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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: PHGD
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 10/21/2013 (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

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

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

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

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

10. THE FACILITY IS CERTIFIED AS:

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

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

PCR by review of the facility's plan of correction to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Refer to CMS 2567B. Effective 9/29/13, the facility is certified for 145 skilled nursing facility beds. Continuing waiver of K67 approved.

17. SURVEYOR SIGNATURE Date :
Susanne Reuss, HFE NEII 10/17/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 12/26/2013 (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 **11/22/2013** (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5223 December 26, 2013

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 September 29, 2013, the above facility is certified for:

145 Skilled Nursing Facility/Nursing Facility Beds

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

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,

Colleen Leach

Colleen B. Leach, Program Specialist
Program Assurance Unit, Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900, St. Paul, MN 55164-0900
Telephone #: (651)201-4117 Fax #: (651)215-9697

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

December 12, 2013

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

RE: Project Number S5223022

Dear Mr. Linn:

On September 12, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 22, 2013. 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 21, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on October 26, 2013 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 22, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 29, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 22, 2013, effective September 29, 2013 and therefore remedies outlined in our letter to you dated September 12, 2013, will not be imposed.

Your request for a continuing waiver involving the deficiency(ies) cited under 0067 at the time of the August 22, 2013 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

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

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245223	A. Building B. Wing	10/21/2013

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0156** Reg. # **483.10(b)(5) - (10), 483.10(t** LSC	**09/29/2013**	ID Prefix **F0166** Reg. # **483.10(f)(2)** LSC	**09/29/2013**	ID Prefix **F0242** Reg. # **483.15(b)** LSC	**09/29/2013**
ID Prefix **F0253** Reg. # **483.15(h)(2)** LSC	**09/29/2013**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	**09/29/2013**	ID Prefix **F0309** Reg. # **483.25** LSC	**09/29/2013**
ID Prefix **F0315** Reg. # **483.25(d)** LSC	**09/29/2013**	ID Prefix **F0353** Reg. # **483.30(a)** LSC	**09/29/2013**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	**09/29/2013**
ID Prefix **F0412** Reg. # **483.55(b)** LSC	**09/29/2013**	ID Prefix **F0441** Reg. # **483.65** LSC	**09/29/2013**	ID Prefix **F0469** Reg. # **483.70(h)(4)** LSC	**09/29/2013**
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	SR/AK	10/17/2013	16022	10/17/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
8/22/2013	

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245223	01 - MAIN BUILDING 01	10/26/2013

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0050	09/29/2013	ID Prefix Reg. # NFPA 101 LSC K0052	09/20/2013	ID Prefix Reg. # NFPA 101 LSC K0054	09/29/2013
ID Prefix Reg. # NFPA 101 LSC K0062	09/29/2013	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
8/22/2013	

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: PHGD
Facility ID: 00149

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **08/22/2013** (L34)

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

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

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

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

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

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

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
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)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Vidya Tomar, HFE NE II 10/17/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Enforcement Specialist 11/22/2013 (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 **11/22/2013** (L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN# 245223

At the time of the standard survey completed August 22, 2013, the facility was not in substantial compliance and the most serious deficiencies were found 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. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results. Post Certification Revisit to follow.

An investigation of complaint H5223070 had not been substantiated during this survey.

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7043

September 12, 2013

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

RE: Project Number S5223022

Dear Mr. Linn:

On August 22, 2013, 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. In addition, at the time of the August 22, 2013 standard survey the Minnesota Department of Health completed an investigation of complaint number H5223070 that was found to be unsubstantiated.

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55108-2970

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by October 1, 2013, 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 October 1, 2013 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by November 22, 2013 (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 22, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

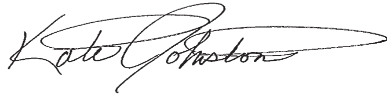
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

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

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

Feel free to contact me if you have questions.

Sincerely,



Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File

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

PRINTED: 09/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING ______ B. WING ______	C 08/22/2013

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

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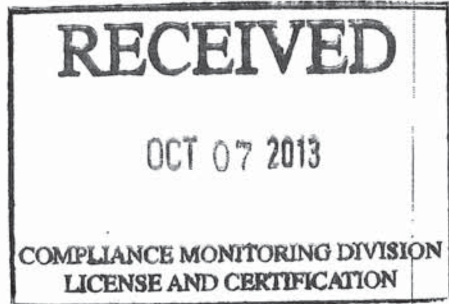
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A standard recertification survey was conducted and a complaint investigation(s) had also been completed at the time of the standard survey. An investigation of complaint H5223070 had not been substantiated during this survey.	F 000	10/17/13 SER  	
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the	F 156	1. Corrective Action: a. Education was provided to the staff who issue denials on timeliness of issuance and maintaining a copy for file. 2. Corrective Action as it applies to other residents: a. The Policy and Procedure for issuing Medicare Denials was reviewed and remains current. b. A facility wide audit will be completed to assure all resident's needing a Medicare Denial have been issued and a copy maintained. c. A 2 person system will be developed so there is always a double check that Denials are issued timely and a copy maintained.	9/29/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 9/23/2013

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

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F 156	Continued From page 1 items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State	F 156	3. Date of Completion: 9/29/13 4. Reoccurrence will be prevented by: a. All Residents who are due a Medicare Denial will have a 2 person check to assure the Denial was issued timely and a copy maintained. This will be an ongoing practice going forward to assure compliance. This double check system will be a part of monthly QA oversight on an ongoing basis. 5. The Correction will be monitored by: Medicare Coordinator	

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F 156	Continued From page 2	F 156		

ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

This REQUIREMENT is not met as evidenced by:
Based on document review, and interview, the facility failed to provide residents with the appropriate denial notice when they were discontinued from or failed to qualify for Medicare coverage for 3 of 3 residents (R91, R103, and R113) in the sample reviewed.

Findings include:

During review of the facility issued form titled, "Notice of Medicare Provider Non-Coverage" there was not a prior 48 hour communication verbally or in writing informing the resident of the discontinuation of services.

