Document review of the dated 4/10/14, Directed Continuing these activare important to me; I I like these types of TM Movies; Action, like the During an observation 7:00 p.m., R83 was lasside. Eyes were open to verbal communicatit television, no CD and During an observation 10:48 a.m. and 1:00 pon the right side. Eyes no response to verbal	ing day 5/18/15, at 2:30 mained on R87's face. On n observations from 7:10 e facial hair remained on .m., nursing assistant not get to shave R87 m., the registered nurse as informed R87 had not 17/15. The care plan was tho explained that the ald have incorporated the as it was the expectation daily. ctivities as directed by the me activity plan of care, ed staff: Quality of Life: rities I did prior to admission like this type of music:Rap,	F2	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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OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING _ COMPLETED 245223 B. WING 05/21/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1412 WEST FOURTH STREET RED WING HEALTH CENTER RED WING, MN 55066 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 282 Continued From page 35 F 282 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 F 312 483.25(a)(3) ADL CARE PROVIDED FOR F 312 SS=E DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to

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OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII			(X3) DATE SURVEY COMPLETED	
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The care plan dated 3 alteration in hygiene// directed staff, "I recei wash once a week I a hygiene needs. Goals and odor-free daily. Ir residents' skin during irritation or breakdow however the care plan facial hair for resident On 5/17/2015 at 5:48 interview R17, she wa gray/white facial hairs chin area approximate Resident was unable when queried. On 5/18/15 at 8:51 a.r observed in her room white sheet and was conumerous facial hairs. On 5/19/2015 at 7:39 -F was observed to conumerous facial hairs. R117 was witnessed to the evening of 5/17/15 days of the survey on R117's clinical record facility on 2/11/15, and included respiratory facions was a was concluded respiratory facility on muscle we do struction, muscle we	ADL's/shower/bath and ve a partial bath and a hair am dependent on staff for all st. I would like to be clean interventions Staff monitor bath and cares for signs of an and further evaluates" In did not address shaving the communicate her needs as observed to have several at to the upper lip and the ely one half inch long. The communicate her needs are and 11:45 a.m. R17 was laying in bed covered with a observed to still have a.m., nursing assistant (NA) amplete R17's peri cares. At fit in bed without been on have several facial hairs of and during subsequent 5/18/15 and 5/19/15.	F3	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.	t	

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PRINTED: 06/10/2015 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ 245223 B. WING 05/21/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1412 WEST FOURTH STREET RED WING HEALTH CENTER RED WING, MN 55066 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETION **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 312 | Continued From page 38 F 312 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 guite 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

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CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED		
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F 312	bed with facial hair. During an interview or licensed practical nurse R117 were unshaven reason why R17 and they should have bee assistants are busy at I should not use that a have enough staff her assistants to shave the nursing assistant don't verified that R17 and because she was buston assistant staffing and nursing assistants. Further difficult to complete the and at times I do not the was in tears and point emotional when talking they need help and deal shave [R17] and because at times [R17] and said hair or were expectation is, resider shaved daily." On 5/20 indicated, the care plate R17 and R117. Policy and procedure	in 5/19/15 at 10:24 a.m., see (LPN)-B verified R17 and and stated, there was no R117 were unshaven and in shaven. "Nursing and we had many call-ins and as an excuse. We don't see, but I will tell the nurse sem. I don't know if the traced money or not" 19/15 at 10:37 a.m., NA-FR117 were unshaven by due to insufficient nursing they are always short of or the stated, "It is very see resident ADLs as required aske lunch breaks." NA-Fred out, she was always grabout residents because serve better. "Will go drill try to shave [R117] 7] would not let them shave serve indicated, "I will not bring the because they don't have registered nurse (RN)- A on verified that R17 and R117 and R15 at 2:22 p.m. RN-A in does not address shaving	F 312				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER G HEALTH CENTER		•	141	REET ADDRESS, CITY, STATE, ZIP CODE 2 WEST FOURTH STREET D WING, MN 55066		05/21/2015
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F 312	with or supervision of necessary to keep the Each resident should equipment."	shaving residents as em clean and well groomed. have their own shaving	F3	312			
	hair removal. R87 was observed on approximately 5/8 inch hairs on his checks, clineck area. The follow p.m. the facial hair rem 5/19/15 during random hair remained on their The annual minimum of 3/5/15 identified diagnocerebrovascular accide traumatic brain injury a express and understar indicated R87 required personal hygiene. R87 indicated R87 could not tasks on his own and with the anticipated and malnterventions included electric razor cleaning aper protocol. On 5/19/15, at 12:30 p. (NA)-I verified she did reduring the shift. The not R87 does like to get a sproblem the next day.	was not provided facial 5/17/15 at 7:12 p.m. with I long dark and light facial Inin, upper lip and upper Ining day 5/18/15, at 2:30 Inained on R87 's face. On In observations, the facial Resident's face. Idata set (MDS) dated I losses included Rent, dementia and I language). The MDS Rextensive assist with I's care plan, dated 4/15/15 I longer complete grooming I longer complete grooming I longer complete grooming I longer to me by staff. Staff assist/maintain I lafter each use and weekly I m., the nursing assistant I lot get to shave R87 I lursing assistant indicated I shave so it should not be a					
t t	On 5/19/15 at 2:45 p.m coordinator (RN)-B was been shaved since 5/17 blan directed . RN-B Ind assistant should have in	informed R87 had not 7/15 and what the care dicated the nursing					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		NSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER G HEALTH CENTER			1412	ET ADDRESS, CITY, STATE, ZIP CODE WEST FOURTH STREET WING, MN 55066	1 0	05/21/2015
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	does not direct staff of added, it somehow was developed. R87 was not provided incontinent of bowel. On 5/19/15 at 7:10 a.m. Broda wheelchair at the breakfast to be served throughout breakfast a moved to the hallway. In the hallway. Carpets would move from area assistance of staff. At a the licensed practical rehis room. With staff assistand up using a transification incontinent of stool. LP applied a clean brief to transfer pole. R87's sk creases and wrinkles. The annual MDS dated diagnoses included cerdementia and traumatic (inability to express and The MDS indicated R8' with all activities of daily and toileting. The MDS incontinent of bowel an care plan directed staff before and after meals On 5/19/15 at 10:35 a.m. resident had been incorskin on buttocks and thideep creases and wrinkledeep creases and wri	also verified the care plan in grooming R87 daily, and its missed when care plan with toileting care and was in. R87 was sitting in a le dining table waiting for rather than the same and the table and until 8:45 a.m. when rather than the wheelchair as were being cleaned so he to another area by the approximately 10:30 a.m. burse (LPN-C) took R87 to sistance, R87 was able to fer pole. R87 was N-C provided pericare and rather than the was red with deep in living including transfers indicated the R87 is displayed by the current to toilet upon rising, and at hour of sleep. The current to toilet upon rising, and at hour of sleep. The current to toilet upon rising, and at hour of sleep. The current to toilet upon rising, and at hour of sleep. The current to toilet upon rising, and at hour of sleep. The current to toilet upon rising, and at hour of sleep. The current to toilet upon rising assistant 87 up before 7:00 a.m. ble to get back to R87.	F	312			

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NAME OF		245223	B. WING				
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F 318	helped her. On 5/19/15 at approxiiverified the findings arbeen repositioned and R102 was dependent hygiene/grooming and hair removal. R 102 was observed of darker colored facial his chin and upper neck. mind being shaved. A the room indicated R10 however, was usually The visitor added another frequently and always when visiting. On 5/19/15 at 2:00 p.m was made and R102's for long facial hair on entire was visiting and confirm shaved for a few days at F-C verified R102 is not when she visits and ofter R102. The initial MDS dated 11 diagnoses included gual	mately 2:45 p.m., RN-B and agreed R87 should have I toileted sooner. On staff for all personal was not provided facial in 5/18/15 at 2:38 p.m. with air on his cheeks, upper lip, R102 indicated he doesn't family member (F)-M in 102 liked to be clean shaven not shaved when visiting, her family member visits would shave the R102 in a random observation face continued to have the face. At this time F-B and R102 had not been and that she would do it. It is usually clean shaven are frequently shaves in the current care plan all grooming/shaving in the RN-B verified the personal for R102 and it would cossible.	F 318	312			
PM CMS 2507	(/02 00) D						1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 318 SS=D	Continued From page		F:	318	<u>F 318</u>		
	resident, the facility m with a limited range o	and services to increase or to prevent further			Immediate corrective action: Orders were received for resident (R83) on 5/21/15 to have therapy screen and establish new ROM guidelines.		w/30/15
	by: Based on observation review the facility failed rehabilitative services	for 3 of 3 resident (R83, for rehabilitative services to			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.		
	between therapy and motion (ROM) for R83 During an observation R83 was receiving penursing assistants (NA to be struggling to sep	on 5/19/15, at 7:20 a.m.,			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.		
	range of motion was b and FM-A expressed t and tighter" in the arm				Residents with established restorative nursing guidelines will be reviewed to ensure their individual programs are implemented as directed. Residents with a		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY

		IDENTIFICATION NUMBER:	A. BUILDING	COMPLETED	
		245223	B. WING		05/21/2015
	ROVIDER OR SUPPLIER G HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1412 WEST FOURTH STREET RED WING, MN 55066	
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F 318	ROM at the last care During interviews wi and NA-K on 5/19/1 that the therapy dep for R83. During internurse (LPN)-B and I did not do ROM for provided the ROM provided to tracheosto and unspecified intra Minimum Data Set (4/29/15, indicated unspecified intra Minimum Data Set (4/29/15, indicated unspecified intra Minimum Data Set (MDS) on impairment and unal The document titled, Discharge Summary ROM [range of motion will tolerate PROM [instretching program in [bilateral] LE [lower contracture] LE [lower	th nursing assistants NA-F 5, at 10:50 a.m., both thought artment was providing ROM views with licensed practical LPN-H both thought nursing R83 because therapy rogram for R83. ronic medical record (eMR) 3 was admitted to the facility tive diagnoses from R83's 5/19/15, listed, but was not my, septicemia, endocarditis, acranial hemorrhage. The MDS) assessment dated ander section B Hearing, read; Comatose, Persistent discernable consciousness. on the quarterly Minimum 1/28/15, as severe cognition pole to answer questions. PT-Therapist Progress and read, End of Care 4/23/15, and an aread, End of Care 4/23/15, and an aread aread ender to increase B extremity] ext. [extension] to ext PROM to neutral and [dorsi-flexion] to effective	F 31	functional limitation in ROM or contracture without a restoration 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 conducte 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.	n d

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		DNSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	to same SNF [skilled management of positi The physical therapist therapy discharge was 11:30 a.m., and verified been given a referral the does not know if the farmed the facility form was a records but not received the director of nursing 5/20/15, at 8:50 a.m. a have received passive nursing staff and the Fither plan of care. On 5/17/15 at 7:13 p.m. had a contracture on mass not being worn and fracture. During random observes 5/19/15 from 7:10 a.m. the wheelchair in the discharge the would self propel wheelength as back into the dining return to hallway by the was no evidence of a mass of 5/20/15 at 1:00-2:30 p. right wrist orthotic. The annual minimum of 3/5/15 indicated R87 will diagnoses that include accident, traumatic brast The MDS indicated R8 upper/lower extremities	nursing facility] with staff oning. It (PT)-A responsible for the senterviewed on 5/19/15, at ad nursing should have to continue with PROM and acility form was completed. The second of the second o	F	318			

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OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING _ 245223 B. WING 05/21/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1412 WEST FOURTH STREET RED WING HEALTH CENTER RED WING, MN 55066 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245223	B. WING				05/21/2015
RED WIN	ROVIDER OR SUPPLIER G HEALTH CENTER			141:	EET ADDRESS, CITY, STATE, ZIP CODE 2 WEST FOURTH STREET D WING, MN 55066		55/21/2015
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	separator and wrist/hat the care plan was not team would have to reconstruction on 5/17/15 at 5:43 p.r. registered nurse (RN)-contracture of the left extension orthotic. During random observ 2015, R102 did not we 5/18/15 at 2:40 p.m., F. chair in room watching F-M. F-M reported R10 on the left arm and he 5/19/15 at 2:40 p.m., F. a Broda chair. F-N was rectangular brown pillo between the lower arm unsure where the elbox A review of the initial m dated 11/20/14 indicated diagnoses that included traumatic brain injury. TR102 was totally deper personal hygiene/shavi limitations in range of m sides bilaterally. Discharge summary for (OT), dated 4/30/15, waindicated R102 "require assistance to appropria hand and wrist orthotics and " Mother and staf	and orthotic. RN-B agreed being followed and the eview the use of the orthotic. In. during staff interview, the B reported R102 had a farm and wore a left elbow ration on 5/18, and 5/19/19/19/19/19/19/19/19/19/19/19/19/19/	·	318			

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION NG	(X3) D	PATE SURVEY OMPLETED
		245223	B. WING			05/24/2045
	PROVIDER OR SUPPLIER G HEALTH CENTER		•	STREET ADDRESS, CITY, STATE, ZIP CODE 1412 WEST FOURTH STREET RED WING, MN 55066	L	05/21/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORR X (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
SS=D	summary and print ou apply the elbow orthor R102. This information information book on the indication as to who make information. The "care assistants which provicare for the residents, update regarding the constant of the indicated a new elbow obtained for him., it has specifically and would comfortable. Staff had on 5/20/15 at approximand Licensed practical room for the elbow extina a bottom dresser draction of 5/20/15 at 12:00 p. appeared the splint wait had not been added cards for the nursing a it must have been missindicated the care plant updated. 483.25(h) FREE OF ACHAZARDS/SUPERVIS The facility must ensure environment remains a as is possible; and each adequate supervision apprevent accidents.	at of pictures on how to tic correctly to the left arm of an was placed in an ane unit. There was no may have read the cards" used by the nursing ded information on how to lacked any information or use of the elbow orthotic. In the occupation therapist or orthotic had just been ad been fitted to R102 have been more descent the description of the elbow orthotic and found it awer. In the RN-B verified it as not being used daily and to the care plan or care ssistants. RN-B indicated sed. The RN manager and care cards would be CCIDENT ION/DEVICES e that the resident as free of accident hazards	F 3.	Immediate corrective action RN-C received re-education failing to report the loose siderails in a timely manner. The siderails for resident (R) were repaired on 5/20/2015	for 58)	6/30/15

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3	(X3) DATE SURVEY COMPLETED		
		245223	B. WING_				05/21/2015		
	RED WING HEALTH CENTER			STRE 1412 RED					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	HOULD BE COMPLETION			
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:		FS	323	Corrective action as it applies to others: The policy and procedure titled "Side Rail Use" was reviewed and remains current.				
	On 5/18/15, at 11:45 observed on each side inspection the side rattached to the bed abut the upper portions noted to wiggle and lebed and were not per When asked at 11:45 rails, R58 replied the from falling out of bed afraid of falling out of When asked if the side about in bed or to get stated he used the pothe bed and extended	a.m., two half side rails were le of R58's bed. Upon further ills were noted to be firmly the base of the side rail, so of both side rails were ean outward away from the pendicular to the mattress. a.m. why R58 had the side rails were to prevent him d. When R58 was asked if bed, R58 replied "No." le rails helped R58 move in and out of bed, R58 le (which was placed beside it to the ceiling.) At 11:53 the side rails was reported RN)-C, who had no			Nursing staff will complete a physical device assessment for all residents with siderails according to facility policy and procedure any noted loose siderails 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 weekly such as the conducted on each unit to ensure side rails are in good repair.	e F			
	were still observed or RN-C was interviewer rails had not been rep stated the maintenant contacted yesterday a stated the resident did falls, would hang onto himself into and out of However, RN-C did no	ot report to the maintenance side rails until 5/20/15.			be shared with the QA committee for their input on need for continued monitori The correction will be monitored by: Maintenance director and or designee	the ng.			

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING		A-100-100-100-100-100-100-100-100-100-10	COMPLETED	
245223		B. WING			05/21/2015		
NAME OF PROVIDER OR SUPPLIER RED WING HEALTH CENTER				1	STREET ADDRESS, CITY, STATE, ZIP CODE 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)			IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 323	previous morning (5/2 request to fix the side the maintenance direct At 10:45 a.m. the mai interviewed and states side rail had not been RN-C until "yesterday On 5/21/15, at 10:50 a interview, that since the they felt "much better. R58 felt before with the "not very safe." R58's care plan updat used a transfer pole with feeling weak or tired the Another section of the 5/10/13, revealed R58 and used one 1/2 side and positioning. The complete following: staff were to were available and in good "highest level of functional theorem and impainterview for Mental Stehr and completed on scored 14/15, indicating intact."	e rail had been fixed the 0/15.) MS-E stated the rail had been received from ottor. Intenance director was define the request to fix R58's received verbally from (5/20/15.) Intenance director was define the request to fix R58's received verbally from (5/20/15.) Intenance director was define the request to fix R58's received verbally from (7/20/15.) Intenance director was define the received verbally from (7/20/15.) Intenance director was define the side rails were replaced during an ene side rails were replaced (7/20/15.) Intenance director was define the side rails were replaced (7/20/15.) Intenance director was define side and (7/20/15.) Intenance dir	F	323			
	483.25(k) TREATMEN NEEDS	T/CARE FOR SPECIAL	F3	328			

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245223	B. WING_	B. WING		05/21/2015	
NAME OF PROVIDER OR SUPPLIER RED WING HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1412 WEST FOURTH STREET RED WING, MN 55066		, <u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 328	The facility must ensure proper treatment and special services: Injections; Parenteral and enteral Colostomy, ureterostomy care; Tracheostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT by: Based on observation review, the facility fail hand hygiene, per fact tracheotomy care to 1 tresidents (R163) during findings include: Appropriate hand hygical during observation of change for R163. On 5/19/15, starting a practical nurse (LPN-I hands and don gloves complete a gastrostomy change for R163. However, LPN-B did right did ressing change before tracheotomy dressing Still wearing the same removed the old gauzerices.	al fluids; omy, or ileostomy care; is not met as evidenced in, interview and document ed to provide appropriate elility policy, when providing of 2 ventilator dependenting tracheostomy care. iene was not followed a tracheotomy dressing t 9:44 a.m., licensed in the elility policy is a tracheotomy dressing t 9:44 a.m., licensed in the elility policy is a tracheotomy dressing t 9:44 a.m., licensed in the elility is a complete the GT is beginning the change for the resident. It is soiled gloves, LPN-B is pad from around the	F3	Immediate corrective action: LPN – B received re-education for failing to change gloves and perform hand hygiene per poli and procedure. Corrective action as it applies 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.	су	a 30/15	
	Still wearing the same removed the old gauz	soiled gloves, LPN-B					

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OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING 245223 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 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION **PREFIX PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 328 | Continued From page 52 F 328 normal saline and cleansed around the The correction will be tracheotomy tube. LPN-B then removed the monitored by: soiled gloves and washed their hands before donning new gloves and placing a new gauze pad Director of Nursing and/or around R163's GT site. Then without removing designee. 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 329 483.25(I) DRUG REGIMEN IS FREE FROM F 329 UNNECESSARY DRUGS SS=D Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DA	(X3) DATE SURVEY COMPLETED	
	245223		B. WING			05/24/2045		
NAME OF PROVIDER OR SUPPLIER RED WING HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1412 WEST FOURTH STREET RED WING, MN 55066					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 329	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.		F 3	29	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.		Q30/15	
	by: Based on interview ar facility failed to ensure administered with resp dosages for 1 of 5 resi unnecessary medication. Findings include: According to the current had the potential to record acetaminophen.	ect to potential excessive dents (87) reviewed for			Licensed nursing staff and Trained Medication Aides will be re-educated on the policy and procedure by 6/30/2015,			

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AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	1' '	TE SURVEY MPLETED
		245223	B. WING			0	5/21/2015
RED WIN	ROVIDER OR SUPPLIER G HEALTH CENTER			1412	EET ADDRESS, CITY, STATE, ZIP CODE 2 WEST FOURTH STREET D WING, MN 55066		0/E1/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
	was admitted to the fadiagnoses of cerebral contracture of joints a joint, hand. The curre read: Acetaminophen oral three times a day house order that read give 650 mg by mouth for pain. Give 650 mg needed) for minor pain greater than 100.5. Do Tylenol in a 24 hr period The scheduled Tyleno On dose of the 650 mg for pain would exceed hours. A review of the April 20 administration record i as needed 650 mg do occasions. R87 receivexceeded the 3000 mg and 4/28/15, when he dose. On 5/20/15 at approximation registered nurse (RN)-	acility on 4/15/13, with artery occlusion, that many sites, and pain in the physician orders indicate. Tablet 1000 mg (milligram). R87 also had a standing: Tylenol (Acetaminophen) a every 4 hours as needed orally every 4 hours prn (as nor temp (temperature) or not exceed 3000 mg of od." I amount equals 3000 mg. grevery 4 hours as needed the limit of 3 grams in 24 O15 medication andicated R87 received an use of Tylenol on 2 separate are ded medication which grand Tylenol amount on 4/27 received as as needed mately 2:00 p.m., the B verified the physician as needed doses in April recommended dose. Utility as needed dose. Utility to the nurse the Tylenol orders.	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		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMF	SURVEY
		245223	B. WING			05/	21/2015
	ROVIDER OR SUPPLIER G HEALTH CENTER			14	REET ADDRESS, CITY, STATE, ZIP CODE 12 WEST FOURTH STREET ED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 329	Continued From page	55	F:	329			
F 353 SS=E	483.30(a) SUFFICIEN PER CARE PLANS	NT 24-HR NURSING STAFF	F:	353	<u>F 353</u>		a 30 15
	provide nursing and remaintain the highest pand psychosocial well determined by resider individual plans of car. The facility must provinumbers of each of the personnel on a 24-hor care to all residents in care plans: Except when waived usection, licensed nurse personnel. Except when waived usection, the facility munurse to serve as a chaduty. This REQUIREMENT by: Based on observation review, the facility failed were available to mee residing on the 2nd floresidents (R17 and R2 and had the potential states).	de services by sufficient e following types of ur basis to provide nursing accordance with resident under paragraph (c) of this			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 noncare assignments. All residents who are interviewed to assure their needs are being met satisfactorily. Families will be interviewed when resident is unable.		

