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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: HSK0

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00149

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245223**
2.STATE VENDOR OR MEDICAID NO.
(L2) **955270700**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/04/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **130** (L18)
13.Total Certified Beds **130** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	130			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 10/12/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Sr. Health Program Rep 10/12/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

CMS Certification Number (CCN): 245223

October 12, 2018

Administrator
Red Wing Health Center
1412 West Fourth Street
Red Wing, MN 55066

Dear Administrator:

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 September 25, 2018 the above facility is certified for:

130 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 130 skilled nursing facility beds.

Your request for waiver of K521 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,

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

Electronically delivered

October 12, 2018

Administrator
Red Wing Health Center
1412 West Fourth Street
Red Wing, MN 55066

RE: Project Number S5223029

Dear Administrator:

Please note that this facility has been chosen as a Special Focus Facility (SFF). CMS' policy of progressive enforcement means that any SFF nursing home that reveals a pattern of persistent poor quality is subject to increasingly stringent enforcement action, including stronger civil monetary penalties, denial of payment for new admissions and/or termination of the Medicare provider agreement.

On September 12, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 16, 2018. 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 October 4, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on October 12, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 16, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 25, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 16, 2018, effective September 25, 2018 and therefore remedies outlined in our letter to you dated September 12, 2018, will not be imposed.

Your request for a continuing waiver involving the deficiency cited under F521 at the time of the August 16, 2018 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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: HSK0

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00149

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(L1) **245223**
2.STATE VENDOR OR MEDICAID NO.
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3. NAME AND ADDRESS OF FACILITY
(L3) **RED WING HEALTH CENTER**
(L4) **1412 WEST FOURTH STREET**
(L5) **RED WING, MN** (L6) **55066**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/16/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	130			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Jennifer Kolsrud , HFE NE II 09/26/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Sr. Health Program Rep 10/11/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN- 24 5223

Red Wing Health Center requests a waiver for the K521. The facility is documented to be fully sprinklered and has auto shutoff of the HVAC system. Additionally, evidence that corrective action would pose an unreasonable hardship on the facility. Cost to improve HVAC system would cost approximately $530,000. It is also estimated that such work would disrupt the normal use of patient areas for at least 6 months.

HVAC
Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications.
18.5.2.1, 19.5.2.1, 9.2

Electronically delivered

September 12, 2018

Red Wing Health Center
Attn: Administrator
1412 West Fourth Street
Red Wing, MN 55066

RE: Project Numbers S5223029,H5223106, H5223107, H5223108

Dear Administrator:

Please note that this facility has been chosen as a Special Focus Facility (SFF). CMS' policy of progressive enforcement means that any SFF nursing home that reveals a pattern of persistent poor quality is subject to increasingly stringent enforcement action, including stronger civil monetary penalties, denial of payment for new admissions and/or termination of the Medicare provider agreement.

On August 28, 2018, 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 electronically delivered CMS-2567, whereby corrections are required. In addition, at the time of the August 28, 2018 standard survey the Minnesota Department of Health completed an investigation of complaint numbers H5223106, H5223107, H5223108 that were found to be unsubstantiated.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: gary.nederhoff@state.mn.us
Phone: (507) 206-2731
Fax: (507) 206-2711

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 September 25, 2018, 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 September 25, 2018 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC 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,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

• 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 ePoC 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 ePoC 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 ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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 November 16, 2018 (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 February 16, 2019 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting an ePoC 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 electronic 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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING _____ B. WING _____	C 08/16/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on August 13, 14, 15 & 16, 2018, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS Red Wing Health Center is a Special Focus Facility (SFF) and received a recertification survey on August 13, 14, 15 & 16, 2018. Also a complaint investigations had been completed at the time of the SFF survey. At the time of the survey, an investigation of the following three complaints: H5223106 Not substantiated H5223107 Not substantiated H5223708 Not substantiated The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as	F 554		9/25/18