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F 156	Continued From page 3 There was no indication on the form issued to R91, as to a verbal contact with the representative that services would end on 6/14/13, and the signature from the patient representative was 6/17/2017 {sic}. There was an undated written note on the back of R91's form indicating verbal contact had been made to the representative. R103 had the service end date as 3/9/13 and was signed by the representative on 3/9/13 without prior notice of an end date. R113's Notice of Non-Coverage form read services will end 6/30/13, and the representative signed the form 7/6/13. There was no written notes on the documents to indicate verbal contact had been made prior to the end of coverage date. During an interview on 6/22/13, at 11:00 a.m. the business office director (BOD) explained the denial notices are sent via registered mail to the representatives after the services have ended. BOD verified a verbal contact should be made and documented two days prior to the end of services.	F 156		
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by:	F 166	1. Corrective Action: a. Resident # 95 was seen by the dentist on 8/22/13 and the resident and family are not interested in obtaining dentures for the resident.	9/29/13

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F 166	Continued From page 4 Based on interviews, and document review, the facility failed to respond to grievances with prompt investigation, resolution and follow up for 1 of 1 (R95) resident reviewed for a missing upper denture. Findings include: The facility did not promptly investigate and follow-up on R95's missing upper denture. During a family interview by telephone on 8/19/13, at 7:47 p.m. family member (F)-B reported R95 was missing her upper dentures that she came with. F-B stated, "[R95]'s upper dentures are missing for a long time which could cause swallowing problem for her." F-B stated, she would like something done about R95's missing dentures and no one seems to know how it happened, she had not heard anything further as to whether or not they were found, or what else was being done. Interview conducted with registered nurse (RN)-B on 8/20/13, at 9:18 a.m., verified R95's missing upper denture and staff made her aware of it sometime in February or March 2013 and that R95 currently has no dentures in place. RN-B further stated, F-B was made aware of missing dentures in March 2013. Interview conducted with the director of social services (DSS) on 8/20/13, at 9:55 a.m. stated, "I did not know until today because R95 was not on my case load." The DSS verified that the missing property should have been logged, reported and investigated, but proper follow up had not been done and completed.	F 166	2. Corrective Action as it applies to other residents: a. The Policy and Procedure for resident concerns was reviewed and revised 9/18/13. b. All current concern forms will be audited to assure a resolution has been completed. c. Inservices on the policy and procedure for following through on resident concerns and documenting resolutions will be held the week of 9/23/13 for all staff. 3. Date of Completion: 9/29/2013 4. Reoccurrence will be prevented by: a. All resident concerns will be discussed at morning IDT meeting and audited to assure resolution has been completed and documented. These audits will be reported to QA on an ongoing basis moving forward to assure resolutions have occurred. 5. The Correction will be monitored by: Social Services Director/DON	

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F 166	Continued From page 5	F 166		

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Interview conducted with social worker (SS)-B on 8/20/13, at 10:10 a.m. SS-B validated that previous social worker did not complete thorough investigation and she was not informed regarding this concern/incident since she started working with [R95] in July 2013. On 8/21/13, at 12:45 p.m. SS-B verified, there were no resident issue or concern forms filled out for R95 that she could find. SS-B further stated, R95 will be fitted for dentures with Apple Dental Tree tomorrow (8/22/13).

On 8/20/13, SS-B provided surveyor with two progress notes written by social services designee (SSD), first progress note dated 2/28/13, at 3:50 p.m. stated, "Niece and POA for person served come to visit today. She was upset about the condition of the person served room. Upper dentures are lost, white tennis shoes are missing and only one pair of socks were in her drawer. Writer searched other residents rooms only to find one white tennis shoe. Staff were not aware of these items and that they were missing. Housekeeping was called to clean room. Writer will continue to search for items. Calls were placed to staff who are consistency staff on the unit." Second progress note dated 3/4/13, at 3:54 p.m. stated, "[F-B] called writer today to follow up on missing items. [F-B] had brought another pair of shoes, the white ones were not found. Glasses have been found, but dentures were not." It further stated, "Writer told [F-B] a care plan will be put together and an inservice will be done with staff on the unit." However, there was no proof of documentation of missing upper denture in the care plan last review completed on 5/27/13. No further follow-up was conducted.

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During an interview on 8/20/13, at 10:30 a.m., the director of nursing (DON) stated, "There will be a care conference today with [F-B] and this issue will be resolved according to [F-B] request." At 1:27 p.m. DON further revealed, RN-C and RN-D told him, they remember hearing in daily report that [F-B] did not want to replace R95 upper dentures, but "I cannot find any documents anywhere at this time."

Interview conducted with the administrator on 8/20/13, at 1:38 p.m. stated, was told by [SSD], "R95 upper dentures were lost and SSD checked everywhere and could not find it and SSD spoke with F-B who stated they don't want to replace it because at that time, R95 was a private pay when I checked." Administrator further mentioned, he could not find any documents at this moment but will continue looking for documentation hence SSD no longer worked with this facility.

Interview conducted with F-B on 8/20/13, at 1:55 p.m. stated, "care conference was good today, now MA is going to pay for the dentures and guess [R95] will be happy when [R95] heard the news that [R95] can have new dentures." F-B further stated, "[R95] is gaining weight and [R95] getting new dentures, this will be good for her."

Care plan last review completed on 5/27/13, stated, "I cannot longer complete my own oral hygiene tasks. I do not have my own teeth. I have and use upper dentures. I can no longer complete my own oral hygiene. I would like staff to anticipate and complete oral hygiene tasks for me." Care plan further stated, "Staff monitor and encourage [R95] to report improper fit or damage to denture or partial materials for follow up. Staff

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F 166	Continued From page 7 report dental concerns or needs to chosen provider for follow up. Staff of 1 place [R95]'s dentures in mouth before meals, provide oral cares, and remove/cleanse dentures at HS (bedtime)." The policy and procedure titled, "issues or concerns that are non-care related," stated, "It is the facility goal that your concerns be addressed and resolve as soon as possible. If after discussing your concern with the appropriate staff member, you have not had a satisfactory resolution to the problem, you are encourage to communicate your concerns in written form using a document called the resident issue or concern forms-457 (attachment). This form is available from each nursing supervisor, the social service office and the receptionists. This report, when completed by either the person served/patient or family member, is used as a tool by our staff to investigate the issue at hand and to initiate the problem solving process."	F 166		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview, the facility failed to honor a bathing	F 242	1. Corrective Action: a. Resident # 40 was offered bathing as soon as it was discovered he had a concern. 2. Corrective Action as it applies to other residents: a. The Policy and Procedure for bathing choice was reviewed and revised on 9/18/2013. b. All residents will have their care plans reviewed to assure the bathing choices are current. c. Inservices on bathing will be held the week of 9/23/2013 with all nursing staff. 3. Date of Completion: 9/29/2013	9/29/13