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG		TE SURVEY MPLETED
		245223	B. WING _			05/21/2015
	ROVIDER OR SUPPLIER G HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 353	Findings includes: R17 was observed to evening of 5/17/15, a of the survey on 5/18. 5/17/2015 at 5:48 p.n interview R17, was of gray/white facial hairs chin area approximat. Resident was unable when queried. On 5/1 a.m. observed R17 in covered with a white inumerous facial hairs noted R17 lying in be unshaven during continursing assistant (NA-At 7:55 a.m. was left by NA-F. -At 10:04 a.m. observin bed then NA-F left R117 was witnessed the evening of 5/17/13 days of the survey on 5/17/2015 at 5:48 p.m interview R117, was of gray/white facial hachin area. Resident whis needs when queri and 11:43 a.m. observup in his wheelchair b 5/19/2015 at 7:39 a.m with facial hair and what 10:27 a.m. unshave	have several facial hairs the and during subsequent days /15 and 5/19/15. On an during an attempt to observed to have several at to the upper lip and the ely one half inch long. to communicate her needs 8/15 at 8:51 a.m. and 11:45 her room lying in bed sheet observed to still have. On 5/19/2015 at 7:39 a.m. do with facial hair or inuous observations while observed to still have in bed without been shaven sed NA-F repositioned R17 the room. The facial hairs of and during subsequent for the facial hairs of the properties of the upper lip and the facial hairs to the upper lip and the facial hairs t	F3	Staffing will continue to discussed each day by the Administrator, Supervised Scheduler and Nurse May and adjustments made with needed. Staff will be re-educated attendance policy and procedure. Recurrence will be preverby: Ongoing interviews of reand families will occur day the Abaqis program and evaluated quarterly. Includes interviews are que regarding needs of reside being met and satisfaction assistance. The correction will be monitored by: Director of Nursing and/odesignee	ne DON, or, anagers where I on the ented sidents aily using luded in estions ents on with	

STATE AND P	EMENT PLAN OF	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3)	<u>3 NO. 0938-0391</u> DATE SURVEY COMPLETED
			245223	B. WING		_	05/04/004 =
		ROVIDER OR SUPPLIER G HEALTH CENTER		•	STREET ADDRESS, CITY, ST 1412 WEST FOURTH STRE RED WING, MN 55066		05/21/2015
PRI	4) ID EFIX AG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F	t a f f e e e e e e e e e e e e e e e e e	approximately 15 to 2 changing wet diaper. During an interview or licensed practical nurs R117 were unshaven reason why R17 and It they should have beer assistants are busy ar I should not use that a have enough staff here assistants to shave the During interview with Na.m. verified that R17 abecause she was busy assistant staffing and the nursing assistant. Furtificially to complete the and at times I do not take and at times R17 and will trylimes R17 would not lead the and at times R17 and will trylimes R17 would not lead the and the senough staff." During interview with Name. Stated, "Staffing is are not updated with resiving (ADL) such as Ho ave sufficient staffing in they have potential to he ave no call no show are policy is not been for	O minutes for assistant with 5/19/15 at 10:24 a.m. with se (LPN)-B verified R17 and and stated, there was no R117 were unshaven and a shaven. Nursing at we had many call-ins and s an excuse. We don't se, but I will tell the nurse em." NA-F on 5/19/15 at 10:37 and R117 were unshaven of due to insufficient nursing they are always short of the stated, "It is very to resident ADLs as required alke lunch breaks." NA-Fout, she always emotional tresidents because they better. Will go ahead to shave R117 because at them shave him. In d, "I will not bring my cause they don't have A-G on 5/20/15 at 11:48 troubling, the care cards sident's activities of daily yer lift. I do not feel they in the building. I feel like	F	353		

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION G		E SURVEY MPLETED
		245223	B. WING_			5/21/2015
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1412 WEST FOURTH STREET RED WING, MN 55066		3121720,0
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 353	p.m. stated was worristudent nursing assis assigned for 1 on 1 w supervised. In addition enough staff here to depend of the control of the co	ed and uncomfortable as a tant who gets pulled and ith resident without being n, indicated, "There is not care for the residents or give at a tant who gets pulled and ith resident without being n, indicated, "There is not care for the residents or give at a staff on during the meal mber stated her relative was despite sitting at a feeding ober stated staff would walk the resident a bite to eat, of feed. a.m. registered nurse a while, but not recently, ugh staff, so supervisors either the memory care unit ut on the floor. a.m. nursing assistant n "barely" get all their work onest with you, these people I changed every two hours. "NA-D stated they had or a number of years and fing has been. a.m. the staffing coordinator aware that some of the saistants, who had not taken it test, were not allowed to inselves. The staff y made sure the newly	F 3:	53		

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1`′	PLE CONSTRUCTION G		ATE SURVEY OMPLETED
		245223	B. WING _			05/21/2015
	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CO 1412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 353	supervisor did if there they follow my sched At 11:40 a.m. the sta are short staffed." W a temporary agency coordinator stated "C On 5/21/15, at 12:44 stated there had bee	stant. The staffing ey did not know what the e were sick calls, but "Hope ule." ffing coordinator stated "we nen asked about contacting for assistance the staffing orporate won't allow it." p.m. housekeeper (HK-A) n times when nursing een observed to take a break	F3	53		
	member (F)-B reports overworked; everyon winter it was worse, to plan for when people couldn't get in to work on 5/19/15 at 8:12 at she was working on worefer to work with the Some days there are rough during the winter changes going on, the very many application of 5/19/15 at 12:12 plane was working on wother units. This unit assistants, but now it work done to the besishaves on the unit did	m., LPN-G indicated the unit was pretty busy and would ree nursing assistants. only two. It was also pretty er; there were a lot of e facility was hiring but not				

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OMB NO. 0938-0391

STATEMENT OF DEPICIONALIS MODITARY OF CORRECTION 245223 MAND PLAN OF CORRECTION MARKOP PROVIDER OR SUPPLIER RED WING HEALTH CENTER IMAGE OF PROVIDER OR SUPPLIER RED WING HEALTH CENTER IMAGE OF PROVIDER OR SUPPLIER IXA ID. JUMBARY STATEMENT OF DEPICIONALIS IXA ID. MARKOP PROVIDER OR SUPPLIER IXA ID. JUMBARY STATEMENT OF DEPICIONALIS IXA ID. JUMBARY STATEMENT OF DEPICE OF THE LITE OF THE	CENTER	S FOR MEDICARE & I	MEDICAID SERVICES				OMB NO	D. 0938-0391
MANE OF PROWDER OR SUPPLIER RED WING HEALTH CENTER (24.1) B SUMMANY STATEMENT OF DEPOIENCES RED WING MIN 55068 FERD WING M M 55068 FOR SUMMANY STATEMENT OF DEPOIENCES RED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION PROFINATION FOR MAINING PROPERTY TAG PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION PROFINATION REGULATORY OR LSC IDENTIFYING INFORMATION REGULATORY REGULATORY REGULATORY OR LSC IDENTIFYING INFORMATION REGULATORY REGU			1				(X3) DATE	SURVEY
RED WING HEALTH CENTER RED WING, MAID (X4-10)			245223	B. WING			05	/21/2015
TAG CACHOEPICIENCY MUST BE PRECEDED BY FULL TAG CROSS-REFERENCED TO THE APPROPRIATE					1	412 WEST FOURTH STREET		
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 outs 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.	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
she will reposition some staff or call the other shift person to come in early or contact those who may	F 353	resident had just gotte having enough time e required two staff peo indicated she took a b "there is just too much" On 5/19/15 at 12:46 p morale at the facility wishe cuts her breaks si work done and added reported she doesn't fishe knows she can ginget everything done. On 5/20/15 at 3:30 p.r. a recent weekend and whole building was should be used into midnight to get my LPN-D informed the did told "corporate would health department the added some of the mewere so heavy it cannown hour window of time. Vinformation was passed LPN-D reported no on won't do anything about On 5/20/15 at 9:10 a.r. (SC) indicated she has staffing. She implied in the open shift (Holes) hours and then get so For sick calls, the staffshe will reposition some	en out of bed because of not parlier and that resident ple The nursing assistant preak but not a lunch break, in to do" b.m. LPN-I indicated the was poor. LPN-I added that hort so she can get her is she stays late often. LPN feel she can give the care we and added it was hard to me. LPN-D reported working if the unit was so short. The nort so you couldn't pull from add "that evening I could not done, and I worked over yocharting done." When irector of nursing she was rather get a tag from the en get pool in here". LPN-D redication passes on units of be completed within the 2 When asked if this red on to administration, the red complains because they ut it. The staffing coordinator as to be creative with the if there is no one slotted for staff will pick up for a few meone to come in early. If fing coordinator indicated the staff or call the other shift	F	353			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION			E SURVEY PLETED
		245223	B. WING_			05	/21/2015
	ROVIDER OR SUPPLIER G HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP C 1412 WEST FOURTH STREET RED WING, MN 55066	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BI THE APPROPRIA	-	(X5) COMPLETION DATE
F 353	facility does not use promandate staff to work were working a lot of whole community is a weekend had at least this time. The SC indiversely weekend was the har shifts covered, I informs he works her magic. On 5/21/15 at 9:58 a. (DON) was interviewed DON reported she will regarding staffing conhaving any for awhile recently went to a famsome of the concerns. The DON added she that would do certain water, talk to the resiductivities and free up about how did nursing getting the needed cas supervisor on the evenits have nurse manunit are responsible for DON indicated there was system in place to encompleted. The nurse inform the managers. results from any famil surveys. The don was grievances regarding the facility social work. On 5/21/15 at 10:32 a reviewed recent griev surveyor. 1. Family metals to the staff of the staff of the surveyor. 1. Family metals and the staff of the surveyor. 1. Family metals are the staff of the surveyor. 1. Family metals are the staff of the staff o	cool and they do not a. The SC indicated people extra hours and added the short. The upcoming 17 holes in the schedule at cated the upcoming dest to fill. If I cant get all me the director of nursing and me. The DON explained she nily care plan because of expressed by the family. If I can be a position activities such as pass dents, get people to nursing staff. When asked gensure residents were are, the DON replied there is been an ingest and nights, and the agers. The nurses on the care card updates. The was no system or audit asure all work is getting es on the units should. The don was unaware of cylcustomer satisfaction as unaware of any further the staffing and to contact the care.	F3	,			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	SURVEY PLETED
		245223	B. WING			05/	/21/2015
	ROVIDER OR SUPPLIER G HEALTH CENTER			1	TREET ADDRESS, CITY, STATE, ZIP CODE 412 WEST FOURTH STREET RED WING, MN 55066		
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F 356 SS=C	he wanted the bed pa on for over an hour. nursing station, the ph no answer. When F-I staff member was ava comments included R on for 1 hr plus before Family member (F-E) concern on 12/1/14. I and concerns about of for "halo" care, position equipment. R126 move meeting could be schevisitor for R147 filed a visitor was concerned upset as unit had lots had to wait 45 minutes answered and a new of available for R147. Staffing policy was red A review of the Daily S 5/9/15 indicated reside posting indicated on the p.m the total number of was 14 for a total num review of the actual were vealed three call installocation sheet indicated working a total of 88 he 483.30(e) POSTED N INFORMATION	d R147 had called home as in. The call light had been When F-D called the none rang 12-14 times with D arrived at the unit, only 1 allable. F-D other 147's call light is frequently a call is answered. 2. for R126 filed a grievance F-E had multiple complaints are for R126 including care oning, oral care and working yed from facility before a eduled to reconcile. 3. A concern on 5/8/15. The as family member (F)-D of call lights on and R147 is again for call light to be ordered medication was not equested but not provided. Staffing hours posted for each census was 112. The ne day shift from 6 a.m. to 2 of nursing assistants (NA's) aber of hours worked. A orking day schedule of nursing assistants. The sted there were 11 NA's lours.		353			
	a daily basis: o Facility name.						

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OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED. A. BUILDING __ 245223 B. WING 05/21/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1412 WEST FOURTH STREET RED WING HEALTH CENTER RED WING, MN 55066 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLÉTION DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 356 Continued From page 63 F 356 F356 o The current date. 6/30/15 o The total number and the actual hours worked Immediate Corrective Action: by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: The template for posting total number of hours was reconciled - Registered nurses. - Licensed practical nurses or licensed on 05/29/2015 from 05/01/2015 vocational nurses (as defined under State law). to 05/21/2015. - Certified nurse aides. o Resident census. Corrective Action as it applies to others: The facility must post the nurse staffing data specified above on a daily basis at the beginning Policy and procedure for staffing of each shift. Data must be posted as follows: was reviewed and remains o Clear and readable format. current. o In a prominent place readily accessible to residents and visitors. Supervisor, Nurse Managers and Staffing Coordinator were re-The facility must, upon oral or written request, educated on correcting the make nurse staffing data available to the public actual hours posting to reflect for review at a cost not to exceed the community changes to staffing that have standard occurred that shift by 6/30/2015. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as Reoccurrence will be prevented required by State law, whichever is greater. by: Random weekly audits will be This REQUIREMENT is not met as evidenced conducted on each unit for 90 days to ensure nursing hours are Based on observation, interview and document posted in accordance to facility review, the facility failed to post the actual hours policy. Audit results will be worked for nursing staff directly responsible for shared with the monthly QA resident care per shift. This had the potential to committee for their input and affect 111 residents in the facility. recommendations for continued monitoring. Findings include: The posted hours and the actual working schedule was reviewed from 5/1/15 - 5/21/15

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		ONSTRUCTION		E SURVEY MPLETED
		245223	B. WING			0:	5/21/2015
	ROVIDER OR SUPPLIER G HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1412 WEST FOURTH STREET RED WING, MN 55066		2 WEST FOURTH STREET	•	
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F 356	during which it was n not reconciled to refleshifts. The following the hours posted. A review of the posterevealed five register hours, were included nurse total hours. Hostaffing schedule for registered nurses we schedule. On 5/21/15, at 11:35 stated the posted nurse not reconciled to the posted nurse to the staffing schedule.	oted the posted hours were ect the actual staffing for all issues were identified with d nursing hours for 5/20/15, ed nurses, for a total of 40 in the day shifts registered wever, a review of the 5/20/15, revealed only two re documented on the a.m., the staffing coordinator using hours for 5/20/15,	F	356	Correction will be monitored by: Director of Nursing and/or designee		
	nurse managers and (MDS) nurses. When did hands on care for the staffing coordinator sometimes the shifts example if two people hour shift, it was cour daily staffing hours. Tregular short shifts. A review of the daily sold the staffing hours and the shifts of the daily sold the shifts. A review of the daily sold the shifts of the schedule revealed the assistants. The allocation were 11 NA's working.	reported to fill shifts were pieced together. For e each worked half of an 8 nted as one person on the The facility did not have staffing hours posted for ne day shift from 6 a.m. to 2 of nursing assistants (NA's) nber of hours worked of 105 e actual working day ree call ins of nursing ation sheet indicated there					

STATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE SU COMPLE	
		245223	B. WING			05/21	/2015
	OVIDER OR SUPPLIER	245223		STR 141:	EET ADDRESS, CITY, STATE, ZIP CODE 2 WEST FOURTH STREET D WING, MN 55066		
(X4) ID PREFIX TAG	SUMMARY ST	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 356	registered nurses (R posted hours should of changes. The facility's policy of hours, last revised 1 post the actual hour trained medication a policy reads: "Change the form should an ereplaced. 483.60(c) DRUG REIREGULAR, ACT The drug regimen or reviewed at least or pharmacist. The pharmacist muthe attending physician drug irregiment of the pharmacist faile by: Based on docume the pharmacist faile physician drug irregiment of the pharmacist faile physician drug irregiment.	hours actually worked by IN). The DON verified the I be updated on a daily bases of Posting of Daily Nursing 2/13 indicated the facility will s of RN's LPN's NA's and assistants per shift. The ges will be made each shift on employee call off work is not EGIMEN REVIEW, REPORT ON of each resident must be nace a month by a licensed st report any irregularities to cian, and the director of reports must be acted upon. NT is not met as evidenced ant review and staff interview, ed to identify and report to the gularities for 1 of 5 (R87) mple reviewed for the use of		356	Immediate Corrective Action Resident R87 Tylenol 650mg was discontinued on 5/20/20 Corrective Action as it applie others: All resident Tylenol orders wi reviewed to make sure that t do not exceed the parameter set forth by the provider. All staff will be re-educated of parameters of medications so forth by provider by 06/30/2	PRN 15. If be hey so	6/30/15
	Findings include:						
	According to the co	urrent physician orders, R87					