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

Electronically Signed | 09/18/2018

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING _____ B. WING _____	C 08/16/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 554	Continued From page 1 defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to adhere to the comprehensive self-administration of medications for 1 of 1 resident (R41) who stored medication in the room and self- administered the medications. Findings include: R41's quarterly Minimum Data Set (MDS) an assessment dated 6/25/18, identified R41 had intact cognition. On 8/13/18, at 2:32 p.m. R41 was lying in bed watching television. He had a bedside table immediately next to him on his left side which had an albuterol inhaler on the table. R41 stated he had self-administered the medications in his room. R41 stated the inhaler was "always there" and the he used it on his own for is chronic obstructive pulmonary disease (COPD). The inhaler had medical tape on the side with R41's name and the date 8/5/18, written in black ink. No pharmacy label was affixed to the inhaler. R41's signed Medication Review Report dated 7/20/18, was reviewed and no order for the albuterol inhaler could be identified. Further, the physician orders lacked any dictation or input from the physician on R41 self-administering medications. R41's care plan dated 7/17/18, did not identify R41 had COPD or any respiratory disease. R41 did have a care plan initiated 3/30/18, related to medications and directed staff to administer	F 554	Immediate corrective action: An updated Self- Administration of Medication Assessment for Resident # 41 was completed on 8/16/18. An order for albuterol inhaler and self-administration was obtained. The self-administration of the albuterol inhaler for COPD was added to the Care Plan on 9/18/18. Action as it applies to others: The Policy and Procedure for Self -Administration of Medication was reviewed and remains current. All residents who wish to self- administer medications will be reviewed to assure they have a current Self administration of Medication Assessment, MD order in place, and it is added to the Care Plan. All licensed nurses will be educated on the need for a current Self-Administration of Medication Assessment and MD order for any resident who wishes to self-administer. If it is deemed appropriate for the resident to self-administer, it will be added to their Care Plan. Date of completion: 9/25/2018 Recurrence will be prevented by: Audits of 5 random residents who self-administer medications will be conducted weekly x 30 days and then monthly x 3 to assure they have an accurate Self Administration of Medication Assessment, MD order, and it is Care Planned. The results of these audits will be shared with the facility QAPI	

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	245223	A. BUILDING _____ B. WING _____	C 08/16/2018

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F 554	Continued From page 2 medications as ordered. The care plan lacked any information regarding R41's self-administering his own medications. R41's Self Medication Assessment dated 3/30/18, indicated R41 had the cognitive and functional ability to self-administer medication but requested not to self-administer medications. On 8/16/18, at 9:10 a.m. licensed practical nurse (LPN)-C was asked about R41's albuterol inhaler he self-administered when he felt he needed it. LPN-C said that was correct in that R41 took his own albuterol inhalation medication. It was also true there was no doctors order for or an assessment done to see if R41 had been safe to use the Albuterol inhaler. On asking for any information regarding the albuterol inhaler order and use, none was provided. When interviewed on 8/16/18, at 10:56 a.m. the director of nursing (DON) stated that prior to a resident self-administering a medication, the nurse should check to ensure a physician's order for the medication was current and a self-medication assessment had been done. The DON acknowledged that residents have the right to self-administer medications and R41's assessment would be reevaluated to ensure R41 was able to self-administer medications safely. A facility policy revised 4/2016, Self-Administration of Medications, indicates the nursing is to get an order for self-medication of medications and documentation of the ability to self-administrate medication will appear on the residents plan of care.	F 554	committee for input on the need to increase, decrease or discontinue the audits. The correction will be monitored by: DON/Designee	
F 558	Reasonable Accommodations Needs/Preferences	F 558		9/25/18

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F 558 SS=D	Continued From page 3 CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to accommodate the resident needs by not having the call light within reach in 1 of 18 residents (R63). Findings include: R63's Face Sheet indicated R63 had a history of falling, muscle wasting with atrophy, major depressive disorder, and adult failure to thrive. R63's significant change Minimum Data Set (MDS) an assessment, dated 7/17/18, indicated moderate cognitive impairment, and needed extensive assist for most activities of daily living (ADLs). R63's care plan dated 10/5/15, indicated R63 will use her call light when needing to go to the bathroom. Progress note dated 9/15/17, at 3:50 p.m. identified R63 has been pushing her call light frequently during the shift so far. When staff have answered the call light, resident keeps requesting that we find her a dresser. Facility Visual Bedside Kardex dated 8/16/18, indicated that for fall and safety interventions,	F 558	Immediate corrective action: The call light for resident #63 was placed within reach as soon as the discrepancy was identified. Action as it applies to others: The Policy and Procedure for Answering Call Lights which includes placement of call lights was reviewed and remains current. Education for all nursing staff on proper placement of call lights within reach was held on 8/22, 8/23, 8/28, 8/29, 8/30, 9/4, 9/5, 9/6, 2018. Date of completion: 9/25/2018 Recurrence will be prevented by: Visual audits of call light placement will be conducted for 5 random residents weekly x 4 weeks and monthly x 3 months and results shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. The correction will be monitored by: DON/Designee	

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F 558	Continued From page 4	F 558		

R63 will use her call light when needing to go to the bathroom.