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F 242	Continued From page 8 choice, that was voiced from 1 of 1 resident (R40), which the facility agreed to and had care planned the bathing preference. Findings include: During observation and interview on 8/20/13, at 9:28 a.m. R40 stated, "I have not had a bath in three weeks and I prefer two baths a week, on Monday and Friday." R40's cognition assessment titled Brief interview for mental status, (BIMS) scored a 14 out of 15 indicating independent-decisions consistent/reasonable. R40's diagnosis included multiple sclerosis with total dependence for staff assistance. Document review of R40's plan of care dated 5/22/13, read, "I prefer whirlpool bath mornings." and interventions read, "Staff honors [R40] choice of bath type and times and coordinates accordingly. The nursing assistant (NA) assignment sheet directed staff, "Bath: Mon/Fri AM." When interviewed on 8/21/13, at 2:00 p.m. RN-B reviewed the NA care tracker and verified one bath was signed out for August and that was on Monday 8/5/13. There was no other bath signed out in August out of six opportunities. In July baths were signed out for five of five Mondays but no Fridays (four of four) were signed out as given. Out of a total in July and August of fifteen opportunities for a bath on Monday and Friday, R40 received six baths, all on Monday and none on Fridays.	F 242	4. Reoccurrence will be prevented by: a. Visual audits to assure compliance with bathing will occur 3x weekly on varying units at different times x90 days. The results of these audits will be shared with QA for input on the need to increase, decrease or discontinue the audits. 5. The Correction will be monitored by: DON/Designee	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES	F 253		

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F 253

The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.

This REQUIREMENT is not met as evidenced by:
Based on observation and interview, the facility failed to maintain a sanitary clean environment to prevent odors throughout different areas of the facility. This involved 1 resident (R83) whose family member voiced concern and also had the potential to affect other residents and visitors who resided/visited the areas of the hallways (2 east and 2 west) that had odors.

Findings include:

During observation on 8/20/13, 8/21/13 and 8/22/13, there was a strong urine odor permeating in the hallway of resident area identified as 2 east and 1 west.

During observation on 8/21/13, there was a strong urine odor coming from the bathroom shared by room 1-075 and 1-077. Interview at 9:30 a.m. with housekeeper (H)-A validated the odor was strong in the bathroom and has been a problem for some time but would try a new product in the bathroom today.

Family member (F)-X of R83 arrived on 8/21/13, at 10:15 a.m. and stated, "It smells in here, it always smells in here and other areas of the facility, it smells like pee!" " I come in and clean (R83's) room and check everything, look at this cushion on the chair, I clean it every time I come here!"

F 253 — Provider's Plan of Correction (Completion date: 9/20/13)

An audit of all facility bathrooms was completed on 8/23/2013. Where warranted bathroom grout was scrubbed with an acid cleaner 8/24/2013. On 8/25/2013 these bathrooms were cleaned with an enzymatic cleaner specified for urine clean up. On 9/3/2013 housekeeping began using an enzymatic cleaner specified for urine clean up daily in rooms identified as needing it. Facility policy and procedure was updated 9/20/2013. A daily audit of 8 random bathrooms will be completed for 4 weeks, then it will be done weekly for 2 months, and then it will be referred to the QA committee for further review.
The Correction will be monitored by:
House Keeping Director/Designee

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Environment rounds on 8-22-13 at 2:15 p.m. with the housekeeping director revealed awareness there was a urine odor especially in some bathrooms in the facility and indicated the odor is in the grout since the building was old and had old grout. The resident bathroom between 2-006 was shared with 2-008, potentially affecting 4 residents, room 2-004 was a private bathroom, room 2-001 was shared with 2-003 potentially affecting 4 residents. and room 1-0077 was shared with 1-075 potentially affecting 2 residents which did have strong urine odors and were verified by H-A as needing extra attention.

There was no facility policy to address cleaning of the grout in the bathrooms.

During observation on the evening of 8/19/13 and morning of 8/21/13, there was a strong odor of urine in the hallway of the 3W unit, near rooms 3079, 3081, 3082, and 3084. The odor permeated that area of the hall and the rooms listed to the extent that the origin of the odor could not be located.
When interviewed regarding this odor on 8/21/13, at 9:40 a.m. registered nurse (RN)-A, the nurse manager of the unit, stated that she would look into the situation.
On 8/21/13, at 1:15 p.m. RN-A stated that she researched the odor in this hallway and believed that she found and eliminated the odor source. She removed and replaced a mattress from one of the listed rooms. She stated that she could no longer smell the odor, but would continue to audit the area.
On 8/22/13, at 8:50 a.m. RN-A stated that she had initiated reassessment of the urinary plans of care for the residents in the rooms near the area of this odor.

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When observed on 8/22/13, at 8:40 a.m. no odor could be detected in this hall of the 3W unit.

F 282 SS=D 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:
Based on observation, document review and interview, the facility did not ensure care plans were followed for 3 of 3 residents (R50, R83, R40) who required assist for urinary incontinence care needs, positioning needs and/or bathing needs.

Findings include:

R50 did not receive toileting or repositioning interventions as directed in the current care plan.

Review of the current care plan, dated 8/6/13, identified R50 as being at risk for skin breakdown due to impaired mobility, incontinence and diagnoses of diabetes. It also indicated R50 has functional incontinence and require to be checked and changed every two hours. The care plan directed two staff to assist resident with turning and repositioning every two hours.