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OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING _ 05/21/2015 B. WING 245223 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1412 WEST FOURTH STREET RED WING HEALTH CENTER RED WING, MN 55066 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 428 F 428 | Continued From page 66 Reoccurrence will be prevented had the potential to receive an excessive amount by: of acetaminophen. 2 random weekly audits will be The current physician order sheets revealed R87 conducted on each unit to was admitted to the facility on 4/15/13 with ensure residents with diagnoses of cerebral artery occlusion, acetaminophen orders do not contracture of joints at many sites, and pain in receive a dose in excess of the joint, hand. The current physician orders indicate MD prescribed dose. Audits will R87 had a physician order that read: be conducted for 90 days and Acetaminophen Tablet 1000 mg (milligram) oral audit results will be shared with three times a day. R87 also had a standing the QA committee for their input house order that read: Tylenol (Acetaminophen) on the need for continued give 650 mg by mouth every 4 hours as needed monitoring. 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." Correction will be monitored by: The scheduled Tylenol amount equals 3000 mg. On dose of the 650 mg every 4 hours as needed Director of Nursing and/or for pain would exceed the limit of 3 grams in 24 designee 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 DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		NSTRUCTION	(X3) DATE COMP	
		245223	B. WING _			05/	21/2015
	ROVIDER OR SUPPLIER	<u> </u>		1412	ET ADDRESS, CITY, STATE, ZIP CODE WEST FOURTH STREET WING, MN 55066		
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F 428	The pharmacist repo okay, however it was orders were not disc resident's other pain 483.60(b), (d), (e) Di	n the standing house order. Inted that clinically it was Is too bad the standing house Interpretation of the standing house of the standing house of the standing house or the standin		428 431	F 431		
SS=E	The facility must emit a licensed pharmacia of records of receipt controlled drugs in accurate reconciliation records are in order controlled drugs is more controlled drugs is more conciled. Drugs and biological labeled in accordance professional principle appropriate accessed instructions, and the applicable. In accordance with stacility must store all locked compartment controls, and permit have access to the labeled in the facility must propermanently affixed.	expiration date when State and Federal laws, the I drugs and biologicals in ts under proper temperature only authorized personnel to			Immediate Corrective Action: Medications that were found to not have an open date were removed from the medication cart. Corrective Action as it applies 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.	to	4/30/15
	Comprehensive Dru Control Act of 1976 abuse, except wher package drug distrik	and other drugs subject to the facility uses single unit button systems in which the inimal and a missing dose can			All staff will be re-educated or the policy by 6/30/2015.	1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	İ	245223	B. WING_			05	/21/2015
	PROVIDER OR SUPPLIER		1	14	TREET ADDRESS, CITY, STATE, ZIP CODE 412 WEST FOURTH STREET RED WING, MN 55066		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	- 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 431	Continued From page be readily detected.	: 68	F	431	Reoccurrence will be prevented by:		
	by: Based on observation interview, the facility for were dated when ope removed if expired for	is not met as evidenced n document review and failed to ensure medications ened, labeled correctly and r 2 of 5 units that affected 7 R15, R156, R83, R136 and			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.		
	storage tour with licen on the 3 East unit med was observed to be op	n., during the medication nsed practical nurse (LPN)-F dication carts, medication pened and not dated.			The correction will be monitored by: Director of Nursing and/or designee		
	On 5/17/15 at 1:35 p.r storage tour with the li	but not dated when opened					
	During the tour, the folidentified.	llowing concerns were					
	4/11/15, and not dated - R15's Novolog insulidispensed 4/4/25 and - R156's Novolog flex remained in cart for us	n pen was opened, not dated when opened. pen was opened, and					

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		245223 B. WING			05/21/2015		
NAME OF PROVIDER OR SUPPLIER RED WING HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1412 WEST FOURTH STREET RED WING, MN 55066	•		
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F 431	the medication cart. It - R83's two bottle of hopened and not dated - R136's sodium chlowas opened and not dated - R136's sodium chlowas opened and not detect the second of the second	with no label remained in the was opened and not dated. In the parin sodium solution were distrible ophthalmic ointment dated. The without any identification dication cart. In black R132 and R156 were fithe inhalers. The findings and indicated the items. The director of nursing was addings and verified items of dated when opened. The should be removed from the should be removed from the label, and have not been ecommended by the he policy reads: "Once any cal package is opened,"	F4	31			

245223 B. WING	- 05/21/2015
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, ST RED WING HEALTH CENTER RED WING, MN 55066	TATE, ZIP CODE
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORREITED TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFEREI	S PLAN OF CORRECTION CCTIVE ACTION SHOULD BE COMPLETION COMPLETION DATE DEFICIENCY) (X5) COMPLETION DATE
F 431 Continued From page 70 damaged, or missing labels are returned to the pharmacy for proper labeling before storing. F 441 483.65 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 infection (b) Preventing Spread of Infection (c) Preventing Spread of 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. F 441 Immediate in Immed	corrective action: educated on when to wash hands when eostomy and y tube dressing ording to the policy. Action as it applies to a site care was down a remains current. Deere-educated on 06/30/2015. See will be prevented ekly treatment conducted on each ys to ensure each reliving proper and gastrostomy ges to prevent the ction. Audit results with the monthly erfort their input nodations for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DA	NO. 0938-0391 TE SURVEY MPLETED	
245223		B. WING	B. WING			E/24/2045	
	PROVIDER OR SUPPLIER G HEALTH CENTER		•	1412	EET ADDRESS, CITY, STATE, ZIP CODE WEST FOURTH STREET WING, MN 55066		5/21/2015
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F 441	Continued From page infection.	71	F	141	The correction will be	:	
	by: Based on observation review, the facility faile hygiene during a dress resident (R163); and be (R37, R32 and R138) care device. Findings include: Appropriate hand hygie during observation of a and tracheotomy dress. On 5/19/15, starting at practical nurse (LPN-B their hands and don glaproceeded to check the removing a gauze pad. LPN-B took a clean gasaline, and cleansed at changing gloves or was then removed a gauze tracheotomy area. Still gloves, LPN-B wet ano normal saline and clear tracheotomy. LPN-B stradmitted with a sore an observation a dime size the right of the tracheotomy resent. Then with the stook two Q-tips and clear tracheotomy area. LPN	ene was not followed a gastrostomy tube (GT) sing change for R163. 9:44 a.m. licensed) was observed to wash oves. LPN-B then e GT site for redness by Wearing the same gloves, uze pad soaked in normal round the GT site. Without shing their hands, LPN-B pad from around the wearing the same soiled ther gauze pad with nsed around the ated R163 had been ound the neck and upon e open area was noted to omy, with no drainage same gloves on LPN-B ansed closer around the			monitored by: Director of Nursing and/or designee		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		T			OMB NO. 0938-0391		
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	245223		B. WING			(5/21/2015
	ROVIDER OR SUPPLIER G HEALTH CENTER			14	REET ADDRESS, CITY, STATE, ZIP CODE 12 WEST FOURTH STREET ED WING, MN 55066		0/21/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD E TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		3E	(X5) COMPLETION DATE
	LPN-B proceeded to a package and place the tracheotomy tube. The and LPN-B washed had been also	fith the new gloves on gauze pad around the pad down. Without and washing their hands, open a new gauze pad e new pad around the e gloves were then removed ands. a.m. LPN-B was interviewed and hygiene between R163. LPN-B stated they went from dirty to clean" and as for dressing removals, e first. Drawy/Jejunostomy Site Care evealed glove removal and occur after GT cleansing. Drawy Care policy dated after the old tracheotomy gloves were to be ashed. The policy further were to be worn when ad around the stoma site, ds washed. Jiene In the Healthcare ed 5/2014, revealed hand formed before and after and after handling soiled glucose monitoring on ensed practical nurse	F	441			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245223		IDENTIFICATION NUMBER:		TIPLE C	(X3) DA	(X3) DATE SURVEY COMPLETED	
		B. WING			05/21/2015		
	ROVIDER OR SUPPLIER G HEALTH CENTER			141:	REET ADDRESS, CITY, STATE, ZIP CODE 2 WEST FOURTH STREET D WING, MN 55066		0/21/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOL			(X5) COMPLETION DATE
	room, applied gloves sample from the resid blood glucose from a When LPN-B had com removed the gloves, a exited the room. LPN at approximately 11:20 obtained a blood samplinger and obtained a glucometer. When the LPN-B removed and cleft the room. LPN-B wentered R138's room. a.m., LPN-B applied g sample from R138, Wiremoved and LPN-B indicated she was don glucose's. When asked hands in between residents werified the nurse should have and did not between residents winvasive procedure. Policy revised 5/2014 the Healthcare Settings income and water or alco (ABHR) will always be	and obtained a blood lent's finger to check for personal glucometer. Inpleted the task, she and picked up the tote, and Bernard R32's room of a.m., applied gloves and pile from the resident's reading from the personal stask was completed, disposed of the gloves and went down the hall and At approximately 11:25 loves and obtained a blood then done, the gloves were left the room. LPN-B is ele obtaining blood distanced when the dicated she ot. In, the director of nursing and when the dicated "Hand Washing with whol based hand rub performed at the following is performing any invasive	F	141			



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

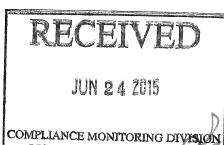
Dear Susanne:

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



LICENSE AND CERTIFICATION

riberen ja

F5223023

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A, BUILDING 01 - MAIN BUILDING 01 245223 B. WING 05/22/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1412 WEST FOURTH STREET **RED WING HEALTH CENTER** RED WING, MN 55066 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) K 000 | INITIAL COMMENTS K 000 POCOK KUN 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. JUN 22 2015 PLEASE RETURN THE PLAN OF N DEPT. OF PUBLIC SAFETY CORRECTION FOR THE FIRE SAFETY STATE FIRE MARSHAL DIVISION **DEFICIENCIES** (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145

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

Administrator 6

(X6) DATE

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.

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 COMPLETED 245223 B. WING 05/22/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1412 WEST FOURTH STREET RED WING HEALTH CENTER RED WING, MN 55066 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K 000 Continued From page 1 K 000 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

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		MEDICAID SERVICES					O. 0938-039	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245223			(X2) MULTIPLE CONSTRUCTION A, BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED		
		B WING			0.5	/22/2015		
NAME OF PROVIDER OR SUPPLIER RED WING HEALTH CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1412 WEST FOURTH STREET RED WING, MN 55066				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
K 000	Continued From page census of 114 at the t		K	000				
	NOT MET as evidence NFPA 101 LIFE SAFE Exit components (such enclosed with construct resistance rating of at arranged to provide a and provide protection other parts of the build. This STANDARD is not Based on observation facility failed to maintain at least one hour in the accordance with the for 2000 NFPA 101, Section could effect 40 out of 1 Findings include: On facility tour between on 05/22/2015, observation of the section of the	TY CODE STANDARD n as stairways) are ction having a fire least one hour, are continuous path of escape, against fire or smoke from ling. 8.2.5,2, 19.3,1,1 ot met as evidenced by: and staff interview, the in a fire resistance rating of exit component llowing requirements of on 19.3,1.1, 8.2.5.2. This 14 residents. n 11:00 AM and 2:00 PM ation revealed that the	Ko	933	Open penetrations above the stairwell and the center stairw were sealed with flame stopp 5000 by members of the maintenance team. To preven occurrence the Plant Operation Director will inspect maintenance and outside vendors work after completed, making sure penetrations are properly seas Completed 5/22/2015 All Stairwells were as needed by lolso The Plant Operations of the Plant Operat	veller int a re- ins ince er it is led.		

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 245223 B WING 05/22/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1412 WEST FOURTH STREET RED WING HEALTH CENTER RED WING, MN 55066 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) K 033 | Continued From page 3 K 033 cables Check all stairwells for this deficiency These deficient practices were confirmed by the K067 AW Plant Operations Director (DP) at the time of discovery. NFPA 101 LIFE SAFETY CODE STANDARD K 067 SS=F A Life Safety Code Waiver is being Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed applied for from CMS for the following in accordance with the manufacturer's reasons: specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 1) There will be no adverse effect on the health and safety of the facility's residents and staff This STANDARD is not met as evidenced by: since: Based on observations and staff interviews, it a. The building is protected was verified that the facility's general ventilating and air conditioning system (HVAC) is not throughout by installed in accordance with the LSC, Section addressable supervised 19.5.2.1 and NFPA 90A, Section 2-3.11 and 3-4.7. A noncompliant HVAC system could affect automatic fire alarm system all 114 residents. installed in accordance with NFPC 72 Findings include: in corridors, hazardous areas, On facility tour between 11:00 AM and 2:00 PM spaces open to the corridor. on 05/22/2015, observations revealed that the b. The building has automatic ventilation system on the 1st, 2nd, and 3rd floors in the 1965 addition utilizes the egress corridor as shutdown of all ventilation the return air for the resident rooms. There was fans upon detection of no balancing report available.

This deficient practice was confirmed by the Plant

smoke or activation of the

building fire alarm system.

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
	245223 B WING				05/22/2015		
	OVIDER OR SUPPLIER			STREET ADDRES 1412 WEST FOU RED WING, MI			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EA	ROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD BE S-REFERENCED TO THE APPROPRIA DEFICIENCY)		ИС
K 067			K	e.	maintenance contracts to service all the fac fire protection systems fire alarm system, spri	ellity's (e.g. nkler table as elarm to fire n. g is basis and r all	

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A, BUILDING 01 - MAIN BUILDING 01 245223 B. WING. 05/22/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1412 WEST FOURTH STREET RED WING HEALTH CENTER RED WING, MN 55066 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X3) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) 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 will disrupt work 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 meaningful portion of the cost. d. Since the building is leased there is no collateral to pledge for the needed financing.

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OMB NO 0938-0391

STATEMENT (AND PLAN OF	ND PLAN OF CORRECTION I IDENTIFICATION NUMBER. I		1	TIPLE CONSTRUCTION ING 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED
		245223	B WING	05/22/2015	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1412 WEST FOURTH STREET RED WING, MN 55066	1 33/12/13
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX			,	BE COMPLETION
K 067			K	e. The lease on the build runs out in about one y making the remain useful life of the build after the 6 month propabout 6 months.	ear ing ing
DRM CMS-2567	(02-99) Pravicus Varsions Obsola	ta Event ID: G30	2621	Facility ID 00149 If co.	tinuation sheet Page 14 of 7

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 COMPLETED 245223 B WING 05/22/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1412 WEST FOURTH STREET RED WING HEALTH CENTER RED WING, MN 55066 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) K 067 Continued From page 4 K 067 Operations Director (DP) at the time of discovery. K 076 NFPA 101 LIFE SAFETY CODE STANDARD K 076 K 076 SS=D Medical gas storage and administration areas are Unsecured "E" cylinder was place in protected in accordance with NFPA 99, Standards for Health Care Facilities. the "E" cylinder rack 5/22/2015 by the Plant Operations Director, New (a) Oxygen storage locations of greater than racks were ordered one for full 3,000 cu.ft. are enclosed by a one-hour separation. cylinders and one for empty cylinders. Signage will be stenciled (b) Locations for supply systems of greater than on the wall over each rack to 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 designate whether it is for full "E" cylinders or empty ones. To be completed by the Maintenance team by 6/30/2015. This STANDARD is not met as evidenced by: Based on observation, the facility was storing medical gas cylinders in a manner not in Nursing staff will be re-educated on conformance with NFPA 99 (1999 edition) proper placement of "E" cylinders in Chapter 4, Sections 4-3.1.1.2 (3) and 4-3.5.2.2 either the empty or full rack by (2). This deficient practice could all 15 out of 114 residents Nursing Management. 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

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OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 245223 B WING 05/22/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1412 WEST FOURTH STREET RED WING HEALTH CENTER RED WING, MN 55066 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLÉTION REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) K 076 Continued From page 5 K 076 The Plant Operations Director and These deficient practices were confirmed by the the DON will be responsible for Plant Operations Director (DP) at the time of monitoring of the oxygen storage to prevent re-occurrence. Audits of K 144 NFPA 101 LIFE SAFETY CODE STANDARD K 144 the oxygen storage room will be SS=F Generators are inspected weekly and exercised completed at random times once under load for 30 minutes per month in weekly for four weeks then monthly accordance with NFPA 99. for two months. Results will be reported to the Quality Assurance Committee for further review. To be corrected by 6/30/2015. K 144 This STANDARD is not met as evidenced by: Based on documentation review and staff The Plan Operations Director interview, the facility failed to inspect the obtained the specified letter from emergency generator in accordance with the Excel energy 5/28/2015 and placed requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 Chapter 6-4.1 and 6.4.2. The deficient it on file. 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

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Sheehan, Pat (DPS)

Sheehan, Pat (DPS)

Sent: Thursday, June 25, 2015 12:56 PM

rochi_lsc@cms.hhs.gov

<u>ö</u>

From:

ပ္ပ 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 Sheekan, 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

Form CIAS-278ER (\$204) PLEWOOS VOISIONS Obsolete

Supervisor S

Form CMS-2786A (03/04) Provious Versions Obsolete

Page 26



Des Moines Office

2400 86th St., Suite 10 Des Moines, 1A 50322 Phone 515-270-4811 Fax 515-331-8037 www.why.com

La Crosse Office

1202 Caledonia Street La Crosse, W1 54603 Phone 608-782-6550 Fax 608-782-1219 www.whyr.com

Winona Office

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

Rochester Office

1712 Third Ave. SE Rochester, MN 55904 Phone 507-280-4201 Fax 507-281-7694 www.whyr.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,

Michael Gostomski, President An Equal Opportunity Employer

Redwing Healthcare Community Medicare Cost Report For the Twelve Months Ending Wednesday, December 31, 2014

	820-89620 820-89630 810-89530 810-89550	810-89500 810-89510 810-89520 820-89600 820-89605 750-84010	800-89100 800-89110 800-89130 800-89135 800-89140 800-89150 800-89160 800-89170 800-89180 800-89180 800-89200 800-89210 800-89220 800-89220 800-89220	730-82000:89999 740-82000:89999 750-84020 750-84030
TOTAL EXPENSES TOTAL NET (INCOME) LOSS	CAPITAL RELATED COSTS - MOVABLE EQUIPMENT GROUP 03-2 Interest-Working Line of Credit Interest-Other Depreciation & Amortization-Equipment Depreciation & Amortization-Financing Costs TOTAL CAPITAL RELATED COSTS- MOVABLE	CAPITAL RELATED COSTS - BUILDING GROUP 01-2 Depreciation & Amortization-Land Improvements Depreciation & Amortization-Building Depreciation & Amortization-Leasehold Improvements Interest-Capital Lease Interest-Lease Contract Property & Related-Property Taxes Property & Related-Insurance MIP TOTAL CAPITAL RELATED COSTS-BUILDING	EMPLOYEE BENEFITS GROUP 03-2 Benefits-Life Benefits-Dental Benefits-Dental Benefits-Other Employee Insurances Benefits-TICA & Medicare Benefits-FICA & Medicare Benefits-FICA & Medicare Benefits-Unemployment Benefits-Unemployment Benefits-Tuition Reimbursement Benefits-Tuition Reimbursement Benefits-Turition Reimbursement Benefits-Uniform Allowance Benefits-Employee Appreciation Benefits-Drug Test/Background Checks Benefits-Employee Vaccinations TOTAL BENEFITS	Information Technology-Other Expenses Marketing-Other Expenses Property & Related-Bed Tax/Surcharge Property & Related-Nursing Home License TOTAL ADMIN & GENERAL - OTHER
11,652,465.18 0.00 172,774.17 0.00	1,190.47 792.90 246,537.68 7,657.20 256, 17 8.25 0.00	17,291.88 212,671.10 674,512.42 17,791.81 326,862.80 45,722.76 21,209.76 1,316,062.53 0.00	5,170.00 307,220.58 16,735.04 3,288.31 326,327.30 44,187.22 19,619.07 6,468.98 418.50 181,190.93 1,914.08 5,601.38 9,118.82 645.32 927,905.53 0.00	SNF HH 72,840.82 6,161.42 441,640.10 14,253.00 1,403,520.08 0.00
11,652,465.18 172,774.17	1,190.47. 792.90 246,537.68 7,657.20 256,178.25	17,291.88 212,671.10 674,512.42 17,791.81 326,862.80 45,722.76 21,209.76 1,316,062.53	5,170.00 307,220.58 16,735.04 3,288.31 326,327.30 44,187.22 19,619.07 6,468.98 418.50 181,190.93 1,914.08 5,601.38 9,118.82 645.32	Total 72,840.82 6,161.42 441,640.10 14,253.00 1,403,520.08
12,048,543.05 0.00 1,131,803.29 0.00	3,743.03 502.81 236,199.83 240,445.67 0.00	34,321.76 428,867.15 769,313.43 98,929.50 55,210.82 21,536.01 1,408,178.67 0.00	6,790.54 497,380.58 17,728.94 3,696.08 1,503.64 338,744.91 63,055.11 17,762.92 6,781.18 471.50 229,493.11 7,604.03 5,100.01 4,280.95 1,427.83 1,89.95 1,202,011.28 0.00	Prior Year SNIF HH 87,021.67 4,244.79 408,174.86 34,232.96 1,266,532.78 0.00
12,048,543.05 1,131,803.29	3,743.03 502.81 236,199.83 240,445.67	34,321.76 428,867.15 769,313.43 98,929.50 55,210.82 21,536.01 1,408,178.67	6,790.54 497,380.58 17,728.94 3,696.08 1,503.64 338,744.91 63,055.11 17,762.92 6,781.18 471.50 229,493.11 7,604.03 5,100.01 4,280.95 1,427.83 1,89.95 1,202,011.28	Total 87,021.67 4,244.79 408,174,86 34,232.96 1,266,532.78



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 <u>only a suggestion</u> 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.