R63 had been observed on 8/13/18, at 1:38 p.m. in her room. The resident call lights are both observed to be lying on the floor. When asked how she gets help if needed, R63 said she used the call light. Then said half the time it is on the floor and unable to use it. R63 then pointed at the call light that was on the floor.

During observation and interview on 8/14/18, at 10:30 a.m. R63 call lights are both lying on the floor and R63 is unable to reach it. Nursing assistant (NA)-C had been asked to see the availability of R63's call lights. NA-C stated, oh both of the call lights are on the floor, the call light should be within her reach and moved the call light so R63 could easily reach it.

During interview on 8/16/18, at 10:47 a.m. licensed practical nurse (LPN)-B regarding call light availability for residents. LPN-B said she would expect a call light to be put in place for every resident, and to not be on the floor. LPN-B said that R63 does use her call light and it should always be in place for her. LPN-B said that she had noticed a problem with that lately as some aides are real good with putting call lights in place and some are not.

During interview on 8/16/18, at 11:55 a.m. registered nurse (RN)-A Stated, my expectation would be to have a residents call light in reach at all times.

During interview on 8/16/18, at 2:40 p.m. director of nursing (DON) stated, my expectation is that a call light should be in reach at all times.

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F 558	Continued From page 5 Facility policy, "Answering the Call Light," revised June 2015, indicated the purpose of this procedure is to respond to the residents request and needs. 6. When a resident is in bed or confined to a chair be sure the call light is within easy reach of the resident.	F 558		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) 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 REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure nail care was provided for 2 of 4 residents (R15 and R58) who were assessed to need staff assistance to meet activities of daily living (ADLs). Additionally failed to ensure shaving was provided to 1 of 4 residents (R15) also assessed to need staff assistance with meeting ADLs. Findings include: R58's Admission Record dated 8/16/18, identified a current admission date of 1/18/18, and a diagnosis of type diabetes mellitus, muscle weakness, and schizoaffective disorder. R58's significant change Minimum Data Set (MDS) an assessment dated 7/11/18, identified R58 to have intact cognition and requires one person extensive assist with personal hygiene.	F 677	Immediate corrective action: Resident# 15 and # 58 were provided nail care and resident# 15 was shaved as soon as the discrepancy was identified. Resident #15 received a shower on 8/23/18. Action as it applies to others: All residents dependent on staff for nail care, shaving and bathing preferences were identified to assure tasks are on care plan and TAR. The Policy for ADL Care which includes nail care, shaving and bathing was reviewed and remains current. Education on shaving and nail care needs was provided to all nursing staff on _8/22, 8/23, 8/28, 8/29, 8/30, 9/4, 9/5, 9/6, 2018. Date of completion: 9/25/2018 Recurrence will be prevented by: Visual audits of 5 residents will be conducted weekly x 4 weeks, then	9/25/18

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F 677	Continued From page 6 Care plan dated 1/18/18, identified R58 needs one person assist with nail care, with an approach to have nail care weekly usually with bathing. R58's Visual Bedside Kardex, dated 8/16/18, identified R58 to need nail care weekly, usually on my bath day. R15's face sheet indicates that R15 had been admitted to facility three years ago, with diagnoses that include: Quadriplegia, Tracheostomy status, major depressive disorder. R15's care plan dated 1/16/17, regarding grooming needs: I need 1 assist to complete ADLs, trim my nails after my bath as needed, observe for facial hair and help me shave as needed. On 8/14/18, at 10:46 a.m. during interview and observation, R15 stated that he liked to be clean shaven and his fingernails trimmed as they are always long. R15 noted to have dark whiskers on upper lip and chin. Also fingernails on both hands noted to have grown past the end of the finger tips. On 8/15/18, at 9:29 a.m. During observation of a.m. cares, nursing assistant (NA)-A observed to assist R15 with sponge bath, incontinence cares and dressing. At no time was R15 offered shaving of facial hair or nail care. On 8/16/18, at 2:40 p.m. R15 was asked how is shower went. R15 stated did not get a shower, they say I can't have one due to my wound. Asked if he received a bed bath, R15 stated, "I got the usual" with the bed bath. R15 said that he	F 677	monthly times 3 months to assure shaving, nail care and bathing preference is provided as care planned. The results of these audits will be shared with the facility QAPI Committee for input on the need to increase, decrease or discontinue the audits. The correction will be monitored by: DON/Designee	

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F 677	Continued From page 7	F 677		

had not been shaved, nor nails trimmed.