On 8/22/13 at 8:20 a.m., R50 was sitting in the dining room being assisted with breakfast by staff person. At 9:07 a.m., R50 was wheeled into her

F 253

F 282

1. Corrective Action:
   a. Staff responsible for repositioning Resident # 50 and # 83 were counseled on 9/18/13. Incontinent care was provided to Resident # 50 as soon as the discrepancy was discovered. Staff responsible for releasing Resident # 83 pelvic straps were counseled on 9/18/13. Resident # 40 was offered bathing opportunity as soon as it was discovered he had a concern.
2. Corrective Action as it applies to other residents:
   a. The Policy and Procedure for following care plan was reviewed and remains current.
   b. All Resident care plans will be reviewed to assure their plan of care for repositioning, incontinent care, bathing desires, and positioning device removal are current.
   c. Inservices on following care plans will be held the week of 9/23/13 for all nursing staff.
3. Date of Completion: 9/29/2013
4. Reoccurrence will be prevented by:
   a. Visual audits will occur 3 x weekly x90 days on different units at varying times to assure compliance is maintained for release of positioning devices/restraints, incontinence care, bathing and repositioning. The results of these visual audits will be shared with QA for input on the need to increase, decrease or discontinue the audits.
5. The Correction will be monitored by: DON/Designee

9/29/13

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

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room by a nursing assistant and was positioned to sit along side the bed when the nursing assistant left. At 10:00 a.m., a nursing assistant wheeled R50 out of the room and down to the 1st floor to see the visiting dentist. At 10:10 a.m. the resident was sitting in a room, with the dental staff. At 11:00 a.m., a nursing assistant returned R50 to her room where a family member was waiting for the resident. The family member then pushed R50 out of the room and down the hall. At 11:30 a.m. two nursing assistants transferred R50 into the bed using a full body lift. R50 was checked for incontinence and found to be incontinent of bowel and bladder. Nursing assistant (NA)-E indicated the resident's skin was red and with small open areas. The licensed nurse (LPN)-B was retrieved and concurred the skin on the buttocks area was bright red and had scant open areas's. The surrounding skin on buttocks and upper thighs was bright red with deep creases and wrinkle lines. LPN-B instructed staff to apply the skin protection cream available for the resident.

On 8/22/13 at 10:10 a.m., nursing assistant (NA)-G confirmed taking R50 to the visiting dentist on 1st floor, but did not provide any other cares for R50 that morning. At 11:20 a.m., NA-E indicated R50 was on her assignment, but thought other nursing assistants's would have checked R50 for incontinence when she was on a break. NA-E verified the resident had not been checked or changed since R50 was gotten out of bed around 7:30 a.m.
On 8/22/13 at 1:40 p.m. the unit registered nurse (RN)-G verified the resident should have been repositioned sooner and the care plan had not been followed.

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R83's care plan was not followed for releasing the pelvic restraint and for positioning.

The plan of care dated 7/26/13, read, "Pelvic positioning straps that I cannot self release. Staff to check [R83] every 30 minutes for safety and release pelvic straps and reposition every two hours and prn (whenever necessary) for a minimum of 60 seconds."

During an observation on 8/20/13, at 10:03 a.m. R83 was sitting in a Broda brand wheel chair with pelvic four inch straps coming across the legs preventing R83 from changing position to buttocks while seated.

During continuous observations on 8/21/13, from 7:10 a.m. until 10:23 a.m., R83 sat up in the Broda chair for 3 hours and thirteen minutes, without an offer to change position, to offload from the sitting position or to have the restraint straps released from the Broda Chair.

At 10:23 a.m., nursing assistant (NA)-C and licensed practical nurse (LPN)-D were observed to check R83, while in the Broda chair, to see if the incontinence brief was wet. Interview with LPN-D regarding observations of R83 sitting in the Broda chair since 7:10 a.m., without releasing the restraint, off-loading and position change revealed LPN-D was not sure about offloading or the frequency involving a position change for R83.

R40's care plan was not followed for bathing

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F 282	Continued From page 14 needs. Document review of R40's plan of care dated 5/22/13, read, "I prefer whirlpool bath mornings." and interventions read, "Staff honors [R40] choice of bath type and times and coordinates accordingly. The nursing assistant assignment (NA) sheet read, "Bath:Mon/Fri AM." When interviewed on 8/21/13, at 2:00 p.m. RN-B checked the NA care tracker and verified one bath was signed out for August and that was on Monday 8/5/13. There were no other baths signed out in August out of six opportunities. In July baths were signed out for five of five Mondays but no Fridays (four of four) were signed out as given. Out of a total in July and August of fifteen opportunities for a bath on Monday and Friday, R40 received six baths, all on Monday and none on Fridays.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview, the facility failed to provide the necessary care and services for 2of 3 residents	F 309	1. Corrective Action: a. The staff responsible for repositioning Residents # 50 and # 83 were counseled on 9/18/13. 2. Corrective Action as it applies to other residents: a. The Policy and Procedure for repositioning was reviewed and remains current. b. All residents will have their care plans reviewed to assure the repositioning needs are current. c. Inservices on repositioning will be held the week of 9/23/13 with all nursing staff. 3. Date of Completion: 9/29/2013	9/29/13

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F 309	Continued From page 15 (R50, R83) who required assist with positioning needs. Findings include: R50 did not receive the necessary care and services related to being repositioned. R50 had diagnosis of dementia, irritable bowel syndrome and incontinence. On 8/22/13 from 8:20 a.m. to 11:30 a.m. R50 was not repositioned for a total of 3 hours and 10 minutes. Review of the current care plan, dated 8/6/13, identified R50 as being at risk for skin breakdown due to impaired mobility, incontinence and diagnoses of diabetes. The care plan directed two staff to assist resident with turning and repositioning every two hours. The NAR Assignment Card, updated 8/16/13, indicated R50 should be offloaded/turned and repositioned every two hours and as needed. The annual Minimum Data Set (MDS), dated 1/30/13, noted R50 was dependent on 2 staff for transfers and mobility. Review of a nursing note dated 8/22/13 read: "Apply barrier cream on buttocks prn and every change. She has a slight rash and the start of a sore on her buttocks". On 8/22/13 at 8:20 a.m., R50 was sitting in the dining room being assisted with breakfast by staff person. At 9:07 a.m., R50 was wheeled into her room by a nursing assistant and was positioned to sit along side the bed when the nursing assistant left. At 10:00 a.m., a nursing assistant wheeled R50 out of the room and down to the 1st floor to see the visiting dentist. At 10:10 a.m. the resident was sitting in a room, with the dental	F 309	4. Reoccurrence will be prevented by: a. Visual audits to assure compliance with repositioning will occur 3x weekly on varying units at different times x90 days. The results of these audits will be shared with QA for input on the need to increase, decrease or discontinue the audits. 5. The Correction will be monitored by: DON/Designee	