Red Wing Health Center June 10, 2015 Page 2

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

Minnesot	a Department of Healt	h			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	E CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	AND	COMPLETED
		00149	B. WING		05/21/2015
NAME OF PE	ROVIDER OR SUPPLIER	STREET ADI	RESS, CITY, STA	ATE ZIP CODE	
			T FOURTH ST		
RED WING	HEALTH CENTER		, MN 55066	REET	
	OLIM MAN DV DT	ATEMENT OF DEFICIENCIES	T	DOOMDEDIG SLAN OF CORPECTION	
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	
				DEFICIENCY)	
2 000	Initial Comments		2 000		
	initial Continuonte				
	****ATTEN	TION*****	Ind/15		
			4/24/15		
	NH LICENSING CORRECTION ORDER		10		
			SEF		
	In accordance with Minnesota Statute, section				
		on order has been issued			
	pursuant to a survey. If, upon reinspection, it is				1
	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 co				
		ule provided at the tag		·	
		number indicated below.			
	When a rule contains	several items, failure to			
		e items will be considered			
		ack of compliance upon		1	
		/ item of multi-part rule will			
		ent of a fine even if the item			
	corrected.	ng the initial inspection was			
	corrected.				
	You may request a he	earing on any assessments			
1		non-compliance with these			
		written request is made to			
		15 days of receipt of a			
	notice of assessment				
:					
	INITIAL COMMENTS				
		2015, surveyors of this		Minnesota Department of Health is	
		sited the above provider and		documenting the State Licensing	
	the following correction			Correction Orders using federal softw	are.
		completed, please sign and these orders and return the		Tag numbers have been assigned to Minnesota state statutes/rules for Num	sing
		ota Department of Health,		Homes.	Sing
	Health Regulation Div	•		Homes.	
	artment of Health DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
a area are organic		SOLI CIEN NEI NEGENTATIVE O GIGNATURE		TITLE	(VO) DUIT

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

PRINTED: 06/24/2015 FORM APPROVED

Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION :	(X3) DATE SURVEY COMPLETED
		00149	B. WING		05/21/2015
	PROVIDER OR SUPPLIER	1412 WES	DRESS, CITY, S ST FOURTH G, MN 5506		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICE OF THE APPROPROPROPROPROPROPED OF THE APPROPROPROPROPROPROPROPROPROPROPROPROPRO	D BE COMPLETE
2 000		ige 1	2 000	The assigned tag number appears far left column entitled "ID Prefix The state statute/rule number and corresponding text of the state statut out of compliance is listed in the "Summary Statement of Deficienci column and replaces the "To Comportion of the correction order. The column also includes the findings are in violation of the state statute statement, "This Rule is not met as evidenced by." Following the survifindings are the Suggested Method Correction and the Time Period Following Correction. PLEASE DISREGARD THE HEAD THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION SUBMIT A PLAN OF CORRECTION STATUTES/RULES.	Tag." the tute/rule les" oly" his which after the s reyors d of or OING OF THIS
2 540	Resident Assessme Subpart 1. Assessme conduct a comprehe resident's needs, what capability to perform significant impairments nursing assessments.	o Subp. 1 & 2 Comprehensive ent ment. A nursing home must ensive assessment of each hich describes the resident's n daily life functions and ents in functional capacity. A at conducted according to section 148.171, subdivision is part of the comprehensive	2 540		

Minnesota Department of Health

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00149	B. WING		05/2	1/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS CITY S	STATE, ZIP CODE		
WANE OF I	NOVIDER OR COLL FIER		T FOURTH	·		
RED WIN	IG HEALTH CENTER		G, MN 5506			
(V4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	COMPLETE DATE
2 540	Continued From pa	age 2	2 540			
	-					
	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 stat	tus measurement;				
	C. physical and mental functional status;					
		d physical impairments;				
		tatus and requirements;				
		ments or procedures;				
		psychosocial status;				
	H. discharge p					
	I. dental condit					
	J. activities pot					
	K. rehabilitationL. cognitive state					
	M. drug therapy					
	N. resident pre					
	14. Tooldon pro	10.01.000.				
	•	ent is not met as evidenced				
	by:					
		ion, interview and document				
		ailed to repair side rails in a				
	timely manner for i	of 1 resident (R58).				
	Findings includes:					
	On 5/18/15. at 11:4	5 a.m. two half side rails were				
		side of R58's bed. Upon further				
		rails were noted to be firmly				
		I at the base of the side rail,				
		on of both side rails were noted				
	to wiggle and lean	outward away from the bed				
		endicular to the mattress.				
		45 a.m. why R58 had the side				

STATEMENT OF DEFICIENCIES		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	PLETED
	00149	B. WING		05/2	21/2015
NAME OF PROVIDER OR SUPI	PLIER STREET	DDRESS, CITY, S	STATE, ZIP CODE		
DED WING HEALTH OF	1412 W	ST FOURTH	STREET		
RED WING HEALTH CEN	RED W	NG, MN 5506	6		
PREFIX (EACH DEFIC	RY STATEMENT OF DEFICIENCIES DIENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
from falling outhey were afra replied "No." VR58 move about bed, R58 state placed beside ceiling.) At 11: rails was repowho had no combined the rails had not be stated the main contacted yes stated the resifalls, would have himself into an However, RNdepartment the On 5/21/15, at (MS-E) stated previous morn request to fix to the maintenant At 10:45 a.m. interviewed an side rail had no RN-C until "yee On 5/21/15, at interview that they felt "much	ed the rails were to prevent him to fed. When R58 was asked if id they would fall out of bed, R58 When asked if the side rails helped out in bed or to get in and out of ed he used the pole (which was the bed and extended to the 53 a.m. the condition of the side red to registered nurse (RN)C, omment. 10:00 a.m. the loose side rails rived on the bed. At 10:03 a.m. erviewed regarding why the side een repaired or replaced. RN-C intenance department had been rerday about the side rails. RN-C dent did not have a problem with ing onto the transfer pole and swir ind out of bed with staff assist. C did not report to the maintenance is loose side rails until 5/20/15. 9:40 a.m. maintenance staff the side rail had been fixed the ing (5/20/15.) MS-E stated the he side rail had been received from the received from the maintenance director was and stated the request to fix R58's to been received verbally from sterday" (5/20/15.) 10:50 a.m. R58 stated during an since the side rails were replaced in better." When asked how safe as with the old side rails, R58 stated				

Minnesota Department of Health STATE FORM

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
7.110	01 0011112011311		A. BUILDING:			
		00149	B. WING		05/2	1/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
RED WIN	NG HEALTH CENTER		ST FOURTH : G, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 540	R58's care plan upoused a transfer pole feeling weak or tired. Another section of the 5/10/13, revealed Rand used one 1/2 sand positioning. The following: staff were were available and "highest level of fund as at risk for falls incontinence and in Interview for Mental eHR and completed scored 14/15, indicating intact. SUGGESTED MET The director of nursipolicy and procedure system, monitor and start transfer in the second start transfer in the se	dated 8/14/12, revealed R58 e when transferring. That if they were to ask for help. the care plan, updated R58 could offload when in bed side rail to do this for mobility the care plan also indicated the eto ensure assistive devices in good repair to assist in anction with bed mobility." completed in the electronic dated 4/21/15, revealed R58 because of unsteadiness, impaired mobility. A Brief all Status (BIMS) found in the don 4/21/15, revealed R58 stating R58 was cognitively	2 540			
	completed to assur are identified and m	sessments are conducted, re the needs of all residents net. R CORRECTION: Twenty-one				
2 560	MN Rule 4658.0409 Plan of Care; Conte	5 Subp. 2 Comprehensive ents	2 560			
	Subp. 2. Contents	of plan of care. The	Name of the Control o			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

NAME OF PROVIDER OR SUPPLIER RED WING HEALTH CENTER RED WING HEALTH CENTER (X4) ID PREFIX TAG (X4) ID PREFIX TAG (CA) ID PREFIX TAG 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: R1412 WEST FOURTH STREET RED WING, MN 55066 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OAMPIET OAMPI		IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
NAME OF PROVIDER OR SUPPLIER RED WING HEALTH CENTER 1412 WEST FOURTH STREET RED WING, MN 55066 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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:				A. BUILDING.			
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) 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 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:			00149	B. WING		05/2	1/2015
CX4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE 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 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:	NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG 10	RED WIN	IG HEALTH CENTER					
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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:		OUBARA DV OTA					()(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:	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETE
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:	2 560	Continued From pa	ge 5	2 560			
		comprehensive plate objectives and time long- and short-terrand mental and psylidentified in the contassessment. The compassessment include the increquired by Minnes subdivision 14, para This MN Requirements by: Based on observation interview, the facility comprehensive plate facial hair removal R117, R102) review Findings include:	n of care must list measurable stables to meet the resident's in goals for medical, nursing, ychosocial needs that are inprehensive resident comprehensive plan of care dividual abuse prevention plan ota Statutes, section 626.557, agraph (b). The sent is not met as evidenced ion, document review and y did not develop a in of care regarding shaving or for 3 of 4 residents (R17, yed for personal cares.				
		Staff will proceed to (resident's) depend	o care plan residents lence on staff and to maintain				
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."		alteration in hygiendirected staff, "I reconstructed wash once a week hygiene needs. Goand odor-free daily, residents' skin during irritation or breakdo	d 3/18/15, identified R17 had e/ADL's/shower/bath and seive a partial bath and a hair I am dependent on staff for all als: I would like to be clean. Interventions Staff monitoring bath and cares for signs of own and further evaluates"				

Minnesota Department of Health

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Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00149	B. WING		05/2	21/2015
	PROVIDER OR SUPPLIER	1412 WES	DRESS, CITY, S ST FOURTH G, MN 5506			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 560	Continued From pa	ge 6	2 560			
	shaving. R117 was observed the evening of 5/17 days of the survey of the CAA dated 2/20 is dependent on staincontinent of bowl skin during ADL's a reported for further proceed to care pladown and to maintal. The care plan dated	d 3/4/15 focused, "Cognition: I				
	being vent dependenceds much of the questions. My mem my communication knowing my family, Interventions: Staff as instructed by the anticipate my needs not address shaving. During an interview licensed practical not R117 were unshave reason why R17 and they should have be	norage (hemorrhage) and ent unable to express my time. I can nod to yes or no ory is difficult to assess due to deficits. My abilities are where I am and time of year. will assist in decision making family or resident. Please s. However the care plan did g facial hair for resident. on 5/19/15 at 10:24 a.m., urse (LPN)-B verified R17 and en and stated, there was no d R117 were unshaven and een shaven. LPN-B care plan did not address				

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00149	B. WING		05/2	21/2015
	PROVIDER OR SUPPLIER	1412 WES	DRESS, CITY, S ST FOURTH: G, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 560	On 5/20/15 at 2:22 verified, the care plant R17 and R117. Policy and procedudated revision Marc facility must developed for each resident the objectives and time medical, nursing, massessment (the Massessment (the Massessment (the Massessment) care plans include short-term goals, of outcomes, as well as specific disciplines plan from becoming	p.m., registered nurse (RN)-A an did not address shaving for re titled care planning process, the 2013, indicated, "1. The para comprehensive care plan at includes measurable tables to meet a resident's tental and psychosocial needs the comprehensive DS of the RAI)	2 560			
	R102 was observed darker colored facial lip, chin and upper ridoesn't mind being (F)-M in the room in clean shaven howe when visiting. The was made and R10 long facial hair on ewas visiting and conshaved for a few da F-C verified R102 is when she visits, and R102's care plan, later and colored to the colo	did not address shaving. If on 5/18/15 at 2:38 p.m., with all hair on his cheeks, upper leck. R102 indicated he shaved. A family member adicated R102 liked to be ever, was usually not shaved visitor added another family lently and always would shave up.m., a random observation 2's face continued to have entire face. At this time, F-B and firmed R102 had not been lays and that she would do it. If the shape it is not usually clean shaven defrequently shaves R102. The state of the shape is the clean, neat and well				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00149	B. WING		05/2	1/2015	
	PROVIDER OR SUPPLIER	1412 WES	DRESS, CITY, S ST FOURTH S G, MN 55066				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
2 560	groomed daily. How does not identify pe needs for R102. On 5/20/15 at 12:00 care plan did not idegrooming/shaving ribe updated as soo	vever the current care plan ersonal grooming/shaving Dip.m. the RN-B verified the	2 560				
	Reed, Sheryl						
	interview, the facility comprehensive plant facial hair removal the R117, R102) review Findings include: R17 was observed evening of 5/17/15, of the survey on 5/1. The Care Area Asset	n of care regarding shaving or for 3 of 4 residents (R17, yed for personal cares. to have several facial hairs the and during subsequent days					

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY LETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	LETED
		00149	B. WING		05/2	1/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
		1412 WES	T FOURTH	STREET		
RED WIN	NG HEALTH CENTER	RED WING	3, MN 55066	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 560	Continued From pa	age 9	2 560			
	Potential dated 3/9/dependent on staff Staff will proceed to (resident's) depend dignity and cleanlin The care plan date	/15, indicated, "Resident is for all ADL's and cares o care plan residents lence on staff and to maintain				
	directed staff, "I rec wash once a week hygiene needs. Go and odor-free daily residents' skin duri irritation or breakdo	ceive a partial bath and a hair I am dependent on staff for all als: I would like to be clean. Interventions Staff monitoring bath and cares for signs of own and further evaluates"				
	R117 care plan lack shaving.	ked interventions regarding				
	the evening of 5/17	d to have several facial hairs 7/15, and during subsequent on 5/18/15 and 5/19/15.				
	is dependent on sta incontinent of bowl skin during ADL's a reported for further	20/15 indicated, " Resident aff for all ADL's and is and bladder. Staff monitor and peri-care with any changes reval (evaluation). Staff will an residents risk for skin break ain skin integrity."				
	am cognitively impaintra-cerebral hemoleoning vent dependenceds much of the questions. My men	d 3/4/15 focused, "Cognition: I aired due to: DX of morage (hemorrhage) and ent unable to express my time. I can nod to yes or no nory is difficult to assess due to deficits. My abilities are				

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			, , , , , , , , , , , , , , , , , , , ,			
		00149	B. WING		05/2	1/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
RED WI	IG HEALTH CENTER		ST FOURTH : G, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 560	knowing my family, Interventions: Staff as instructed by the anticipate my need not address shavin During an interview licensed practical in R117 were unshave reason why R17 art they should have backnowledged the shaving facial hair of the shaving facial hair facility must develo for each resident the objectives and time medical, nursing, in that are identified in assessment (the M Care plans include short-term goals, of outcomes, as well as specific disciplines plan from becoming provides rationale if the basis for evaluation.	where I am and time of year. will assist in decision making a family or resident. Please s". However the care plan did g facial hair for resident. You on 5/19/15 at 10:24 a.m., rurse (LPN)-B verified R17 and an and stated, there was no ad R117 were unshaven and een shaven. LPN-B care plan did not address for R17 and R117. p.m., registered nurse (RN)-A an did not address shaving for re titled care planning process, ch 2013, indicated, "1. The p a comprehensive care plan at includes measurable etables to meet a resident's mental and psychosocial needs in the comprehensive DS of the RAI)	2 560			
	R102 was observed	d on 5/18/15 at 2:38 p.m.,with al hair on his cheeks, upper				

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Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMPI	
		00149	B. WING		05/2	1/2015
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
RED WIN	IG HEALTH CENTER		ST FOURTH S G, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 560	lip,chin and upper ridoesn't mind being (F)-M in the room in clean shaven howe when visiting. The visits frequency on 5/19/15 at 2:00 was made and R10 long facial hair on ewas visiting and conshaved for a few da F-C verified R102 is when she visits, and R102's care plan, la R102 would like to groomed daily. How does not identify peneeds for R102. On 5/20/15 at 12:00 care plan did not idegrooming/shaving ribe updated as soo was the expectation SUGGESTED MET. The director of nurse the policy and process needed, staff tramonitored and eval comprehensive plan lists measurable ob meet each resident.	neck. R102 indicated he shaved. A family member indicated R102 liked to be ever, was usually not shaved visitor added another family uently and always would shave p.m., a random observation 02's face continued to have entire face. At this time, F-B infirmed R102 had not been ays and that she would do it. In some indicated be clean, neat and well wever the current care plantersonal grooming/shaving of p.m. the RN-B verified the entify personal needs for R102 and it would on as possible. RN-B verified it in to be shaved daily. THOD OF CORRECTION: Issing or designee could assure edures are reviewed, revised ained and systems assessed, luated to assure the nof care is developed and objectives and timetables to	2 560			
2 565	MN Rule 4658.040	5 Subp. 3 Comprehensive	2 565			

Minnesota Department of Health

(X3) DATE SURVEY

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMP	LETED	
,		00149	B. WING		05/2	1/2015
	PROVIDER OR SUPPLIER	1412 WES	DRESS, CITY, S BT FOURTH B, MN 5506			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
	Continued From paragraph Subp. 3. Use. A comust be used by all care of the resident This MN Requirements by: Citation Text for Tag Reed, Sheryl Based on observation review, the facility faccordance with the for 2 of 2 residents shaving and for not Findings include: R87's care plan, da could no longer con own and wanted his anticipated and medincluded staff assisting assisting and for staff assisting and medincluded staff assisting assisting and medincluded staff assisting assisti	ge 12 Imprehensive plan of care personnel involved in the personnel i		CROSS-REFERENCED TO THE APPROI		DATE
	R87 was observed approximately 5/8 ir hairs on his checks neck area. The follop.m., the facial hair 5/19/15 during rand a.m. to 10:30 a.m., R87's face. On 5/19/15 at 12:30	use and weekly per protocol. on 5/17/15 at 7:12 p.m. with nch long dark and light facial, chin, upper lip and upper owing day 5/18/15, at 2:30 remained on R87's face. On lom observations from 7:10 the facial hair remained on p.m., nursing assistant did not get to shave R87				

(X2) MULTIPLE CONSTRUCTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ,	E CONSTRUCTION	COMPI		
		00149	B. WING		05/2	1/2015
	PROVIDER OR SUPPLIER	1412 WES	DRESS, CITY, S ST FOURTH S G, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 565	On 5/19/15 at 2:45 coordinator (RN)-B been shaved since reviewed with RN-E nursing assistant si shave during the daresidents are shaved. R83 did not receive plan of care. Document review of dated 4/10/14, Directontinuing these are important to me I like these types of Movies; Action, liked. During an observat 7:00 p.m., R83 was side. Eyes were op to verbal communicatelevision, no CD at During an observat 10:48 a.m. and 1:00 on the right side. Eyen or response to verbour adio, no televistape playing. When interviewed of Family member (F) discouraged" because to see R83 "more in being so young and and videos, which we reviewed on the right side of the see R83 "more in the see R83" more in the see R83 "more in the see R83" more in the see R83 "more in the see R83" more in the see R83 "more in the see R83" more in th	p.m., the registered nurse was informed R87 had not 5/17/15. The care plan was who explained that the nould have incorporated the ay as it was the expectation	2 565			

PRINTED: 06/24/2015

FORM APPROVED Minnesota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING 00149 05/21/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1412 WEST FOURTH STREET RED WING HEALTH CENTER RED WING, MN 55066 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 565 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

Minnesota Department of Health

of care.

are providing care as directed by the written plan

TIME PERIOD FOR CORRECTION: Twenty-one

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00149	B. WING		05/2	1/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
RED WIN	IG HEALTH CENTER		T FOURTH : 3, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 15	2 565			
	(21) days.					
2 570	MN Rule 4658.0409 Plan of Care; Revis	5 Subp. 4 Comprehensive sion	2 570			
	care must be review interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent participation of the guardian or chosen quarterly and within	A comprehensive plan of wed and revised by an im that includes the attending ared nurse with responsibility dother appropriate staff in mined by the resident's needs, practicable, with the resident, the resident's legal a representative at least a seven days of the revision of resident assessment required 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 and 1 of 3 residents (R87) with therapy recommendations.					
	Findings include:					
	and Risk Factors we lectronic health re assessment reveal the facility with a someasured 2.5 x 3.5 the result of previous products and the second sec	Evaluation of Skin Inspection ras completed in R163's cord (eHR) on 5/14/15. The ed R163 had been admitted to car on the coccyx, which centimeters and which was pressure ulcers. An eHR d 5/14/15, at 9:38 a.m., noted				