During interview on 8/16/18 at 2:42 p.m., NA-B stated that shaving and fingernail care is to be completed on bath days and as needed. NA-B then verified that R15 had long fingernails, and the presence of facial hair on upper lip and chin.

On 8/16/18, at 2:44 p.m., registered nurse (RN)-B stated, that shaving and nail care is to be done at least on bath day and when resident requests. RN-B had been asked to see R15's fingernails. RN-B said the fingernails are "a little" long. At the same time R15 said to RN-B that liked to been clean-shaven and fingernails shorter. RN-B stated, "Well, we can do that."

On 8/16/18 4:19 p.m., director of nursing (DON) stated residents should be shaved at least once per week and nails be trimmed as needed with residents request.

Policy dated 11/2016, "ADL Assistance Provided per Care Plan" indicates to assure ADL assistance is provided to all residents based upon assessment and care plan.
R58 had been observed and interviewed on 8/14/18, at 9:41 a.m. R58 seated in wheelchair located in room. R58 had a long gray beard and his fingernails appear very long on both hands. R58 stated, "My thumbs need to be clipped really bad."

During observation on 8/16/18, at 10:35 a.m. R58 is on his bed on his right side, and all of his fingernails remained untrimmed.

During interview on 8/16/18, at 10:31 a.m. nursing assistant (NA)-D verified R58's fingernails

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F 677	Continued From page 8 are long and stated, "Yeah, they could use a clipping." I can't do it thought because he is diabetic, the nurses will have to do it. His shower day was yesterday so it should have been done then. During interview on 8/16/18, at 10:38 p.m. licensed practical nurse (LPN)-B verified R58's fingernails are long, and stated he is diabetic and nails should be trimmed by a nurse on shower day weekly and as needed. During interview on 8/16/18, at 2:46 p.m. director of nursing (DON) stated, my expectation for a diabetic resident is to get appropriate nail care, offer to clip nails on bath days, and if resident refuses it should be documented. Facility policy, Care of Fingernails and Toenails, revised 1/14, identified the purpose is to clean the nail bed, to keep nail beds trimmed, and to prevent infections. 3. Licensed staff should trim the nails of diabetic residents or residents with circulatory impairments.	F 677		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required	F 726		9/25/18

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F 726	Continued From page 9 at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure nursing assistant staff performing oral suctioning for 1 of 1 resident (R15) completed competency in oral suctioning and were practicing with professional boundaries. This had the potential to affect residents who may require oral suctioning currently living in the facility. Findings include: R15 face sheet indicates that R15 admitted to facility on 2/11/15, with diagnoses that include: Quadriplegia, Tracheostomy status, major depressive disorder. During on Observation on 8/15/18, at 8:52 a.m. nursing assistant (NA)-A went to R15 to answer	F 726	F726 Competent Nursing Staff: Oral Suctioning Immediate corrective action: CNA-A was given 1:1 re-education on 8/30/2018 on the Scope of Practice and tasks allowed within CNA certification. Included in the education was not to perform oral suctioning. Action as it applies to others: The Policy and Procedure of Scope of Practice remains current. All nursing staff were educated on the Scope of Practice on 8/22, 8/23, 8/28, 8/29, 8/30, 9/4, 9/5, 9/6. Date of completion: 9/25/2018 Recurrence will be prevented by: 5 random nursing assistants/TMA□s will be visually audited 5x week x 30 days	