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staff. At 11:00 a.m., a nursing assistant returned R50 to her room where a family member was waiting for the resident. The family member then pushed R50 out of the room and down the hall. At 11:30 a.m. two nursing assistants transferred R50 into the bed using a full body lift. R50 was checked for incontinence and found to be incontinent of bowel and bladder. Nursing assistant (NA)-E indicated the resident's skin was red and with small open areas. The licensed nurse (LPN)-B was retrieved and concurred the skin on the buttocks area was bright red and had scant open areas's. The surrounding skin on buttocks and upper thighs was bright red with deep creases and wrinkle lines. LPN-B instructed staff to apply the skin protection cream available for the resident.
On 8/22/13 at 10:10 a.m., nursing assistant (NA)-G confirmed taking R50 to the visiting dentist on 1st floor, but did not provide any other cares for R50 that morning. At 11:20 a.m., NA-E indicated R50 was on her assignment, but thought other nursing assistants's would have checked R50 for incontinence when she was on a break. NA-E verified the resident had not been checked or changed since R50 was gotten out of bed around 7:30 a.m.
On 8/22/13 at 1:40 p.m. the unit registered nurse (RN)-G verified the resident should have been repositioned sooner and stated the care plan had not been followed.

R83 was not re-positioned for over 3 hours.

During continuous observations on 8/21/13, from 7:10 a.m. until 10:23 a.m., R83 sat up in the Broda chair, with pelvic positioning straps attached, for 3 hours and thirteen minutes,

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F 309	Continued From page 17 without an offer to change position. Review of a 7/4/13 Braden Scale, for predicting pressure sore risk identified R83 was a risk for skin breakdown related to impaired mobility and incontinence. R83's diagnosis included Huntingtons's Chorea with uncontrolled movements. A signed and dated 2/2/12, physical restraint and consent form, indicated R83 required the use of a physical restraint pelvic strap for medical symtoms of Huntington's with Chorea movements when in the Broda chair. Review of R83's plan of care, dated 7/26/13, read, "Pelvic positioning straps that I cannot self release. Staff to ckeck [R83] every 30 minutes for safety and release pelvic straps and reposition every two hours and prn (whenever necessary) for a minimum of 60 seconds." Review of the facility policy titled Restraint Policy and dated 11/2012, read, "Physical Restraint" means any manual method of physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body" Under procedure step 12. the document read, "Check and observe resident at least every thirty (30) minutes to ensure safety (unless through assessment more frequent checks are warranted. and procedure step 13. read, Residents in restraints should be released at least every two (2) hours, exercised for ten (10) minutes and then repositioned. During continuous observations on 8/21/13, from	F 309		

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7:10 a.m. until 10:23 a.m. R83 sat up in the Broda chair for 3 hours and thirteen minutes, without an offer to change position, to offload from the sitting position or to have the restraint straps released from the Broda Chair.

On 8/21/13, at 8:30 a.m., the activity aide took R83 to the dining room for breakfast. R83 was fed breakfast at 8:40 a.m. and moved to the activity room at 9:00 a.m. to watch television. At 9:37 a.m. the activity aide returned R83 to the bedroom and turned on the television. At 10:15 a.m. two family members arrived and began to express concern regarding R83s toileting and positioning.

At 10:23 a.m., NA-C and licensed practical nurse (LPN)-D came to check R83 to see if the incontinence brief was wet, while R83 was still sitting up, restrained in the Broda chair. Surveyor asked LPN-D about offloading R83's buttocks, since restrained in Broda chair since 7:10 a.m., and LPN-D was not sure about offloading or about the frequency R83 was to have a positiion change.

R83's incontinence brief was, "Wet" according to LPN-D and instructions were given to NA-C to get the mechanical lift. R83 was assisted to bed and also noted to be incontinent of stool. R83's buttocks were observed to be red and inflamed. RN-B came to assist with cares and verified R83's bilateral buttocks were red and inflammed looking from incontinence of stool and there was wrinkling of the skin and deep crevices from the incontinence brief. RN-B was not sure about the offloading but stated R83 typically was checked before and after breakfast and would be put to bed in the afternoon.

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F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview, the facility failed to ensure incontinence interventions were implemented for 1 of 3 residents (R50) reviewed for incontinence care. Findings include: Resident 50 did not receive incontinence interventions as assessed and directed on the current plan of care. R50 diagnoses included dementia, irritable bowel and urinary incontence. On 8/20/13 at approximately 1:15 p.m., Resident 50 was sitting in the wheelchair, next to bed in room. The resident ' s slacks were wet/soiled in the groin area and resident was holding on to them in the groin area and tugging at it. R50 was not able to be interviewed. On 8/22/13 from 8:20 a.m. to 11:30 a.m. R50 was not toileted or repositioned for a total of 3 hours and 10 minutes. On 8/22/13 at 8:20 a.m., R50 was sitting in the dining room being assisted with breakfast by staff person. At 9:07 a.m., R50 was wheeled into her room by a nursing assistant and was positioned to sit along side the bed when the nursing assistant left. At 10:00 a.m., a nursing assistant	F 315	1. Corrective Action: a. Resident # 50 was provided incontinent care as soon as the discrepancy was discovered. 2. Corrective Action as it applies to other residents: a. The Policy and Procedure for Assistance with Toileting was reviewed and revised on 9/18/13. b. All residents will have their care plans reviewed to assure their incontinent needs are current. c. Inservices on providing incontinent care according to each care plan will be held with all nursing staff the week of 9/23/13. 3. Date of Completion: 9/29/2013 4. Reoccurrence will be prevented by: a. Visual audits for incontinent care according to care plan will be conducted 3xweekly x90 days on varying units at different times. The results of these audits will be shared with QA for input on the need to increase, decrease, or discontinue the audits. 5. The Correction will be monitored by: DON/Designee	9/29/13