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(X3) DATE SURVEY

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
,			A. BUILDING:			
		00149	B. WING		05/2	1/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
RED WIN	IG HEALTH CENTER		T FOURTH			
			3, MN 5506		ION	0.5
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 570	Continued From pa	ge 16	2 570			
	area "over a fragile eHR progress note	with Mepilex in the coccyx area. Area is closed." Another dated 5/15/15, at 11:11 p.m. an "excoriated skin on		·		
	was to be turned ar staff every two hou However, the tempo updated after identi	orary care plan indicated R163 and repositioned by one to two rs and when necessary. Orary care plan was not fication of a new pressure area which was noted on				
	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.					
	(ADON) was inform of the open area or physician was also ADON reported the	sistant director of nurses ned and verified the presence of the coccyx. The resident's present at the time and the copen area to the physician, oilex sponge dressing to the				
	temporary care plan R163's new coccyx upon review of the coccyx pressure uld a.m. the ADON reviand had no comme care plan not havin					
	R102's plan of care	was not updated with a				

6899

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1412 WEST FOURTH STREET RED WING HEALTH CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 570 Continued From page 17 therapy recommendation.	
NAME OF PROVIDER OR SUPPLIER RED WING HEALTH CENTER (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 570 Continued From page 17 STREET ADDRESS, CITY, STATE, ZIP CODE 1412 WEST FOURTH STREET RED WING, MN 55066 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 2 570 Continued From page 17	
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) PREFIX TAG Continued From page 17 1412 WEST FOURTH STREET RED WING, MN 55066 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 2 570	1/2015
RED WING, MN 55066 (X4) ID PREFIX TAG Continued From page 17 RED WING, MN 55066 RED WING, MN 55066 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 2 570 2 570 Continued From page 17 2 570	
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 1 D PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 2 570 Continued From page 17 2 570	
2 or o Continuou i rom page ii	(X5) COMPLETE DATE
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)-M 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. The Care card care cards for the nursing assistants. RN-B indicated it must have been missed. The RN-B indicated it would also be added.	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00149	B. WING		05/2	1/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE		
NAME OF	TROVIDER OR OUT FEEL		T FOURTH			
RED WI	NG HEALTH CENTER		G, MN 55066			
(V4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ON	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETE DATE
2 570	Continued From pa	age 18	2 570			
	for a fall with an inj	ury.				
	On 5/17/15 at 7:13 currently had a fract wearing a sling for on 5/3/15 at 1:30 a. in a fracture of the another fall on 5/10 No injury was report a review of the faci Report was comple 5/3/15 and indicate the floor in the reside the floor in the reside the hospital for evaluation fractured right hum was completed and developed. They in the use of a transfer pole was b 5/17/15 the following keep bedroom dood to keep surrounding sleeping. The care include the injury of or other intervention care plan did not in it was to be worn of 0n 5/20/15 at 2:50 interventions and the not been updated the and services needs In addition, a review lacked evidence of arm and wrist. A 5 had a "Special Accindicating he was at to not follow normal."	p.m., RN-B reported R87 ctured right humerus and was the right arm. R87 had a fall .m. in his room which resulted right humerus. R87 had .//15 from the bed to the floor. rted lity's Unusual Occurrence eted. The form was dated d the resident was found on dent's room. R87 was sent to luation and treatment of a erus. A post fall assessment d other interventions were ncluded: therapy to evaluate er pole, and place bed in a low rent care plan indicated the leing reevaluated and on ag intervention was added: to r racked open at night and try g area quiet to assist with e plan was not updated to f the fractured right humerus, ns to direct staff care. The clude care for the sling, when r removed etc. p.m. RN-B reviewed the ne care plan and agreed it had o include the injury and care				

AND DIAN OF CORRECTION INTERCATION NUMBER:	(X3) DATE SURVEY COMPLETED	
A. BUILDING:		
00149 B. WING 05/21/20	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 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) OMPLETE DATE	
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. On 5/20/15 at 1:0-2:30 p.m., R 87 was not wearing a right wrist orthotic. On 5/20/15 at 1:0-2:30 p.m., R 87 was not wearing a right wrist orthotic. On 5/20/15 at 1:0-2:30 p.m., R 87 was no the result of the res		

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00149	B. WING		05/2	1/2015
NAME OF E	PROVIDER OR SUPPLIER	STREET AD	DRESS. CITY. S	STATE, ZIP CODE		
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RED WIN	IG HEALTH CENTER		G, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 570	Continued From pa	ge 20	2 570			
	separator and wrist	R87 would refuse the finger /hand orthotic. RN-B agreed ot been revised or updated to s.				
	SUGGESTED MET	HOD 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 (21) days.	R CORRECTION: Twenty-one				
2 800	MN Rule 4658.0510 Staffing requirement	O Subp. 1 Nursing Personnel; nts	2 800			
	home must have of number of qualified registered nurses, I nursing assistants residents at all nurs in all buildings if mo	requirements. A nursing a duty at all times a sufficient nursing personnel, including icensed practical nurses, and to meet the needs of the ses' stations, on all floors, and one than one building is udes relief duty, weekends, cements.				
	by: Based on observat review, the facility f	ent is not met as evidenced ion, interview and document ailed to assure enough staff neet the needs for residents				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COMP	LETED	
		00149	B. WING	·	05/2	1/2015
	PROVIDER OR SUPPLIER	1412 WES	DRESS, CITY, S ST FOURTH S G, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 800	residents (R17 and and had the potenti unit of the 111 resident in the potenti unit of the 111 resident in the findings includes: R17 was observed evening of 5/17/15, of the survey on 5/15/17/2015 at 5:48 p interview R17, was gray/white facial had chin area approxim Resident was unabwhen queried. On 5 a.m. observed R17 covered with a whith numerous facial had noted R17 lying in bunshaven during conursing assistant (N-At 7:55 a.m. was less by NA-F. -At 10:04 a.m. obsein bed then NA-F le R117 was witnessed the evening of 5/17 days of the survey of 5/17/2015 at 5:48 pinterview R117, was of gray/white facial chin area. Resident his needs when que and 11:43 a.m. obsup in his wheelchai 5/19/2015 at 7:39 at 15:48 pinterview R117 was of gray/white facial chin area. Resident his needs when que and 11:43 a.m. obsup in his wheelchai 5/19/2015 at 7:39 at 15:48 pinterview R117 was with the survey of gray/white facial chin area. Resident his needs when que and 11:43 a.m. obsup in his wheelchai 5/19/2015 at 7:39 at 15:48 pinterview R117 was with the survey of gray/white facial chin area. Resident his needs when que and 11:43 a.m. obsup in his wheelchai 5/19/2015 at 7:39 at 15:48 pinterview R117 was with the survey of gray/white facial chin area. Resident his needs when que and 11:43 a.m. obsup in his wheelchai 5/19/2015 at 7:39 at 15:48 pinterview R117 was with the survey of gray/white facial chin area. Resident his needs when que and 11:43 a.m. obsup in his wheelchai 5/19/2015 at 7:39 at 15:48 pinterview R117 was with the survey of gray/white facial chin area.	floor. This affected 2 of 7 R117) residents on the unit al to affect all residents on the lents that resided in the facility. to have several facial hairs the and during subsequent days 18/15 and 5/19/15. On .m. during an attempt to observed to have several irs to the upper lip and the ately one half inch long. le to communicate her needs 5/18/15 at 8:51 a.m. and 11:45 in her room lying in bed e sheet observed to still have irs. On 5/19/2015 at 7:39 a.m. bed with facial hair or ontinuous observations while NA)-F gave peri-care: eft in bed without been shaven erved NA-F repositioned R17 off the room. d to have several facial hairs /15, and during subsequent on 5/18/15 and 5/19/15. On off. and during subsequent on 5/18/15 and 5/19/15. On off. and during subsequent on 5/18/15 and 5/19/15. On off. and during subsequent on 5/18/15 and 5/19/15. On off. and during subsequent on 5/18/15 and 5/19/15. On off. and during subsequent on 5/18/15 and 5/19/15. On off. and during subsequent on 5/18/15 and 5/19/15. On off. and during subsequent on sitting an effort to sequence of the series of	2 800			

Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING: B. WING 05/21/2015 00149 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1412 WEST FOURTH STREET RED WING HEALTH CENTER RED WING, MN 55066 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (FACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 800 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

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2 800	the policy is not been who does no call not they are doing." During an interview p.m. stated was wo student nursing assassigned for 1 on 1 supervised and some an hour breaks. In a not enough staff he give quality of care. Miller, Sue On 5/17/15, at 2:00 member approached there was not enough the family makes the resident girls at 10:0 (RN-C) stated once there may not be enough the polymorphism of the	en followed that is why staff of show continue to do what				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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	TO TIEAETH GENTER	RED WING	G, MN 55066			
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2 800	their nursing assistation work on a unit by the coordinator stated thired nursing assistanother nursing assistanother nursing assistanother nursing assistanother nursing assistanother nursing assistanother stated to supervisor did if the they follow my scheet they follow my scheet they follow my scheet as short staffed." At a temporary agency coordinator stated to the they follow they assistants had not so they could get at the same formulation of the same formulation of the same formulation of the same for when people couldn't get in to work they would prefer to work assistants. Some calso pretty rough did not satisfact the same formulation of t	ant test, were not allowed to nemselves. The staff they made sure the newly tants were working with sistant. The staffing they did not know what the ere were sick calls, but "Hope edule." taffing coordinator stated "we When asked about contacting y for assistance the staffing "Corporate won't allow it." 4 p.m. housekeeper (HK-A) then times when nursing been observed to take a break ill of their work done. Example 10:00 a.m. family writed the staff seem short and one looks tired. During the they didn't seem to have a le called in or when they ork. 2 A.M. LPN-G indicated the ing on was pretty busy and the with three nursing days there are only two. It was uring the winter; there were a gon, the facility was hiring but	2 800			
	she was working or other units. This ur assistants, but now	2 p.m. NA-I reported the unit n was heaven compared to the nit use to have two nursing it just has one. I get all my est I can, NA-I reported the				

NAME OF PROVIDER OR SUPPLIER RED WING HEALTH CENTER 1412 WEST FOURTH STREET RED WING, MN 55066 SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY REQUILATORY OR LSC IDENTIFYING INFORMATION) 2 800 Continued From page 25 shaves on the unit did not get done today as I just didn't have time. NAI 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. Sin implied if there is no one solited for the open shiff (Holes) staff will pick up for a few hours and then get someone to come in early. For sick calls, the staffing coordinator indicated	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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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	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETE
she will reposition some staff or call the other shift person to come in early or contact those who may	2 800	shaves on the unit didn't have time. No resident had just go having enough time required two staff prindicated she took as "there is just too must be cuts her breaks work done and add reported she doesn't she knows she can get everything done. On 5/20/15 at 3:30 a recent weekend as whole building was any where. LPN-D get all my treatment into midnights to get LPN-D informed the told "corporate wouthealth department added some of the were so heavy it can hour window of time information was pat LPN-D reported no wont do anything all on 5/20/15 at 9:10 (SC) indicated she staffing. She implied the open shift (Hole hours and then get For sick calls, the she will reposition significant to the staffing. She implied the open shift (Hole hours and then get For sick calls, the she will reposition significant to the staffing. She implied the open shift (Hole hours and then get For sick calls, the she will reposition significant to the staffing of the staf	did not get done today as I just A-I also stated another otten out of bed because of not e earlier and that resident eople. The nursing assistant a break but not a lunch break, uch to do" 5 p.m. LPN-I indicated the y was poor. LPN-I added that is short so she can get her ed she stays late often. LPN of the feel she can give the care give and added it was hard to expend the unit was so short. The short so you couldn't pull from said "that evening I could not the short so you couldn't pull from said "that evening I could not the done, and I worked over extract my charting done." When the director of nursing she was all rather get a tag from the then get pool in here." LPN-D medication passes on units nnot be completed within the 2 extraction. When asked if this seed on to administration, the one complains because they bout it. a.m. the staffing coordinator has to be creative with the end if there is no one slotted for each staff will pick up for a few someone to come in early. It affing coordinator indicated some staff or call the other shift.				

Minnesota Department of Health

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RED WING HEALTH CENTER 1412 WEST FOURTH STREET RED WING, MN 55066	
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2 800 Ave 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, gat 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 results from any family/customer satisfaction surveys. The don was unaware of results from any family/customer satisfaction surveys. The animy member (F)-D filed a	

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Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA

STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	
			7. DOILDING.			
		00149	B. WING		05/2	1/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
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2 800	F-D for R147 repor he wanted the bed on for over an hour nursing station, the no answer. When staff member was a comments included on for 1 hr plus befor a high part of the posting could be subject of the posting could be subject as unit had lead to wait 45 minutes and a near a wailable for R147. Staffing policy was A review of the Dait 5/9/15 indicated resposting indicated open the total numb was 14 for a total nurse working a total of 8 more posting a to	ted R147 had called home as pan. The call light had been. When F-D called the phone rang 12-14 times with F-D arrived at the unit, only 1 available. F-D other I R147's call light is frequently ore a call is answered. 2. E) for R126 filed a grievance. F-E had multiple complaints t care for R126 including care itioning, oral care and working noved from facility before a cheduled to reconcile. 3. A d a concern on 5/8/15. The ed as family member (F)-D ots of call lights on and R147 attes again for call light to be aw ordered medication was not requested but not provided. By Staffing hours posted for sident census was 112. The n the day shift from 6 a.m. to 2 er of nursing assistants (NA's) umber of hours worked. A I working day schedule ins of nursing assistants. The licated there were 11 NA's	2 800			
	monitor, assess an	sing and/or designee could d evaluate to assure is provided to assure the		·		

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=		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
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RED WIN	IG HEALTH CENTER	RED WING	G, MN 55066	5		
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2 800	Continued From pa	age 28	2 800			
	needs of residents	are met.	MANUAL CALANS TITLE COLOR			
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General		2 830			
	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.					
	by: Based on observat review, the facility f appropriate trached	ent is not met as evidenced ion, interview and document failed to provide the otomy care to 1 of 2 ventilator ts (R163) during tracheostomy				
	Findings include:					
		nygiene was not followed of a tracheotomy dressing				
	On 5/19/15, starting practical nurse (LP	g at 9:44 a.m. licensed N-B) was observed to wash				

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2 830	their hands and dorproceeded to compore dressing change for However, LPN-B did dressing change be tracheotomy dressing the saremoved the old gast tracheotomy tube. It is soiled gloves and we donning new gloves around R163's GT their gloves and we proceeded to open place a new gauze tube. LPN-B stated R163's ore around the ned dime size open are tracheotomy, with regarding the lack of dressing changes of thought "you always since the treatment the dirty part was discovered.	In gloves. LPN-B then blete a gastrostomy tube (GT) in R163. In do not complete the GT before beginning the ling change for the resident. In the soiled gloves, LPN-B ling pad from around the soaked a new gauze pad with cleanse around the LPN-B then removed the line washed their hands before is and placing a new gauze pad site. Then without removing lineshing their hands, LPN-B a new gauze pad pad around the tracheotomy. In the lineship is t	2 830	DEFICIENCY)		
	hand washing was The facility's Trach 3/2014, revealed the dressing was remo	to occur after GT cleansing. eotomy Care policy dated nat after the old tracheotomy oved, gloves were to be s washed. The policy further				

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Minnesota Department of Health

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2 830	indicated that glove placing a new gauz then removed and SUGGESTED MET. The director of nurs and revice policies hand hygiene with care, and could prothe care of resident vent residents. The designee could devappropriate care is	es were to be worn when e pad around the stoma site, hands washed. THOD OF CORRECTION: sing or designee, could review and procedures related to vent residents, monitoring and ovide staff education related to the related to hand hygiene with edirector of nursing or velop an audit tool to ensure	2 830			
2 895	Motion Subp. 2. Range of that is directed tow through positioning implemented and recomprehensive resof nursing services development of a reprovides that: B. a resident with receives appropriating increase range of redecrease in range.	motion. A supportive program and prevention of deformities and range of motion must be naintained. Based on the ident assessment, the director must coordinate the tursing care plan which the treatment and services to notion and to prevent further of motion.	2 895			

Minnesota Department of Health

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DED WING HEALTH CENTER 1412 WES		DRESS, CITY, S ST FOURTH S G, MN 55066			
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Lacina, Mary Beth Based on observation review the facility fair rehabilitative services R102) reviewed for maintain or increase. Findings include: The facility did not cobetween therapy and motion (ROM) for R. During an observation R83 was receiving pursing assistants Note to be struggling to socares. Both NA's enlegs." When interviewed on Family member (FM) "discouraged," becauting an ending the motion was and FM-A expressed and tighter" in the anterpolation FM-A revealed expression at the last care. During interviews with and NA-K on 5/19/1 that the therapy depfor R83. During interviews with and NA-K on 5/19/1 that the therapy depfor R83. During interviews with and NA-K on 5/19/1 that the therapy depfor R83. During interviews with and NA-K on S/19/1 that the therapy depfor R83. During interviews with and NA-K on S/19/1 that the therapy depfor R83. During interviews with and NA-K on S/19/1 that the therapy depfor R83. During interviews with and NA-K on S/19/1 that the therapy depfor R83. During interviews with and NA-K on S/19/1 that the therapy depfor R83. During interviews with and NA-K on S/19/1 that the therapy depfor R83. During interviews with and NA-K on S/19/1 that the therapy depfor R83. During interviews with and NA-K on S/19/1 that the therapy depfor R83. During interviews with and NA-K on S/19/1 that the therapy depfor R83. During interviews with and NA-K on S/19/1 that the therapy depfor R83. During interviews with and NA-K on S/19/1 that the therapy depfor R83. During interviews with an NA-K on S/19/1 that the therapy depfor R83. During interviews with the therapy depfor R83. During interviews with an NA-K on S/19/1 that the therapy depfor R83. During interviews with an NA-K on S/19/1 that the therapy depfor R83. During interviews with an NA-K on S/19/1 that the therapy depfor R83.	on, interview and document illed to provide nursing es for 3 of 3 resident (R83, 87, rehabilitative services to e range of motion (ROM) coordinate the plan of care d nursing to provide range of 83. on on 5/19/15, at 7:20 a.m. berineal cleansing from NA-F and NA-K who seemed eparate R83's legs for the acouraged R83 to "relax your on 5/18/15, at 11:32 a.m. 1)-A expressed being ause it did not seem like the seeming completed for R83 d thinking R83 was "stiffer rms and legs. Furthermore, essing concerns about R83's econference in March 2015. ith nursing assistants NA-F 5, at 10:50 a.m. both thought views with licensed practical LPN-H both thought nursing R83 because therapy	2 895			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE	
AND PLAN OF CORRECTION	NOF CORRECTION IDENTIFICATION NOMBER.				
	00149	B. WING		05/2	1/2015
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
RED WING HEALTH CENTER		ST FOURTH S G, MN 55066			
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on 11/21/13. The aplan of care, dated limited to tracheos and unspecified in Minimum Data Se 4/29/15, indicated Speech and Vision vegetative state/not R83 was assessed Data Set (MDS) of impairment and under the document title Discharge Summa ROM [range of motive will tolerate PROM stretching program [bilateral] LE [lower-15 degrees and homaintain B ankle II and safe positioning development of corrisk for contracture complete dependence precautions. Wake Discharge plan and to same SNF [skill management of position of program of the physical therat therapy discharge 11:30 a.m. and vegiven a referral to not know if the face	283 was admitted to the facility active diagnoses from R83's 15/19/15, listed, but was not tomy, septicemia, endocarditis, tracranial hemorrhage. The discernable consciousness. If on the quarterly Minimum of 1/28/15, as severe cognition hable to answer questions. If (A) PT-Therapist Progress and try read, End of Care 4/23/15, otion] ankle. Goal-The patient of passive range of motion] and of in order to increase B rextremity] ext. [extension] to ip ext PROM to neutral and the properties of the propert	2 895			