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F 726	Continued From page 10 call light, R15 stated "I need suctioning." NA-A stated, "Ok." NA-A then proceeded to apply gloves and turned on suctioning machine sitting on nightstand next to R15's bed. NA-A then placed an oral Yankauer suction catheter (a rigid hollow tube made of metal or disposable plastic with a curve at the distal end to facilitate the removal of thick oral secretions during oral suctioning) was placed into R15's mouth, for 30 second then removed. Yankauer was placed back on nightstand in wrapper. R15 showed no signs of coughing, gagging, or shortness of breath. On 8/15/18, at 9:59 a.m. registered nurse (RN)-A was observed to complete wound care for R15. R15 stated to NA-A they "need suctioning" at this time. NA-A started to assist R15 with oral suctioning by reaching for Yankauer tubing to it pick up, when RN-A stated "I need to do that." RN-A then removed gloves, washed hands and walked around bed and switched places with NA-A. RN-A proceed to assist R15 with oral suctioning with oral suctioning while NA-A stood on other side of bed. On 8/16/18, at 8:00 a.m. NA-A asked surveyor if had found out answer, again stated that it would depend on facility policy and if NA-A had been properly trained regarding oral suctioning. NA-A then stated that she had put there was nothing in written form that, NA-A was a where. Proceed to say that training was by a nurse, with the permission of a previous director of nursing (DON). During interview on 8/16/18, at 4:35 p.m., with the DON, who stated, "No, nursing assistant nor trained medication aides are allowed to do oral	F 726	then monthly x 3 to assure tasks performed are within their scope of training. The correction will be monitored by: DON/Designee	

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F 726	Continued From page 11 suctioning, unless trained." On asking for information in regards to NA-A having had training/competency, none was provided. Welcov healthcare: Education documentation", which included the associate has been educated or coached on the following topics: Nursing assistants are not allowed to perform treatments or give medications to residents. This is out of you scope of practice. Any treatments or medications to be given to residents must be given by a licensed practical nurse (LPN) or TMA (as long as it is within your scope of practice). If you are asked by a nurse to complete a treatment or give a medication, you are to tell them that it is out of your scope of practice. This includes, but not limited to wound treatments, medicated lotions, ointments, powders, and disconnecting and reconnecting tube feedings. This is not all-inclusive, if you have question speak with you unit manager, or DON.	F 726		

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	245223	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/28/2018**

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K 000	INITIAL COMMENTS 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. OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us and Angela.K 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 compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a). Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC)	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/18/2018

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/28/2018**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN appenman@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 3 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. In 1999 a small addition was added to the west wing. Because the original building and the 2 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 protected by a full fire sprinkler system. 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 130 beds and had a	K 000		

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K 000	Continued From page 2 census of 87 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 200 SS=F	Means of Egress Requirements - Other CFR(s): NFPA 101 Means of Egress Requirements - Other List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 18.2, 19.2 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (19.2) This deficient practice could affect the safety of all (67) the residents, staff and visitors within the Facility. Findings Include: On facility tour between 11:00 AM and 03:00 PM on 8/28/2018, observation and documentation reviewed revealed the following: The Facility does not have a current fire door inspection report. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 200	K 200 The facility has a current fire door inspection report. Documentation of inspection will be recorded and maintained by the Director of Maintenance annually. The facility will insure compliance annually, monitored by Administrator/Maintenance Director. Documentation will be reviewed by QAPI Committee for 90 days.	9/25/18
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101	K 291		9/25/18

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K 291	Continued From page 3 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (19.2.9.1) This deficient practice could affect the safety of all (67) the residents, staff and visitors within the Facility. Findings Include: On facility tour between 11:00 AM and 03:00 PM on 8/28/2018, observation and documentation reviewed revealed the following: The Facility does not have copy of emergency lighting testing monthly and annual test This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 291	K 291 Emergency Lighting is tested monthly by facility Maintenance Department. Documentation of testing will be recorded and maintained by the Director of Maintenance. Documentation will be reviewed by QAPI Committee for 90 days.	
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or	K 324		9/25/18

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K 324	Continued From page 4 * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2) This deficient practice could affect the safety of all (67) the residents, staff and visitors within the Facility. Findings Include: On facility tour between 11:00 AM and 03:00 PM on 8/28/2018, observation and documentation reviewed revealed the following: The Facility does not have a annual kitchen hood inspection reports. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 324	K 324 Facility kitchen hood has been inspected. Documentation of the inspection shall be maintained annually by the Director of Maintenance. The kitchen hood inspection will be scheduled annually by the Maintenance Director. Annual compliance monitored by the Administrator.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National	K 345		9/25/18