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F 315	Continued From page 20 wheeled R50 out of the room and down to the 1st floor to see the visiting dentist. At 10:10 a.m. the resident was sitting in a room, with the dental staff. At 11:00 a.m., a nursing assistant returned R50 to her room where a family member was waiting for the resident. The family member then pushed R50 out of the room and down the hall. At 11:30 a.m. two nursing assistants transferred R50 into the bed using a full body lift. R50 was checked for incontinence and found to be incontinent of bowel and bladder. Nursing assistant (NA)-E indicated the resident's skin was red and with small open areas. The staff nurse was retrieved and concurred the skin on the buttocks area was bright red and had scant open areas's. The surrounding skin on buttocks and upper thighs was bright red with deep creases and wrinkle lines. The licensed practical nurse (LPN)-B instructed staff to apply the skin protection cream available for the resident. The annual Minimum Data Set (MDS), dated 1/30/13, noted R50 was dependent on 2 staff for transfers and toileting. The current care plan, dated 8/6/13, identified R50 as being totally dependent on staff for all toileting and repositioning and directed staff to assist with incontinence care and check and change every two hours and as needed. The NAR Assignment Card, updated 8/16/13, indicated R50 should be toilet/checked every two hours and as needed. On 8/22/13 at 10:10 a.m., nursing assist (NA)-G confirmed taking R50 to the visiting dentist on 1st floor, but did not provide any other cares for R50 that am. At 11:20 a.m. , (NA)-E indicated R50 was on her assignment, but thought other nursing assistants ' s would have checked R50 for incontinence when she was on a break. NA -E verified the resident had not been checked or	F 315		

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F 315	Continued From page 21 changed since R50 was gotten out of bed around 7:30 a.m. On 8/22/13 at 1:40 p.m. the unit registered nurse (RN)-G verified the resident should have been checked and changed sooner and stated the care plan had not been followed.	F 315		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure enough staff were available to meet the needs for residents residing on the 1st floor. This affected 3 residents	F 353	1. Corrective Action: a. An additional staff person was assigned to Unit 1 West when it was discovered the NAR on that unit was flustered and behind in her work, even though there was a ratio of 2 staff to 13 residents scheduled this day. 2. Corrective Action as it applies to other residents: a. An additional person will be assigned to float between Unit 1E and 1W on the dayshift to assist with meals and cares. This person will either be a nursing assistant or an activity assistant who is also a nursing assistant. b. The Unit Manager has been changed on 1 West. c. The 1 West nurse will be assigned to complete cares on a group of residents. d. The facility will continue to assess the staffing patterns on all units based upon census and care needs and schedule accordingly. e. The facility has a vigorous hiring campaign in place and does teach the NAR class in-house. 3. Date of Completion: 9/29/2013	9/29/13

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(R95, R40, R83) of 28 residents on the unit and had the potential to affect all 28 residents on the unit of the 120 residents that resided in the facility.

Findings include:

R40 did not receive a bath per R40's choice or as care planned.

During stage one interview, 8/20/13, at 9:28 a.m., which includes questions regarding bathing and staffing levels, R40 stated, "I have not had a bath in three weeks and I prefer two baths a week, on Monday and Friday."

R40's cognition assessment titled, Brief interview for mental status, (BIMS) scored a 14 out of 15 indicating independent cognition. R40's diagnosis included multiple sclerosis with total dependence for staff assistance.

Document review of R40's plan of care dated 5/22/13, read, "I prefer whirlpool bath mornings." and interventions read, "Staff honors [R40] choice of bath type and times and coordinates accordingly. The nursing assistant assignment sheet read, "Bath:Mon/Fri AM."

When interviewed on 8/21/13, at 2:00 p.m. registered nurse (RN)-B checked the nursing assistant (NA) care tracker document and verified one bath was signed, as given, for August and that was on Monday 8/5/13. There was no other bath signed out in August out of six opportunities. In July baths were signed out for five of five Mondays but no Fridays (four of four) were signed out as given. Out of a total in July and August of fifteen opportunities for a bath on

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F 353	Continued From page 23 Monday and Friday, R40 received six baths, all on Monday and none on Fridays. R83 was not re-positioned for over 3 hours. During observations on 8/20/13, at 10:03 a.m. R83 was sitting in a Broda brand wheel chair with pelvic four inch straps coming across the legs preventing R83 from changing position to buttocks while seated. R83 diagnosis included Huntington's Chorea (neurodegenerative disorder) dysphagia (difficulty swallowing) weight loss and a history of falls from the chair. R83 care area assessment revealed a fall risk requiring physical restraints, pelvic straps while in the Broda chair. R83 transfers with 2 staff assist using the mechanical lift. unable to communicate needs and has BIMS (Brief interview for mental status) score of 6 indicating potential for severely impaired-never/rarely made decisions,cognitive impairment. During continuous observations on 8/21/13, from 7:10 a.m. until 10:23 a.m. R83 sat up in the Broda chair for 3 hours and thirteen minutes, without an offer to change position, to offload from the sitting position or to have the restraint straps released from the Broda Chair. R83 was up at 7:10 a.m. and did not immediately upon arrising have glasses on. Licensed practical nurse (LPN)-D and nursing assistant (NA)-C left the room and told R83 they would get the glasses, which were at the nursing station. R83 was thrashing arms and legs so severely that the Broda chair was moving about the room, bumping into the walls and the bed. R83 was calling out continuously for eye glasses. At 7:20 a.m. NA-C tried to reassure R83 and stated, "She [LPN-D] is getting them [R83],	F 353	4. Reoccurrence will be prevented by: a. Audits of staffing patterns will be completed each week on each unit to review staffing compared to census and care needs. Changes will be made accordingly. This will be an ongoing procedure and will be discussed at monthly QA. 5. The Correction will be monitored by: Administrator and DON	

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[LPN-D] is next door with your neighbor and will be right in." At 7:30 a.m. LPN-D put on R83's glasses and R83 stopped thrashing about the room rocking the Broda chair from bed to wall to window area after, 20 minutes of waiting for the glasses. R83 was unable to move buttocks because of the restraints across both thighs.