Minnesota Department of Health

The director of nursing (DON) was interviewed on

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL			TE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED	
	00149		B. WING		05/2	1/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
			T FOURTH				
RED WII	NG HEALTH CENTER		G, MN 5506				
(V4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	 N	(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE	
2 895	Continued From pa	ge 33	2 895				
	5/20/15, at 8:50 a.n have received pass	n. and verified R83 should live range of motion from the e ROM should be added to					
	had a contracture of was not being worn fracture. During random obs 5/19/15 from 7:10 at the wheelchair in the breakfast meal and would self propel was back into dining to hallway by the nuevidence of a right at 1:00-2:30 p.m. Rwrist orthotic. The annual minimum 3/5/15 indicated R8 diagnoses that incluaccident, traumatic The MDS indicated upper/lower extrem assistance with actiphysician orders incontracture of joint physician order for worn during the day to apply during morbedtime. Check ski current care plan la a contracted right a identified R87 had a request indicating h	p.m. the RN-B indicated R87 on right arm, however the splint and R87 had a right humerus ervations on 5/17/15 and on a.m. to 10:20 a.m. R87 sat in e dining room during the then in the hallway. R87 heelchair short distance such room, but would then return ursing station. There was no hand/wrist orthotic. On 5/20/15 87 was not wearing a right arm data set (MDS) dated 7 was admitted with uded cerebral vascular brain injury and dementia. R87 had no impairment of ities and needed extensive vities of daily living. Current dicated a diagnoses of of multiple sites. R87 had an "right hand/wrist orthotic to be a 0800-2000 as tolerated. staff ning cares and removed at an each shift." A review of the cked evidence of R87 having rm and wrist. A 5/8/2013 entry a "Special Accommodation" he was aware of the risks and we normal facility protocol					

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SI AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING:	URVEY
AND PLAN OF CORRECTION IDENTIFICATION NOWIBER. A. BUILDING:	ETED
00149 B. WING 05/21	/2015
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
1412 WEST FOURTH STREET	
RED WING HEALTH CENTER RED WING, MN 55066	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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 1:00 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	

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Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00149	B. WING		05/2	1/2015
	PROVIDER OR SUPPLIER	1412 WES	DRESS, CITY, S T FOURTH S			
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2 895	chair in room watch F-M. F-M reported on the left arm and 5/19/15 at 2:40 p.m broad chair. F-N warectangular brown between the lower unsure where the A review of the initi dated 11/20/14 indidiagnoses that incl traumatic brain inju R102 was totally depersonal hygiene/s limitations in range sides bilaterally. Discharge summar (OT), dated 4/30/13 indicated R102 "reassistance to approhand and wrist orth and " Mother and orthotic and all state on per program all A review of the moevidence the informadded to the care is summary and print apply the elbow ord R102. This information book of indication as to whinformation. The "cassistants too providence for the reside update regarding to 0.5/20/15 at 9:40 indicated a new elliobtained for him., in the control of the care is summary and print apply the elbow ord R102. This information book of indication as to whinformation. The "cassistants too providence for the reside update regarding to 0.5/20/15 at 9:40 indicated a new elliobtained for him., in the control of the care is the case of the reside update of the reside up	ning television and visiting with R102 did not wear any splint he was not sure why. On n., R102 was sitting in room in as visiting and R102 had a pillow under the left elbow and arm and chest wall. F-N was albow splint was. al minimum data set (MDS) cated the resident had uded quadriplegia and ary. The MDS also indicated apendent on staff for all having and had functional of motion in upper and lower by for occupational therapy 5, was reviewed. The summary equires maximum physical popriately donn, doff bilateral notics and left elbow brace"		DEFICIENCY		

PRINTED: 06/24/2015 FORM APPROVED Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING_ 05/21/2015 00149 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1412 WEST FOURTH STREET RED WING HEALTH CENTER RED WING, MN 55066 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX PRÉFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 895 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

SUGGESTED METHOD OF CORRECTION:

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

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.

2 920 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:

updated.

G3Q611

2 920

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE	SURVEY LETED
ANDILAN	OF CONNECTION	BENTI IOATION NOMBER.	A. BUILDING:		OOM! EETED	
00149		B. WING		05/2	1/2015	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
RED WIN	NG HEALTH CENTER		ST FOURTH S G, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 920	Continued From pa	 age 37	2 920			
	Based on observati interview the facility hygiene care for 4 of	ion, interview and document y failed to provide personal of 4 residents (R17, R117, R87 re dependent upon staff for				
	Findings Include:					
		to have several facial hairs the and during subsequent days 18/15 and 5/19/15.				
	facility on 3/3/11, ar included respiratory damage, cognitive	d noted R17 was admitted to nd had diagnoses, which y ventilator, anoxic brain impaired, urinary obstruction, Medication that included Paxil, enytoin.				
	3/13/15, identified F	inimum Data Set (MDS) dated R17 required total assist with ers, dressing, toileting, bathing ne needs.				
	Daily Living (ADL's) Potential dated 3/9/ dependent on staff Staff will proceed to	essment (CAA) for Activities of) functional/Rehabilitation /15, indicated, "Resident is for all ADL's and cares o care plan residents lence on staff and to maintain less."				
	alteration in hygiendirected staff, "I reconstructed wash once a week hygiene needs. Goand odor-free daily, residents' skin during	d 3/18/15, identified R17 had e/ADL's/shower/bath and ceive a partial bath and a hair I am dependent on staff for all als: I would like to be clean. Interventions Staff monitoring bath and cares for signs of the part and further evaluates.				

STATEMEN	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY
		00149	B. WING		05/2	21/2015
	PROVIDER OR SUPPLIER	1412 WES	DRESS, CITY, S ST FOURTH S G, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED CORRECTION (CROSS-REFERENCE)	D BE	(X5) COMPLETE DATE
2 920	however the care proposed facial hair for resident on 5/17/2015 at 5:4 interview R17, she are gray/white facial hand chin area approximance Resident was unable when queried. On 5/18/15 at 8:51 observed in her roow white sheet and wanumerous facial hair on 5/19/2015 at 7:3 -F was observed to 7:55 a.m., R17 was shaven by NA-F. R117 was witnessed the evening of 5/17/2015 at 7:3 clinical reconfacility on 2/11/15, and included respiratory obstruction, muscled diabetes type II. Meand insulins. R117's quarterly ME "rarely/never understands." Identify with bed mobility, tratoileting, personal harmonic response in the CAA dated 2/20 dependent on staff.	ent. 48 p.m., during an attempt to was observed to have several irs to the upper lip and the lately one half inch long. Ile to communicate her needs a.m. and 11:45 a.m. R17 was om laying in bed covered with a las observed to still have irs. 39 a.m., nursing assistant (NA) complete R17's peri cares. At a left in bed without been and to have several facial hairs /15, and during subsequent on 5/18/15 and 5/19/15. and noted R117 was admitted to land had diagnoses, which y failure, chronic airway a weakness, hypertension, edication that included Lasix	2 920			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	
		00149	B. WING 05		05/2	1/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
RED WIN	IG HEALTH CENTER		T FOURTH			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 920	Continued From pa	ge 39	2 920			
	for further eval (eva	e with any changes reported aluation). Staff will proceed to risk for skin break down and egrity."				
	am cognitively impaintra-cerebral hemre being vent dependenceds much of the questions. My memmy communication knowing my family, On 2/18/15 my BIV severely impaired a myself. Intervention	morage (hemorrhage) and ent, unable to express my time. I can nod to yes or no nory is difficult to assess due to deficits. My abilities are where I am and time of year. IS assessment indicates as I am rarely able to express as: Staff will assist in decision ed by the family or resident.				
	interview R117, was of gray/white facial	48 p.m. during an effort to so detected to have quite a lot hairs to the upper lip and the twas unable to communicate eried.				
		a.m. and 11:43 a.m., R117 is room sitting up in his sed unshaven.				
	On 5/19/2015 at 7:5 bed with facial hair.	39 a.m., R117 was laying in				
	licensed practical n R117 were unshave reason why R17 ar they should have b assistants are busy	on 5/19/15 at 10:24 a.m., lurse (LPN)-B verified R17 and en and stated, there was no id R117 were unshaven and een shaven. "Nursing or and we had many call-ins and at as an excuse. We don't				

have enough staff here, but I will tell the nurse

PRINTED: 06/24/2015

FORM APPROVED Minnesota Department of Health (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: B. WING 05/21/2015 00149 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1412 WEST FOURTH STREET **RED WING HEALTH CENTER** RED WING, MN 55066 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 920 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. Shervl R87 needed assistance from staff for

hair removal.

G3Q611

grooming/shaving and was not provided facial

R87 was observed on 5/17/15 at 7:12 p.m. with approximately 5/8 inch long dark and light facial

Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE :	
ANDIDAN	OF CONTRECTION		A. BUILDING:			
		00149	B. WING		05/2	1/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
DED WIN	IC UEALTH CENTER	1412 WES	T FOURTH	STREET		
RED WING HEALTH CENTER RED WING		3, MN 55066)			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 920	Continued From pa	ge 41	2 920			
	hairs on his checks neck area. The foll p.m. the facial hair 5/19/15 during ranchair remained on the The annual MDS didiagnoses included dementia and traur (inability to express The MDS indicated with personal hygie 4/15/15 indicated R grooming tasks on grooming needs to by staff. Interventic assist/maintain electuse and weekly per On 5/19/15 at 12:30 (NA)-I verified she during the shift. The R87 does like to ge problem the next don 5/19/15 at 2:45 coordinator (RN)-B been shaved since plan directed staff. assistant should had during the day. RN does not direct staff added, it somehow developed. R87 was not providing the day. RN does not direct staff added, it somehow developed. R87 was not providing the day. RN does not direct staff added, it somehow developed. R87 was not providing the day. RN does not direct staff added, it somehow developed. R87 was not providing the day. RN does not direct staff added, it somehow developed. R87 was not providing the day. RN does not direct staff added to be ser throughout breakfa was moved to the N wheelchair in the h	remained on R87's face. On some observations, the facial ne resident's face. ated 3/5/15 identified cerebrovascular accident, matic brain injury and aphasia and understand language). R87 needed extensive assistine. R87's care plan, dated this own and wanted his be anticipated and met for me ons included Staff ctric razor cleaning after each protocol. Op.m. the nursing assistant did not get to shave R 87 ne nursing assistant indicated at a shave so it should not be a aay. p.m. the registered nurse was informed R87 had not 5/17/15 and on what the care RN-B Indicated the nursing assistant incorporated the shave I-B also verified the care plan of on grooming R87 daily, and was missed when care plan and the was missed when care and was led with toileting care and was	2 920			

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE COMP	
		00149	B. WING		05/2	1/2015
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	TATE, ZIP CODE		
RED WI	NG HEALTH CENTER		T FOURTH S 3, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 920	area by the assista 10:30 a.m. the licer took R87 to his roo was able to stand was incontinent of and applied a clear the transfer pole. For creases and wrinkl The annual minimus 3/5/15 identified discerebrovascular act traumatic brain injuexpress and under indicated R87 need activities of daily like toileting. The MDS incontinent of bower care plan directed before and after mon 5/19/15 at 10:30 resident had been skin on buttocks and deep creases and On 5/19/15 at 12:00 R87 up before 7:00 able to get back to so thankful LPN-C on 5/19/15 at approverified the finding been repositioned R102 was depend hygiene/grooming hair removal. R 102 was observed darker colored faction and upper nemind being shaved the room indicated however, was usually the standard to t	ince of staff. At approximately insed practical nurse (LPN-C) im. With staff assistance, R87 up using a transfer pole. R87 stool. LPN-C provided pericare in brief to R87 while standing at R87's skin was red with deep es. It was been used agnoses included ecident, dementia and arry and aphasia (inability to estand language). The MDS ded extensive assist with all wing including transfers and indicated the R87 was el and bladder. The current staff to toilet upon rising, eals and at hour of sleep. It is a many side of the continent of stool and the ind thighs was red with multiple wrinkles. If p.m., NA-I verified getting and a many she had not been a R87. NA-I indicated she was				

	OF CORRECTION	IDENTIFICATION NUMBER:	1 ` '	E CONSTRUCTION	COMP	PLETED
		00149	B. WING		05/2	21/2015
RED WING HEALTH CENTER 1412 WES			DRESS, CITY, S ST FOURTH S G, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	.D BE	(X5) COMPLETE DATE
2 920	when visiting. On 5/19/15 at 2:00 was made and R10 long facial hair on e was visiting and cor shaved for a few da F-C verified R102 is when she visits and The initial MDS date diagnoses included brain injury. The M dependent on staff R102's care plan, la R102 would like to groomed daily. How does not identify pe needs for R102. On 5/20/15 at 12:00 care plan did not id grooming/shaving r updated as soon a	p.m. a random observation 02's face continued to have entire face. At this time F-B nfirmed R102 had not been ays and that she would do it. s not usually clean shaven of frequently shaves R102. The second of the fact of th	2 920			
	review and revise p needed, train staff, and evaluate to ass necessary care and indivdualized comp	sing and/or designee could colicy and procedures as assess the system, monitor sure that residents receive the discretices based on an orehensive assessment. R CORRECTION: Twenty-one				
21390	MN Rule 4658.0800	0 Subp. 4 A-I Infection Control	21390			
	Subp. 4. Policies a	and procedures. The infection				

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(X3) DATE SURVEY COMPLETED	
00149		B. WING		05/21	/2015	
NAME OF PROVIDER OR SUPPLIER RED WING HEALTH CENTER	1412 WES	ST FOURTH S				
	RED WIN	G, MN 55066) 			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE	
21390 Continued From pa	ge 44	21390				
control program muprocedures which parecellection to identify residents; B. a system for control of outbreaks C. isolation and reduce risk of trans D. in-service exprevention and con E. a resident he immunization progratefined in part 465 procedures of resid the prevention and F. the development employee health popractices, including defined in part 4656 G. a system for H. a system for H. a system for products which affed disinfectants, antise incontinence product. I. methods for a current standards of the procedure of the products which affed disinfectants and the products which affed disinfectants are producted in the products which are producted in the product which are producted in the product which are producted in the producted	ust include policies and provide for the following: based on systematic data or nosocomial infections in a detection, investigation, and so of infectious diseases; disprecautions systems to mission of infectious agents; ducation in infection trol; ealth program including an am, a tuberculosis program as 8.0810, and policies and lent care practices to assist in treatment of infections; ment and implementation of policies and infection control a tuberculosis program as 3.0815; reviewing antibiotic use; review and evaluation of lect infection control, such as eptics, gloves, and					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SU COMPLET (X3) DATE SU COMPLET (X4) ID PREFIX TAG (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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) (X4) ID PREFIX TAG (X2) MULTIPLE CONSTRUCTION (X3) DATE SU (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SU (X3) DATE SU (X3) DATE SU (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SU (X3) DATE SU (X3) DATE SU (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SU (X3) DATE SU (X3) DATE SU (X3) DATE SU (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SU (COMPLET (A) BUILDING: (B) WING (PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ETED
NAME OF PROVIDER OR SUPPLIER RED WING HEALTH CENTER (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 21390 Continued From page 45 residents in the facility who used care device. Findings include: Appropriate hand hygiene was not followed	(X5) COMPLETE
RED WING HEALTH CENTER 1412 WEST FOURTH STREET RED WING, MN 55066 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 21390 Continued From page 45 residents in the facility who used care device. Findings include: Appropriate hand hygiene was not followed	COMPLETE
RED WING, MN 55066 (X4) ID PREFIX TAG Continued From page 45 residents in the facility who used care device. Appropriate hand hygiene was not followed	COMPLETE
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 21390 Continued From page 45 residents in the facility who used care device. Findings include: Appropriate hand hygiene was not followed	COMPLETE
residents in the facility who used care device. Findings include: Appropriate hand hygiene was not followed	
Findings include: Appropriate hand hygiene was not followed	
Appropriate hand hygiene was not followed	
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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION O149 DETITIVE CONSTRUCTION A BUILDING: B. WIND O5/21/2015	Minneso	ta Department of He	ealth			FORIVIA	AFFINOVED
NAME OF PROVIDER OR SUPPLIER RED WING HEALTH CENTER (X4) ID PREFIX TAGGET AND A STATE AN	STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				
A			00149	B. WING		05/2	1/2015
CALL DEPTICIENT CALL	NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 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 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, Shery! 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.	RED WIN	IG HEALTH CENTER					
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.	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	_D BE	COMPLETE
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	21390	thought "you always since the treatment the dirty part was do. The facility's Gastro policy dated 2/2014 hand washing was. The facility's Trache 3/2014, revealed the dressing was removed and hands indicated that glove placing a new gauz then removed and I. The facility's Hand Setting Guidelines, hygiene was to be pushing equipment. Reed, Sheryl During observation three residents, the (LPN)-B did not was resident On 5/20/15 at 11:15 room, applied gloves sample from the resident when LPN-B had or removed the gloves exited the room. LI at approximately 11 obtained a blood same contents and the same contents are provided to the same contents.	s went from dirty to clean" and was for dressing removals, one first. Destomy/Jejunostomy Site Care revealed glove removal and to occur after GT cleansing. Deotomy Care policy dated at after the old tracheotomy ved gloves were to be swashed. The policy further is were to be worn when e pad around the stoma site, hands washed. Hygiene In the Healthcare dated 5/2014, revealed hand performed before and after and after handling soiled of glucose monitoring on elicensed practical nurse sh her hands in between each as and obtained a blood sident 's finger to check for a personal glucometer. Completed the task, she is, and picked up the tote, and PN-B then entered R32's room applied gloves and ample from the resident's	21390			

PRINTED: 06/24/2015

FORM APPROVED Minnesota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: B. WING_ 05/21/2015 00149 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1412 WEST FOURTH STREET RED WING HEALTH CENTER RED WING, MN 55066 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 21390 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

Minnesota Department of Health

compliance.

is followed, monitored and evaluated to assure

TIME PERIOD FOR CORRECTION: Twenty-one

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE	
AND TERM OF SOURCESTION		A. BUILDING:		JONN ELTED		
		00149	B. WING		05/2	1/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
RED WIN	IG HEALTH CENTER		T FOURTH S 5, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETE DATE
21390	Continued From pa	ge 48	21390			
	(21) days.				er verialistica	
21435	MN Rule 4658.0900 Recreation Program	Subp. 1 Activity and n; General	21435			
	home must provide recreation program based on each indistrengths, and need meet the physical, is well-being of each is comprehensive rescomprehensive plate 4658.0400 and 465 provided opportunit	al requirements. A nursing an organized activity and . The program must be vidual resident's interests, ds, and must be designed to mental, and psychological resident, as determined by the ident assessment and n of care required in parts 58.0405. Residents must be ies to participate in the opment of the activity and				
	by: Based on observati review, the facility fi individualized progr psychosocial wellbe residents (R83) rev	am of activities to meet the eing of each resident for 1 of 3				
:	Findings include:					
	R83 did not receive plan of care.	activities as directed by the				
	at 7:00 p.m., R83 w side. Eyes were op to verbal communic	s on 5/17/15, at 3:00 p.m. and vas laying in bed on the right en but there was no response cation. There was no radio, no r tape playing in the room.				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:			COMP	LETED	
		00149 B. WING 05/21/2		21/2015		
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
RED WIN	IG HEALTH CENTER		T FOURTH			
	- TEALTH GENTER	RED WING	3, MN 55060			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21435	Continued From pa	ge 49	21435			
	During observations 10:48 a.m., and 1:0 on the right side. Ey no response to veri no radio, no televisithe room. When interviewed of Family member (F) discouraged" because tivities as much at to see R83 "more in being so young and videos, which which should still be the facility was away activities in the Mar stated several family frequently and have	s on 5/18/15, at 9:00 a.m., 10 p.m., R83 was laying in bed yes were open but there was bal communication. There was ion, no CD or tape playing in the control of the contro				
	review revealed R8 on 11/21/13. The adplan of care, dated limited to tracheost and unspecified into Minimum Data Set 4/29/15, indicated uspeech and Vision, vegetative state/no R83 was assessed Data Set (MDS) on impairment and una Document review of dated 4/10/14, react these activities I did	ctronic medical record (eMR) as was admitted to the facility ctive diagnoses from R83's 5/19/15, listed, but was not omy, septicemia, endocarditis, racranial hemorrhage. The (MDS) assessment dated under section B Hearing, read; Comatose, Persistent discernable consciousness. on the quarterly Minimum 1/28/15, as severe cognition able to answer questions. of the activity plan of care, I, Quality of Life: Continuing the prior to admission are like this type of music: Rap, I				