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K 345	Continued From page 5 Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72) This deficient practice could affect the safety of all (67) the residents, staff and visitors within the Facility. Findings Include: On facility tour between 11:00 AM and 03:00 PM on 8/28/2018, observation and documentation reviewed revealed the following: The Facility does not have a current copy of the annual fire alarm system testing by Tech One. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 345	K 345 The facility has a copy of the annual fire alarm testing by Tech One. Documentation of the annual testing shall be maintained annually by the Director of Maintenance. Annual compliance monitored by the Administrator.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____	K 353		9/25/18

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K 353	Continued From page 6 c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (9.7.5, 9.7.7, 9.7.8, and NFPA 25) This deficient practice could affect the safety of all (67) the residents, staff and visitors within the Facility. Findings Include: On facility tour between 11:00 AM and 03:00 PM on 8/28/2018, observation and documentation reviewed revealed the following: The Facility did not conduct quarterly fire sprinkler testing. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 353	K 353 The facility has performed quarterly fire sprinkler testing. Documentation of the quarterly fire sprinkler testing shall be maintained by the Director of Maintenance. Documentation will be reviewed by QAPI Committee for 90 days.	
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by:	K 521		9/25/18

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K 521	Continued From page 7 The facility failed to comply with Life Safety Code (19.5.2.1, 9.2) This deficient practice could affect the safety of all (67) the residents, staff and visitors within the Facility. Findings Include: On facility tour between 11:00 AM and 03:00 PM on 8/28/2018, observation and documentation reviewed revealed the following: The ventilation system on the 1st, 2nd, and 3rd floors in the 1965 addition utilizes the egress corridor as the return air for the resident rooms. This deficient practice could affect the safety of all the residents, staff and visitors within this addition from 1965. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 521	K 521 Please see attached waiver.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced	K 712		9/25/18

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K 712	Continued From page 8 by: The facility failed to comply with Life Safety Code (19.7.1.4 through 19.7.1.7) This deficient practice could affect the safety of all (67) the residents, staff and visitors within the Facility. Findings Include: On facility tour between 11:00 AM and 03:00 PM on 8/28/2018, observation and documentation reviewed revealed the following: The Facility did not conduct fire drills for the following month's: Jan, Feb, March, June, Sept. Oct, Nov, Dec. Facility had lost documentation. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 712	K 712 Fire drills are conducted quarterly on each shift under expected and unexpected times under varying conditions. Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Documentation of the monthly drills shall be maintained by the Director of Maintenance. Documentation will be reviewed by QAPI Committee for 90 days.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the	K 914		9/25/18

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K 914	Continued From page 9 electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (6.3.4 (NFPA 99)) This deficient practice could affect the safety of all (67) the residents, staff and visitors within the Facility. Findings Include: On facility tour between 11:00 AM and 03:00 PM on 8/28/2018, observation and documentation reviewed revealed the following: The Facility does not have a current outlet testing report. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 914	K 914 Electrical receptacles shall be tested annually, not to exceed 12 months. Documentation of the testing containing date, room or area tested and results shall be maintained by the Director of Maintenance. Annual compliance monitored by the Administrator.	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if	K 923		9/25/18

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K 923	Continued From page 10 sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (code section applies) This deficient practice could affect the safety of all (67) the residents, staff and visitors within the Facility. Findings Include: On facility tour between 11:00 AM and 03:00 PM on 8/28/2018, observation and documentation reviewed revealed the following: The Facility does not have a current Medical gas training program. This deficient practice was confirmed by the	K 923	K 923 The facility has a Medical gas training program. The education is provided by Northwest respiratory and Relias. Documentation will be reviewed by QAPI Committee for 90 days.	

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K 923	Continued From page 11 Facility Maintenance Director at the time of discovery.	K 923		

PART III – RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

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

PROVISION NUMBER(S)	JUSTIFICATION
K521.	Red Wing Healthcare Community requests a waiver for the K521. The facility is documented to be fully sprinklered and has auto shutoff of the HVAC system. Additionally, evidence that corrective action would pose an unreasonable hardship on the facility. Cost to improve HVAC system would cost approximately $530,000. It is also estimated that such work would disrupt the normal use of patient areas for at least 6 months.

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title	Office	Date
Thomas Linhoff 12424	Fire Safety Supervisor	MN State Fire Marshal Division	09-24-2018