At 8:30 a.m. the activity aide took R83 to the dining room for breakfast. R83 was fed breakfast at 8:40 a.m. and moved to the activity room at 9:00 a.m. to watch television. At 9:37 a.m. the activity aide returned R83 to the bedroom and turned on the television. At 10:15 a.m. two family members arrived and began to express concern regarding R83's care. LPN-D came to give medications to R83 and family member (F)-X asked about toileting and positioning. FM-X stated, "It smells in here, it always smells in here and other areas of the facility, it smells like pee!" F-X continued to express how unhappy the family is with R83's care. Interview further revealed unhappiness with R83 being changed and cleaned up. F-X stated," I come in and clean (R83's) room and check everything, look at this cushion on the chair, I clean it every time I come here! They do not have enough staff, I complained to the state last year and I keep telling the director of nursing here, that there is not enough staff on this unit when you have to deal with Huntington's, The people here do not know how to handle people with Huntingtons. You have to be calm."

At 10:23 a.m., NA-C and LPN-D came to check R83 to see if the brief was wet while R83 was still sitting up, restrained in the Broda chair. Surveyor asked LPN-D about offloading R83's buttocks since restrained at 7:10 a.m., and LPN-D was

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not sure about offloading or the frequency R83 required a position change. LPN-D stated, "We check him before and after meals and he generally lays down after lunch but sits up after breakfast."

R83's brief was "Wet" according to LPN-D and instructions were given to NA-C to get the mechanical lift. R-83 was transferred to bed and staff discovered he was incontinent of stool. R83 was resisting care and did not want to turn on to side. LPN-D stated, "It takes 3-4 staff when [R83] gets in this mood, we have to call in help." FM-X was present and gently encouraged R83's cooperation. FM-X said in front of LPN-D and NA-C, "These are not behaviors, this is Huntington's, they don't know how to deal with this." RN-B came to assist with cares and verified R83's bilateral buttocks were red and inflammed looking from incontinence of stool and there was wrinkling of skin and deep crevices from the incontinence brief. RN-B was not sure about the offloading but stated R83 typically was checked before and after breakfast and would be laid down in the afternoon.

The plan of care dated 7/26/13, read, "Pelvic positioning straps that I cannot self release. Staff to ckeck [R83] every 30 minutes for safety and release pelvic straps and reposition every two hours and prn (whenever necessary) for a minimum of 60 seconds."

The facility policy titled Restraint Policy and dated 11/2012, read, "Physical Restraint" means any manual method of physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual canot remove easily which restricts freedom of movement or

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normal access to one's body" Under procedure step 12. the document read, "Check and observe resident at least every thirty (30) minutes to ensure safety (unless through assessment more frequent checks are warranted. and procedure step 13. read, Residents in restraints should be released at least every two (2) hours, exercised for ten (10) minutes and then repositioned.

Family members and the facility staff voiced concerns regarding lack of staffing on the first floor unit to provide adequate care in a timely manner.

During interview with R95's family member (F)-B reported on 8/19/13, at 7:47 p.m., F-B stated the facility did not always have enough staff available to make sure that residents get the care and assistance they need without long waits. F-B stated, "They don't have enough staff when I come for a visit, I may see one person and no one else and never anybody who knows what is going on, it seems lots of people don't know what they are doing or know what's going on. Nobody seems to have answers when I have questions." F-B stated that R95 does not normally have her eye glasses, stockings or shoes on and said she had reported this to the head nurse, social workers and staff nurses and nothing hd been done about it and that the blame had been put on R95. F-B stated, "this is very important to [R95]." F-B further stated, "Even if [R95] took the glasses, stockings or shoes off, staff should encourage [R95] to put them back on, rather than putting the blame on [R95]."

Interview conducted on 8/20/13, at 9:00 a.m. with nursing assistant (NA)-A, indicated that more help would be appreciated and that the ratio of

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resident to staff was 13 to 1. NA-A stated, "Is is difficult to get everyone up on time for breakfast, it is pretty stressful. It was not like the way it is now since they added 2 more residents on my workload. This makes it little bit more difficult, and now is getting incredibly difficult, the nurse does help me at times. Sometime the nurses get behind because they need to get their job done on time as well."
NA-A stated, "the workload is heavy and difficult to give high standard of cares to the entire residents," he is asigned to. NA-A indicated that it started about 2 weeks ago; 2 residents were added to his workload. NA-A indicated that he had brought it to the nurses attention and the nurses had forwarded the information, but nothing had been done.

On 8/20/13, at 9:05 a.m,. an interview was conducted with licensed practical nurse (LPN)-A, who verified the ratio of resident to staff was 13:1. LPN-A stated, "We help nursing assistants with the Hoyer as much as we can."

During interview on 8/20/13, at 9:05 a.m. NA-B, stated, "Ratio between resident to staff on this floor is 13-15 to 1." NA-B further stated, "I think in Alzheimer's unit, it will be nice to have float NA in between floors especially when resident alarms are going off."

An interview was completed with NA-C on 8/21/13, at 8:30 a.m., who indicated that it was frustrating when the work didn't get done on time and stated, "I don't feel good about it when I cannot do all I need to do for my residents." NA-C said that this has been going on for about a couple of months since more residents were brought down from upstairs.

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F 353	Continued From page 28 Interview conducted on 8/22/13, at 2:50 p.m. NA-D stated, "Resident to staff ratio is 13 to 1" and indicated there were more residents now than before on the unit and that some residents have behaviors. On 8/22/13, at 10:50 a.m. an interview was conducted with the DON regarding staffing levels. The DON provided a template used for staffing that revealed: Days / PM's 1E: 1 TMA / LPN / RN, 1 NAR. 1W: 1 TMA / LPN / RN, 1 NAR. Nights: 1E: 1 NAR. 1W: 1 NAR. No other information or documentation was provided.	F 353		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility	F 371	F 371 The tile on the dish room walls will be replaced with glass board. The remainder of the cited walls will be prepped and painted. The exterior of the stand-up freezer will also be prepped and painted. The metal cupboard has been replaced. The Maintenance Director has placed the dish room on the TELS building management system and scheduled preventive maintenance as needed every six months.	9/29/13

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did not maintain the dishwashing area, the stand-up freezer, and 3 of 6 baking sheets in a sanitary manner, which had the potential to affect 109 of the 120 residents in the facility.