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00149	B. WING	·	05/2	1/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
DED 14/11	IO LIEALTII OENTED	1412 WES	T FOURTH	STREET		
RED WIN	IG HEALTH CENTER	RED WING	G, MN 5506	6		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21435	Continued From pa	ge 50	21435			
		TV programs: Sitcom, Movies; tes of the Caribbean.				
	1:302:30 p.m. mo	on 5/18/15, at approximately ovie Happy Gilmore was ng room. R83 did not attend				
	on 5/19/15, at 9:42 volunteer visitor wh hand massage but sensory stimulation would benefit from what [R83] can con expressed not bein crowded group sett know if [R83] can s is doing." AA-A veri group setting activit	with the activity aide (AA)-A a.m,. revealed R83 has a o comes every two weeks for AA-A is not sure of the for R83 and exactly what he because stated, "I am not sure aprehend." Furthermore AA-A g sure about R83 being in a ing and stated, "We do not ee anything or what the brain fied R83 was not brought to ties and that the nursing staff in the television and music for				
	The director of nurs assure activity progindividual resident's needs, and must be physical, mental, areach resident, as d comprehensive rescomprehensive planursing could assurare reviewed, revisand system assess	rHOD OF CORRECTION: sing and/or designee could grams are based on each interests, strengths and e designed to meet the end psychological well-being of etermined by the ident assessment and n of care. The director of re that policy and procedures ed as needed, staff trained ed, monitored and evaluated activity needs of residents are				

PRINTED: 06/24/2015 FORM APPROVED

Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY COMPLETED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER:

00149

A. BUILDING:	OOMI LETEB
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

Date Display Display	IXED WIII	RED WING, MN 55066							
TIME PERIOD FOR CORRECTION: Twenty-one (21) days. 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 does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacists 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 does not chave adequate justification for the order and if the attending physician does not chave adequate justification for the order and if the attending physician does not chave adequate justification for the order and if the attending physician does not chave adequate justification for the order and if the attending physician does not chave adequate justification for the order and if the attending physician does not chave adequate must be referred for review to the quality assessment and assurance committee required	PRÉFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETE				
(21) days. 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 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 for review if the medical director is not the attending physician for review if the medical director for review if the medical director for review to the quality assessment and assurance committee required	21435	Continued From page 51	21435						
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		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							
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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	i		COMPL	
		00149	B. WING		05/2	1/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
RED WIN	IG HEALTH CENTER		T FOURTH			
TED WIII		RED WING	G, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21530	Continued From pa	ge 52	21530			
	the medical director must refer the matt	If the attending physician is or, the consulting pharmacist er directly to the quality surance committee.				
	by: Based on documenthe pharmacist faile physician drug irreg	ent is not met as evidenced at review and staff interview, ed to identify and report to the gularities for 1 of 5 (R87) apple reviewed for the use of eations.				÷
	Findings include:					
		rrent physician orders, R87 receive an excessive amount				
	was admitted to the diagnoses of cereb contracture of joints joint, hand. The cur R87 had a physicia Acetaminophen Tal three times a day. house order that re give 650 mg by mo for pain. Give 650 r needed) for minor pain.	olet 1000 mg (milligram) oral R87 also had a standing ad: Tylenol (Acetaminophen) uth every 4 hours as needed mg orally every 4 hours prn (as pain or temp (temperature) or Do not exceed 3000 mg of				
	On dose of the 650	enol amount equals 3000 mg. mg every 4 hours as needed sed the limit of 3 grams in 24				

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Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING: _

B. WING _ 05/21/2015 00149

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

1412 WEST FOURTH STREET

RED WIN	IC HEALTH CENTER	ST FOURTH S G, 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
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		
	an advant of Hagith			

	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUII TIPI	E CONSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:			COMP	
		00149	B. WING		05/2	1/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
			T FOURTH			
RED WIN	IG HEALTH CENTER	RED WING	G, MN 55066	3		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21540	Continued From pa	ge 54	21540			
21540	MN Rule 4658.1319 Usage; Monitoring	5 Subp. 2 Unnecessary Drug	21540			
	monitor each reside unnecessary drug to home's policies and pharmacist must reresident's attending physician does not home's recommend adequate justification believes the resident adversely affected, matter to the medical director is the medical director is the medical director physician does not the order and if the change the order, the review to the Qualit (QAA) committee rethe attending physithe consulting phar directly to the QAA.					
	by: Based on interview facility failed to ens administered with r	and document review, the ure medications were espect to potential excessive residents (87) reviewed for eation.				
	Findings include:					
		rrent physician orders, R87 receive an excessive amount				

of acetaminophen.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED	
		00149	B. WING		05/:	21/2015
	PROVIDER OR SUPPLIER	1412 WES	DRESS, CITY, S ST FOURTH G, MN 5506			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21540	The current physicis was admitted to the diagnoses of cereb contracture of joints joint, hand. The cur R87 had a physicia Acetaminophen Ta three times a day. house order that regive 650 mg by mo for pain. Give 650 meeded) for minor greater than 100.5. Tylenol in a 24 hr p The scheduled Tyle On dose of the 650 for pain would exceeded 650 mg occasions. R87 examount on 4/27 an as needed dose. On 5/20/15 at approved a seeded the 3000 RN-B reported she practioner regardin. A policy was requesting the contraction of the cont	ian order sheets revealed R87 e facility on 4/15/13 with oral artery occlusion, is at many sites, and pain in reent physician orders indicate in order that read: blet 1000 mg (milligram) oral R87 also had a standing read: Tylenol (Acetaminophen) buth every 4 hours as needed mg orally every 4 hours prn (as pain or temp (temperature) or Do not exceed 3000 mg of iteriod." enol amount equals 3000 mg. If a grams in 24 in 2015 medication or dindicated R87 received an order of the side of Tylenol on 2 separate and deed the 3000 mg Tylenol of 4/28/15 when he received as exceed the 3000 mg. Tylenol of 4/28/15 when he received as exceed the physician are two as needed doses in April of mg recommended dose. Would talk to the nurse g the Tylenol orders.	21540			
	SUGGESTED ME	THOD OF CORRECTION:				

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00149	B. WING		05/2	1/2015
	PROVIDER OR SUPPLIER	1412 WES	DRESS, CITY, S T FOURTH G, MN 5506			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21540	The Director of Nur work with the medic pharmacist to ensu for appropriate inte parameters for use staff were educated monitoring for unne DON or designee of records to ensure a parameters and do	rsing (DON) or desigee could cal director and consultant are medications were reviewed rventions, monitoring and at the DON could ensure the don the importance of ecessary medications. The could randomly audit resident adequate monitoring, cumentation was in place.	21540			
21620	in accordance with This MN Requirements: Based on observation interview, the facility were dated when o	ent is not met as evidenced ion document review and y failed to ensure medications pened, labeled correctly and	21620			
	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.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00149	B. WING		05/2	1/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
RED WIN	IG HEALTH CENTER		ST FOURTH 3, MN 5506			:
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21620	On 5/17/15 at 1:35 storage tour with the East unit medication observed to be in under without identificated. During the tour, the identified. R32's Novolog instantification of the identified of the identified. R35's Novolog filter mained in cart for dispensed on 3/25/ A Lantus insulin puthe medication cart. R83's two bottle of opened and not datantification of the identification of the ide	p.m. during the medication e licensed practical nurse on 2 n cart, medications were se but not dated when opened tion labels. following concerns were sulin was opened, dispensed ted when opened, sulin pen was opened, and not dated when opened, ex pen was opened, and r use. The pen had been 14 and opened same day, en with no label remained in . It was opened and not dated, if heparin sodium solution were ted. loride ophthalmic ointment of dated. sulers without any identification nedication cart. In black of R132 and R156 were of the inhalers.	21620	DEFICIENCY		
	read: "Drug contain	e of policy, last revised 7/2013 ers having soiled illegible, complete, damaged, or				

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	COMP	LETED	
		00149	B. WING		05/2	1/2015
	PROVIDER OR SUPPLIER	1412 WES	DRESS, CITY, S ST FOURTH S G, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21620	The facility's policy, Medications, Biolog last revised 1/1/13 i ensure that medica expiration date on t retained longer thar manufacturerAlso medication or biolog facility should follow guidelines with responsed medications the date opened on	returned to the pharmacy for one storing. Storage and Expiration of picals, Syringes and Needles, indicated Facility should tions and biologicals have an the label., and have not been in recommended by the policy reads: "Once any gical package is opened, or manufacturer/supplier poect to expiration dates for see Facility staff should record the medication container on has a shortened expiration	21620			
	The administrator, of consulting pharmac policies and proced medications. Nursing necessary to the immedications proper medications. The District pharmacist, couregular basis to ensure the pharmacist of the pharmacist.	director of nursing (DON) and cist could review and revise dures for proper storage of any staff could be educated as apportance of labeling dy and discarding expired DON or designee, along with all audit medications on a sure compliance. R CORRECTION: Twenty-one				
21670		5 A.B.C.D. Resident Units must be provided for each	21670			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		00149	B. WING		05/2	1/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
RED WIN	NG HEALTH CENTER		ST FOURTH G, MN 5506			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21670	convenience of the mattress, and clear weather and reside condition. Each be bedspread. A mois mattress cover must confined to bed and Rollaway type beds not be used. B. A chair or pl than the bed. C. A place adjate personal possession with a drawer. D. Clean bath loften as needed. E. A bed light convenience.	per size and height for the resident, a clean, comfortable in bedding, appropriate for the nt's comfort, that are in good id must have a clean sture-proof mattress or sit be provided for all residents id for other beds as necessary. It is, cots, or folding beds must acce for the resident to sit other accent or near the bed to store ons, such as a bedside table linens provided daily or more reniently located and of an eneeds of the resident while	21670			
	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					

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NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
RED WIN	IG HEALTH CENTER		T FOURTH			
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21670	Continued From pa	ge 60	21670			
	cares. There was fr	ped linen under R83 with riction and shearing as the pulled on the bed linens in an linen under R83.				
	NA-A and NA-K ver linen big enough to nursing assistants of trying to keep the line expressed concern R83's skin. Both nu	on 5/19/15, at 10:30 a.m. both rified the facility did not have fit these type of beds. Both validated the frustration of nen under R83 and both for the friction and shearing of trising assistants said they difficulty with nursing				
	The facility did not p R106's bariatric ma	provide proper fitting linens for attress.				
	supplied the linen to	and NA-K, R106's family of fit the bed because they did not have linen to fit the attresses.				
	(DL) services on 5/	with the director of laundry 19/15, at 3:00 p.m. the DL aly purchased the one size fits				
	The facility did not liftting bed linen.	have a policy regarding proper				
	SUGGESTED MET	HOD OF CORRECTION:				
	develop and impler to ensure linens to Audits could be cor day and the results	sekeeping and laundry could ment policies and procedures fit bariatric beds for residents. Inducted at various times of the of those audits could be lity committee for their review.				

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AND PLAN OF CORRECTION IN IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00149	B. WING		05/2	1/2015
	PROVIDER OR SUPPLIER	1412 WES	DRESS, CITY, S ST FOURTH G, MN 5506			
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21670	Continued From pa TIME PERIOD FOR (21) days.	ge 61 R CORRECTION: Twenty One	21670			
21685	Subp. 2. Physical princluding walls, floor systems, and equip continuous state of with regard to the howell-being of the resortine maintenance. This MN Requirements by: Based on observation review, the facility for orderly and comfort west and 3 east) unurine odors. 2 of 10 window curtains we hemming. 6 of 8 resort R40, and R52) where resident rooms (R44 repair and 1 of 10 restaining on the floor Findings include: Throughout various survey 5/17, 5/18, 5 strong urine odor of west and 3 east hall During a family mere	eration, & Maintenance plant. The physical plant, rs, ceilings, all furnishings, ment must be kept in a good repair and operation ealth, comfort, safety, and sidents according to a written e and repair program. ent is not met as evidenced on, interview and document ailed to maintain a sanitary, able environment. 2 of 3 (2 it hallways had noticeable (R13, R18) residents's room re visibly torn and had frayed sidents (R16, R18, R28, R29, el chairs were dirty. 2 of 10 0, R164) required paint and esident rooms (R98) had dark ing. stimes, each day of the /19 and 5/20/15, there was a pserved to be present in the 2 lways. mber (F-A) interview on	21685			
		m., F-A stated, "Everytime I ing it smells like piss, there				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		00149	B. WING		05/2	21/2015
	PROVIDER OR SUPPLIER	1412 WES	DRESS, CITY, S ST FOURTH S G, MN 55066			
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21685	must be something aware of it for mont they figure it out and verified family mem to complain about the members have comfacility on behalf of speak up and would buring an observation housekeeper (H)-A the hallway and stathe smell." H-A valid odor in the 3 east howhere the odor was being sprayed was Counteractant. During observation 1:30 p.m., on 2 eas resident (R13, R18) frayed, undone hem of the 24 to 36 inch on 5/18/15 at 1:30 p. see the frayed drap validated his family the frayed edges duit will bother them, sixed." When interviewed verified the unhemm "irritating" because in his room and worrepair. During observation	they can do for that. I've been hs, and complaining, why can't d get rid of the smell." F-A ber was not cognitively intact he odor but the family inplained about the odor in the the resident who cannot d not like the odor. Ion on 5/19/15 at 12:00 p.m., was spraying a substance into ted, "We are trying to cover up dated there was a strong urine allway and was not sure a coming from. The product called, Good Sense Odor of room order on 5/18/15, at thallway, there were 2 of 10 window curtains that had inming along the entire length edgings. When interviewed o.m., R18 said he could not ery because of blindness but would not appreciate seeing uring visits and stated, "Maybe so I think they should be on 5/19/15, at 2:30 p.m., R13 aned, frayed curtain was R13 expressed "taking pride" ald like things to be in good	21685			
	housekeeping (DLF	h the director of laundry and I) on 5/19/15, at 2:30 p.m. the rtains needed to be taken				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	1412 WES	DRESS, CITY, S ST FOURTH S G, MN 55066			
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21685	down and repaired During various obset 5/19/15, the wheel R40, and R52, had crumbs present on under the cushions foot plates of the will During observation R18, R28, R29, R4 laundry and housek 2:30 p.m. the DLH needed to be clean will be taken care of there was not a system to clean the wheel chairs and to clean the wheel croom is "deep clean Document review of form titled, Deep Cl R18 had the wheel had the wheel chair had the wheel chair had the wheel chair no other forms proc wheel chair cleanin R16, R29 and R52. Further interview or DLH revealed, whe day shift, but if a ret the housekeeping s wheel chair. The DI are done on the day there is an evening but they are busy d On 5/20/15, at 10:0	and/or replaced. ervations on 5/17, 5/18 and chairs of R16, R18, R28, R29, a build up of grime and the sides of the wheel chair, and in some instances on the heel chair. of the wheel chairs for R16, 0, and R52, with the director of keeping (DLH) on 5/19/15, at verified the wheel chairs ed and the DLH stated, "They of today." The DLH verified them to monitor the cleaning of the housekeeping staff were chairs once a month when the hed." of the facility housekeeping lean Checkoff List, revealed chair cleaned on 4/8/15, R28 or cleaned on 4/2/15 and R40 or cleaned 4/27/15. There were cluced for review to indicate if goccurred in April or May for the sident is up in the wheel chair staff are unable to clean the LH stated, "The wheel chairs y shift if they can get to them, housekeeper from six to ten, oing the dining rooms."				
	was conducted with					

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(X3) DATE SURVEY

Minnesota Department of Health

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00149	B. WING		05/2	1/2015
	PROVIDER OR SUPPLIER	1412 WES	DRESS, CITY, S ST FOURTH S G, MN 55066			
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21685	maintenance directed the corporate house environmental tour, noted to have gough marks on the walls. Verify they were in mand the facility did mand the side of the rothis time. The reside over the orange sponding the spot with his shooff. The housekeep needs to be cleaned SUGGESTED MET. The director of nursiand/or designee conincluding walls, floo systems, and equip state of good repair the health, comfort,	or, housekeeping director and ekeeping director. During the R40 and R164's rooms were les, scratches, and black. The maintenance director did need of repair and painting, not have a system in place be painted. The maintenance director did need of repair and painting, not have a system in place be painted. The maintenance director did need of repair and painting, not have a system in place be painted. The paintenance director did need to have a system in place be painted. The communication was placed on the floor stated the orange marks ins; however when he scraped oe, the orange spot did wipe bing director verified the floor	21685			
	maintenance and re TIME PERIOD FOF (21) days.	R CORRECTION: Twenty One				
21870	MN St. Statute 144. Residents of HC Fa	.651 Subd. 18 Patients & ac.Bill of Rights	21870			
		nsive service. Patients and e the right to a prompt and				

(X2) MULTIPLE CONSTRUCTION

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION :		E SURVEY PLETED
		00149	B. WING		05/2	21/2015
	PROVIDER OR SUPPLIER	1412 WES	DRESS, CITY, S ST FOURTH G, MN 5506			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21870	reasonable respons requests. This MN Requirements by: Based on document facility failed to act to resident council me (R13, R16, R18, R3 specific care and set Findings include: R13, R32 and R124 Resident Council moconcerns of a group floor regarding staff R16, R18, and R52 concerns but were read and the set where the set were read, "*Right heir needs are being answered, can take back to, resident is nurses/aides don't were present at this R124. A review of the Mararesident council min resolution to the Fel concerns.	se to their questions and ent is not met as evidenced t review, and interview, the upon grievances from the eting for 6 of 6 residents 12, R52, R124) who voiced ervice issues on 2 east. I attended the February 2015 eeting and expressed the of resident's from the second education and treatment. further corroborated resident	21870			

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00149	B. WING	·	05/2	21/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY,	STATE, ZIP CODE		
RED WIN	NG HEALTH CENTER	1412 WES	T FOURTH	STREET		
INED WII	TO TIEAETH GENTER	RED WING	G, MN 5506	6	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE
21870	expressed having to the staff to help with R16 referred to, "oti watch out for me, b me they make me we complain." Furthern regular day staff are want them mad at referred the staff will push an take care of me and problems being conformation afraid they will make R16 validated the factor of the problem from validated attending whom she consider her. Review of R16's me annual minimum da 3/18/15, which assess and able to make do During an interview p.m., a concern was complain the staff we want to complain. We was done about it." resident council me R52 expressed consider constant pain from a constant pain from	o wait long periods of time for a cares and position changes, her people that live here try to ut when the staff get mad at wait longer, I don't want to nore, R16 stated, "some of the e sticks in the mud, I don't me." R16 stated, "If I complain, and pull on me more when they determined that hurts. I already have infortable in this chair and I am are me wait longer for help." acility management was aware a resident council which R16 with [R13,R52 and R124] is people who watch out for edical record indicated an ata set (MDS) completed intact.	21870			
	Review of R52's me quarterly MDS comp	ant them to, "Get back at me." edical record indicated a pleted 4/30/15, which R52 egnitively intact and able to				

Minnesota Department of Health

make decisions about care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00149	B. WING		05/2	21/2015
	PROVIDER OR SUPPLIER	1412 WES	DDRESS, CITY, ST ST FOURTH S G, MN 55066	STREET	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21870	During an interview R32 validated the crebruary 2, 2015 reconfirmed the resida bout the lack of rewere afraid of retalistated, "Be sure to because they are staff being mean to Review of R32's may assessed as commake decisions about the lack of R124 talked about the LPN)-A and stated at me, One day she screaming at me for of nursing (DON). The problem but because long they won't do at ous." R124 continues the staff that nursing try to control the resustants do not all their way or expect should need sometic explained the resident talk and watch out finterview [R13], [R1 also expressed con [NA-A] and [NA-B].	con 5/19/15, at 10:32 a.m., concerns addressed at the esident council meeting and dents continued to be upset esolution and that the residents isiation from the staff. R32 talk to [R13] and [R124] seriously concerned about the othem." edical record indicated a hpleted 2/18/15, which R32 cognitively intact and able to out care. on 5/19/15, at 10:37 a.m., licensed practical nurse I, "[LPN-A] is always so made a came into my room or reporting her to the director They know [LPN-A] is a se she has been here for so anything about her retaliation ued to talk about the February enting when the residents tolding assistants (NA)-A and NA-B sidents. "These nursing llow choices, you better do it to wait a long time if you thing." Furthermore, R124 ents on this end of the building for each other. R124 said to 16], and [R52] because they neers about [LPN-A] and	21870			
		ognitively intact and able to			!	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00149	B. WING		05/2	21/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
RED WIN	NG HEALTH CENTER	· · · · - · ·	ST FOURTH 3, MN 5506			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
	discussed being ver from LPN-A and ref back where a cultur required. R13 said early in the morning the culture and ther back together again because he has constated, "The resider here." R13 referred residents who discunursing unit. R13 s R13 considered "buwas one day in Apriafter an incident that felt angry, that I was like being a kid and	on 5/19/15, at 2:30 p.m., R13 ry concerned about retaliation erred to a situation a while e of a wound site was "[LPN-A] came into the room to the appliances, did to left me, she did not put it and R13 felt it was "in spite" implained about her." R13 into the room to [R124], [R16], [R52] as assed the concerns on the hared another situation that allying like in grade school" I when LPN-A laughed at R13 at was upsetting. R13 stated, "I as not worth anything. It was being laughed at." R13 feels ated against him by not talking				
	at me because I con Review of R13's me annual MDS comple assessed as cogniti decisions about car During an interview p.m., a concern was mean to him becaus rough way, but he d fear of retaliation be been here a long tin the unit." R18 stated something wrong to way." R18 validated	with R18 on 5/19/15, at 2:00 s expressed that the staff are se they push him around in a oesn't want to complain for ecause "these people have ne and are the usual staff in d, "Maybe I have done them so they treat me this he did not report to use he stated, "I am afraid				

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00149	B. WING		05/2	1/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI		STATE, ZIP CODE	1	
RED WIN	NG HEALTH CENTER		ST FOURTH			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21870	Continued From pa	ige 69	21870			
	annual MDS compl assessed as cognit decisions about car					
	services (DSS), the registered nurse (R a.m., the minutes o Council were review RN-A, validated the the concerns expre Resident Council more resident council me addressed in the readcording to the DS	with the director of social e director of nursing (DON) and RN)-A on 5/19/15, at 10:45 of the February Resident wed. The DSS, DON and ere was no investigation into essed at the February 2015 neeting. There were no erviews conducted from the eeting or on the 2E unit esident council minutes. SS, the person who recorded il minutes no longer works at				
		the DSS, DON and RN-A erns should have been				
	SUGGESTED MET	THOD OF CORRECTION:				
	that residents concupon timely. The di could review policy monitor systems, in evaluate the procesupon resident coun related to food conc					·
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00149	B. WING	·	05/2	21/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
RED WIN	NG HEALTH CENTER		ST FOURTH S G, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21880	Continued From pa	age 70	21880			
21880	MN St. Statute 144 Residents of HC Fa	.651 Subd. 20 Patients & ac.Bill of Rights	21880			
	shall be encouraged their stay in a facility to understand and expatients, residents, residents may voice changes in policies and others of their content including threat of the grievance procedure well as addresses at the office of Health Fanursing home ombotions.	nces. Patients and residents and assisted, throughout try or their course of treatment, exercise their rights as and citizens. Patients and e grievances and recommend and services to facility staff choice, free from restraint, ion, discrimination, or reprisal, discharge. Notice of the re of the facility or program, as and telephone numbers for the acility Complaints and the area udsman pursuant to the Older ction 307(a)(12) shall be cuous place.				
	residential program 253C.01, every non facility employing me provides outpatient have a written inter at a minimum, sets followed; specifies to limits for facility responses or resident to have advocate; requires grievances; and program an impartial decisio otherwise resolved. residential program 253C.01 which are treatment programs centers with section	e inpatient facility, every mas defined in section nacute care facility, and every nore than two people that mental health services shall rnal grievance procedure that, forth the process to be time limits, including time sponse; provides for the patient e the assistance of an a written response to written ovides for a timely decision by an maker if the grievance is not. Compliance by hospitals, ms as defined in section hospital-based primary s, and outpatient surgery in 144.691 and compliance by e organizations with section				

Minnesota Department of Health

PRINTED: 06/24/2015

FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: __ B. WING 00149 05/21/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1412 WEST FOURTH STREET **RED WING HEALTH CENTER** RED WING, MN 55066 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) 21880 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 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

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concerns.

resolution to the February 2015 resident council

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUPVEY

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00149	B. WING		05/2	1/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
RED WIN	NG HEALTH CENTER		ST FOURTH G, MN 5506			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
21880	expressed having to the staff to help with R16 referred to, "ot watch out for me, b me they make me vomplain." Furthern regular day staff are want them mad at right the staff will push at take care of me and problems being considerated they will make R16 validated the factor of the problem from validated attending whom she considerated her. Review of R16's me annual minimum da 3/18/15, which asse and able to make do During an interview p.m., a concern was complain the staff want to complain. Was done about it." resident council me R52 expressed conlong periods of time chair is very uncom constant pain from to see better custor.	ge 72 on 5/18/15, at 9:20 a.m., R16 o wait long periods of time for n cares and position changes. her people that live here try to ut when the staff get mad at vait longer, I don't want to nore, R16 stated, "some of the e sticks in the mud, I don't me." R16 stated, "If I complain, nd pull on me more when they d that hurts. I already have infortable in this chair and I am e me wait longer for help." acility management was aware in resident council which R16 with [R13,R52 and R124] is people who watch out for edical record indicated an ata set (MDS) completed ssed R16 as cognitively intact ecisions about care. with R52 on 5/18/15, at 3:15 is expressed about, "If I vill get back at me so I don't We complained and nothing R52 made reference to the eting in February 2015 when cerns about having to wait e for assistance, that the wheel fortable, and she is in a knee injury. R52 would like mer service training for the eant them to, "Get back at me."	21880	DEFICIENCY		
	Review of R52's me	edical record indicated a pleted 4/30/15, which R52 ognitively intact and able to				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00149	B. WING		05/2	21/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
RED WI	RED WING HEALTH CENTER RED WII			STREET 6		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21880	make decisions about the lack of reconfirmed the resid about the lack of rewere afraid of retalistated, "Be sure to because they are set staff being mean to Review of R32's me quarterly MDS comwas assessed as comake decisions about the lack of rewere afraid of retalistated, "Be sure to because they are set staff being mean to Review of R32's me quarterly MDS comwas assessed as comake decisions about the lack of R124 talked about the LPN)-A and stated at me, One day she screaming at me for of nursing (DON). The problem but because long they won't do at to us." R124 continues ident council me the staff that nursing	on 5/19/15, at 10:32 a.m., oncerns addressed at the esident council meeting and ents continued to be upset solution and that the residents ation from the staff. R32 talk to [R13] and [R124] eriously concerned about the them." edical record indicated a pleted 2/18/15, which R32 cognitively intact and able to but care. on 5/19/15, at 10:37 a.m., icensed practical nurse, "[LPN-A] is always so mad a came into my room reporting her to the director hey know [LPN-A] is a se she has been here for so anything about the retaliation used to talk about the February eting when the residents told g assistants (NA)-A and NA-B	21880			
	assistants do not al their way or expect should need sometl explained the reside talk and watch out f interview [R13], [R1 also expressed con [NA-A] and [NA-B]. Review of R124's m	sidents. "These nursing low choices, you better do it to wait a long time if you hing." Furthermore, R124 ents on this end of the building for each other. R124 said to 6], and [R52] because they cerns about [LPN-A] and nedical record indicated a pleted 3/18/15, which R124				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00149	B. WING		05/2	21/2015
	PROVIDER OR SUPPLIER	1412 WES	DRESS, CITY, S ST FOURTH G, MN 5506			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21880	was assessed as comake decisions about During an interview discussed being verom LPN-A and ref back where a cultur required. R13 said early in the morning the culture and there back together again because he has constated, "The resident here." R13 referred residents who discunursing unit. R13 s R13 considered "buwas one day in Apriafter an incident that felt angry, that I was like being a kid and the NA-A has retaliated to him for a period of at me because I considered "buwas one day in Apriafter an incident that felt angry, that I was like being a kid and the NA-A has retaliated to him for a period of at me because I considered "buwas one day in Apriafter an incident that felt angry, that I was like being a kid and the NA-A has retaliated to him for a period of at me because I considered "buwas one day in Apriafter an incident that felt angry, that I was like being a kid and the NA-A has retaliated to him for a period of at me because I considered "buwas one day in Apria felt angry, that I was like being a kid and the NA-A has retaliated to him for a period of at me because I considered "buwas one day in Apria felt angry, that I was like being a kid and the NA-A has retaliated to him for a period of at me because I considered "buwas one day in Apria felt angry, that I was like being a kid and the NA-A has retaliated to him for a period of at me because I considered "buwas one day in Apria felt angry, that I was like being a kid and the NA-A has retaliated to him for a period of at me because I considered "buwas one day in Apria felt angry, that I was like being a kid and the NA-A has retaliated to him for a period of at me because I considered "buwas one day in Apria felt angry, that I was like being a kid and the NA-A has retaliated to him for a period of at me because I considered "buwas one day in Apria felt angry, that I was like being a kid and the NA-A has retaliated to him for a period of at me because I considered "buwas one day in Apria felt angry, that I was like being a kid and the NA-A has retaliat	ognitively intact and able to out care. on 5/19/15, at 2:30 p.m., R13 ry concerned about retaliation erred to a situation a while re of a wound site was '[LPN-A] came into the room plants, took off the appliances, did not put it not a left me, she did not put it not not get it may be a left me, she did not put it not left me, she did not put it no	21880			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00149	B. WING		05/2	1/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
RED WIN	IG HEALTH CENTER		ST FOURTH 3, MN 5506			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21880	Continued From page 75		21880			
	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.					
	validated the conce investigated and the	the DSS, DON and RN-A erns should have been e residents should have been ected from any form of				
	The director of nur could ensure that p current, staff are trasystem is in place t	THOD OF CORRECTION: sing or designee of the facility olicies and procedures are ained and that a monitoring o ensure resident rights to re communicated without fear				
	TIME PERIOD FOR	R CORRECTION: Twenty-one	1			

Minnesota Department of Health

PRINTED: 06/24/2015 FORM APPROVED

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00149	B. WING	B. WING		1/2015
	PROVIDER OR SUPPLIER	•	DRESS, CITY, S	STATE, ZIP CODE		
RED WIN	IG HEALTH CENTER	RED WING	3, MN 55066	5		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21880	Continued From pa	ige 76	21880			
	(21) days.					
21995	5 MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults		21995			
	(a) Each facility shongoing written proapplicable licensing of suspected maltrefacility has an intermandated reporter requirements of this internally. Howeve responsible for conreporting requirements of this MN Requirements of this management in the subject of	Il reporting of maltreatment. all establish and enforce an ocedure in compliance with grules to ensure that all cases eatment are reported. If a nal reporting procedure, a may meet the reporting section by reporting r, the facility remains applying with the immediate ents of this section. The procedure of the reporting r, the facility remains applying with the immediate ents of this section. The procedure of the reporting r, the facility remains applying with the immediate ents of this section. The procedure of the reporting r, the facility remains applying with the immediate ents of this section.				
	Findings include:					
	revealed a Brief Int (BIMS) had been of R58 scored 14/15, intact. The eHR carevealed R58 was a dangerous situation to safety in a danger staff to assist me to quarterly minimum revealed R58 was a second revealed R58 was a seco	electronic health record (eHR) erview for Mental Status ompleted on 4/21/15, revealed indicating R58 was cognitively re plan dated 8/12/13, able to "reliably recognize a n", but "cannot remove myself erous situation, I would need a safety." The most recent data set (MDS) dated 4/21/15, always incontinent of urine and sive assistance of one staff for eting.				

Minnesota Department of Health STATE FORM

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00149	B. WING	B. WING		1/2015
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		
RED WIN	IG HEALTH CENTER		T FOURTH			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21995	On 5/18/15, at 11:3 individual interview, nursing assistant (Nanswering the call I and not changing R stated reporting NA and also stated NA facility. On 5/20/15 interviewed again a when cared for by N feeling very good anot treated him wel that NA-F was bette On 5/20/15, at 9:50 (DON) was interviewalleged neglect. Thof the incident. On 5/20/15, at 9:58 recalling speaking when cared for by North the incident. On 5/20/15, at 9:50 (DON) was interviewalleged neglect. Thof the incident. On 5/20/15, at 10:20 one and a half mon NA-D and NA-C the [NA-F] who ignored R58 and was not can presented that Nawrote everything do and presented the incident. On 5/20/15, at 11:0 issue was discussed.	7 a.m., R58 stated during an there were times when NA)-F ignored R58 by not ight, not assisting the resident R58's incontinent product. R58 reported nurse (RN)-C, reported nurse (RN)-C, reported not not explained that NA-F had and NA-F had an "attitude" rethan others. a.m., the director of nurses wed regarding R58's report of e DON reported never hearing name, R58 regarding NA-F not R58. 3 a.m., RN-C reported not with R58 regarding NA-F not R58. 3 a.m., NA-D stated that about this ago, R58 reported to be rewas a nursing assistant the R58, did not do anything for aring for the resident properly. A-D and NA-C, immediately bown that R58 had told them information to RN-C and RN-B seemed happier now and any more "bad information."	21995			
		that", and denied having ninformation of the alleged				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00149	B. WING		05/:	21/2015
	PROVIDER OR SUPPLIER	1412 WES	DRESS, CITY, S ST FOURTH S G, MN 55066			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21995	neglect incident. On 5/20/15, at 11:2 verbally told RN-C had provided RN-B NA-C stated the infafter R58 made the verbalized wanting behavior and attitude cared for R58 and report not having a having to do things self-transferring into On 5/20/15, at 11:2 stated not being aware for R58. SW-A a psychologist as Fabout a new reside at night. SW-A state well with changes a psychologist would R58 was doing bett psychologist. On 5/20/15, at 11:3 had spoken to RN-receiving information regarding R58's allong NA-C had written the piece of paper and the written information stated NA-D and NRN-B or RN-C state information. On 5/20/15, at 2:00	0 a.m., NA-C stated, had what R58 had verbalized and with the written information. ormation was brought to RN-B e report. NA-C stated R58 to die. NA-C stated that R58's de changed whenever NA-F explained that R58 would good evening because of without help, such as a bed. 5 a.m., social worker(SW)-A ware of any possible neglect of a stated R58 had recently seen a stated R58 had recently seen at the next room being noisy and staff felt R58 did not do	21995			

Minnesc	ta Department of He	ealth			FORM	APPROVED
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE COMP	SURVEY
		00149	B. WING		05/2	21/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
RED WIN	IG HEALTH CENTER		ST FOURTH G, MN 5506			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	.D BE	(X5) COMPLETE DATE
21995	NA-F had been terr vulnerable adult (Wreview of NA-F's perincident the DON wrest, but another results of the facility could as potential abuse are immediately reporter residents are protect while an investigation Administrator, direct could assure policie implemented and a completed.	minated because of a A) incident with a resident. A ersonnel file revealed the VA vas referring to did not involve esident residing in the facility. THOD OF CORRECTION: essure that all allegations of thoroughly investigated and ed to the state agency and that eted from potential retaliation	21995			
22000	Reporting - Maltrea Subd. 14. Abuse facility, except home personal care atten establish and enfore prevention plan. The assessment of the penvironment, and ite factors which may even and a statement of to minimize the risk comply with any rule promulgated by the (b) Each facility, agency and personal	s population identifying encourage or permit abuse, specific measures to be taken of abuse. The plan shall es governing the plan	22000			

Minnesota Department of Health (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA **IDENTIFICATION NUMBER:** COMPLETED AND PLAN OF CORRECTION A. BUILDING: B. WING 05/21/2015 00149 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1412 WEST FOURTH STREET **RED WING HEALTH CENTER** RED WING, MN 55066 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 22000 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 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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION		X3) DATE SURVEY COMPLETED	
			A. BUILDING:				
		00149	B. WING		05/2	1/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
RED WI	IG HEALTH CENTER		ST FOURTH G, MN 5506				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI		(X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	COMPLETE DATE	
22000	Continued From pa	ge 81	22000				
	possible neglect of	care.					
	Findings include:						
	Abuse & Neglect Prevealed all inciden suspected mistreat immediately and up nursing supervisor investigating the sit physical assessme all staff involved in the findings. Based from R58, the facilit and procedure. A review of R58's erevealed a Brief Into (BIMS) had been corevealed R58 score cognitively intact. T 8/12/13, revealed Frecognize a danger remove myself to s	titled Vulnerable Adult & revention and dated 5/12, ts of mistreatment or ment were to be reported on receipt of the report the on duty was to begin uation by conducting a nt of the resident, speaking to the situation and document on the information received ty failed to follow the policy lectronic health record (eHR), erview for Mental Status ompleted on 4/21/15, which ed 14/15, indicating R58 was he eHR care plan dated 858 was able to "reliably ous situation", but "cannot afety in a dangerous situation, o assist me to safety." R58					
	was also identified urine and required recent quarterly mir 4/21/15, revealed R	as frequently incontinent of staff assistance. The most nimum data set (MDS) dated 858 was always incontinent of the extensive assistance of					
	individual interview, ignored R58 by not assisting the reside incontinent product registered nurse (R	7 a.m., R58 stated during an there were times when NA-F answering the call light, not ent and not changing R58's . R58 stated reporting NA-F to N)-C. R58 also stated NA-F the facility. On 5/20/15, at					

, , ,		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00440	B. WING		05/21/2015	
		00149			05/2	11/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
RED WIN	IG HEALTH CENTER		T FOURTH 5, MN 5506			
()(1) ID	STAMMIND VETA	TEMENT OF DEFICIENCIES	·	PROVIDER'S PLAN OF CORRECTION		(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
22000	Continued From pa	ge 82	22000			
22000	11:00 a.m., R58 wa NA-F and how R58 and R58 stated not explained that NA-F NA-F had an "attitutothers. On 5/20/15, at 10:2 one and a half mon NA-D and NA-C, th [NA-F] who ignored R58, and was not con 5/20/15, at 11:2 verbally told RN-C had provided RN-B NA-C stated the infrafter R58 made the verbalized wanting behavior and attitude cared for R58 and ereport not having a having to do things self-transferring into and NA-C, immedithat R58 had told the information to RN-C seemed happier no more "bad informa	is interviewed again about felt when cared for by NA-F feeling very good and had not treated him well and de" that NA-F was better than as a.m., NA-D stated that about the ago, R58 reported to ere was a nursing assistant R58, did not do anything for aring for the resident properly. a.m., NA-C stated to have what R58 had verbalized and with the written information. The ormation was brought to RN-B ereport. NA-C stated R58 to die. NA-C stated that R58's de changed whenever NA-F explained that R58 would good evening because of without help, such as a bed. NA-D stated that NA-D ately wrote everything down them and presented the cand RN-B. NA-D stated R58 wand was not mentioning any ion." 4 a.m. R58's alleged neglect and with RN-B, who stated "I that", and denied having in information of the alleged.	22000			
	care for R58. SW-A a psychologist, as F	vare of any possible neglect of a stated R58 had recently seen R58 had been complaining nt in the next room being noisy				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED	
		00149	B. WING		05/2	05/21/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE			
REDWIN	IG HEALTH CENTER	1412 WES	ST FOURTH	STREET			
1125 1111	TO TIEAETH GENTER	RED WING	G, MN 5506	6			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
22000	Continued From pa	ge 83	22000				
	well with changes a psychologist would R58 was doing bett psychologist.	be good for the resident and er since having seen the					
	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.						
	interviewed regardin NA-F had been term vulnerable adult (VA review of NA-F's pe incident the DON w	p.m., the DON was ng NA-F. The DON stated ninated because of a A) incident with a resident. A resonnel file revealed the VA as referring to did not involve sident residing in the facility.					
	SUGGESTED MET	HOD OF CORRECTION:					
	procedures for abus implemented, enfor	ssure established policies and se prevention plan are ced and that allegations of thoroughly investigated.					
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty One					

Minnesota Department of Health STATE FORM