Findings include:

During the kitchen tour on 8/22/13, at 9:30 a.m. the walls in the dishwashing room were covered with chipped and peeling paint. Grout in the tiles on the wall behind the dishwashing line were soiled with dark-brown and black material, and a section of the wall near the dishwasher that was not tiled contained an approximately one foot diameter area of dark brown and black staining. The doors of a large, metal cupboard near the dishwashing line contained large areas of rough, reddish-brown material.
The stand-up freezer interior was heavily coated with frost, and the exterior paint of this freezer was marred and scratched.
Three of six large baking sheets observed contained dark debris on the interior corners.
The dietary director was present on the kitchen tour and stated that she had just started her position in the facility and was still assessing the condition of the kitchen.

F 371 (Plan of Correction)

All baking sheets have been scrubbed, cleaned and sanitized and are now free of debris. The freezer has been defrosted. Dietary staff will be in-serviced on use of proper technique to clean the pans from this point forward. Defrosting the freezer will be added to a cleaning schedule to ensure freezer is defrosted monthly.

The Dietary Director or designee is responsible for monitoring this correction.

Date of completion 9/29/2013

F 412 SS=D — 483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS

The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and

F 412 (Plan of Correction) — Completion date: 9/29/13

1. Corrective Action:
   a. Resident # 46 was seen by the dentist on 8/22/13.
2. Corrective Action as it applies to other residents:
   a. The Policy and Procedure for providing dental services was reviewed revised on 9/18/13.

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F 412	Continued From page 30 must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide on going dental services for 1 of 1 resident (R46) in the sample who needed dental services. Findings include: R46 had multiple diagnose including chronic respiratory failure, chronic airway obstruction, and chronic kidney disease. During an interview on 8/20/13 at 9:43 a.m., R46 indicated having pain on the back teeth and thought her front teeth were going to be fixed. R46 added she had seen the dentist months ago and thought she was to see the dentist again, but had not heard anything. R46 ' s care plan dated 8/14/13 indicated resident could complete own dental hygiene, and staff were to monitor and encourage resident to report mouth irritation or pain for follow up. Staff would assist to arrange routine and emergent dental treatment. The minimum data set (MDS) Oral/Dental Assessment Form, dated 2/6/13 indicated resident wanted cavities filled and a partial made. R46 was seen by the dentist on 4/9/13. The plan on the dental progress note indicated resident to return to clinic (RTC) for fillings and impressions. Review of the medical chart lacked additional information if another dental appointment had been scheduled. The Health Information Manager, (HIM)provided an email from the dental company indicating the dental service had removed the resident from the follow up list due to a bad debt. When the payment had been made, the debt did not get removed.	F 412	b. All residents will be reviewed to assure their dental needs have been met. c. HIM will maintain a log of when a resident is screened and seen for dental services. d. An Inservice on dental services will be held on 9/20/13 for all nursing staff. 3. Date of Completion: 9/29/2013 4. Reoccurrence will be prevented by: a. Audits of dental services needs will be conducted 2x weekly x90 days on varying units at varying times to assure services are scheduled and provided. The results of these audits will be shared with QA for input on the need to increase, decrease or discontinue the audits. 5. The Correction will be monitored by: DON/Designee/HIM	

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F 412	Continued From page 31 On 8/22/13 at 2:30 p.m. the HIM clarified the debt had been paid in January 2013, therefore the dental service did not reschedule the resident. When asked how the facility tracks dental follow up appointments, the HIM indicated R46 did not stay on the facility ' s list and she didn ' t know what happened. On 8/22/13, the director of nursing confirmed the facility should coordinate the follow up list with the dental agency.	F 412		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their	F 441	1. Corrective Action: a. The nurse involved in Resident # 146 dressing change was re-educated on hand washing procedure on 9/17/13. 2. Corrective Action as it applies to other residents: a. The Policy and Procedure for glove usage/hand washing was reviewed and remains current. b. Inservices on glove usage/hand washing will be held the week of 9/23/13 for all nursing staff. 3. Date of Completion: 9/29/2013 4. Reoccurrence will be prevented by: a. Visual audits of nurses will be conducted on glove usage/hand washing with dressing changes/wound treatments 2xweekly x90 days on varying units and different times. The results of these audits will be shared with QA for input on the need to increase, decrease or discontinue the audits. 5. The Correction will be monitored by: Staff Development Nurse/Unit Manager	9/29/13

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hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to provide a sanitary dressing change for 1 of 3 residents (R146) observed for pressure ulcers.
Findings include:
The facility failed to ensure proper hand washing and glove changes during a dressing change and tracheostomy care for R146.
R146 was admitted on 5/28/13 with three pressure ulcers on the abdominal fold area.
R146 required tracheostomy care twice a day.
The initial minimum data set (MDS) dated 6/4/13, indicated the pressure ulcers were stage 3 (full thickness).
On 8/22/13 at 9:00 a.m. licensed practical nurse (LPN)-C prepared to do the dressing change to the abdominal fold. The bedside table was used to place the treatment supplies including normal saline, gauze, telfa packets, skin prep packets, and scissor. LPN-C pulled on gloves; applied normal saline to a clean 4 " x 4 " gauze and moistened the three dressings on R146 ' s abdomen. LPN-C explained this would ease their removal. LPN-C then removed the three telfa like dressings from each wound and threw the soiled dressings in the nearby wastebasket. Each

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F 441	Continued From page 33 soiled dressing had medium drainage, with one having blood like drainage. LPN-C then opened the skin prep packets and wiped each wound individually. LPN-C opened the telfa dressing and used the scissor, cutting the dressing three times to fit the abdominal wounds. LPN-C then removed gloves. LPN-C donned another pair of gloves, removed R146 ' s tracheostomy dome and removed a soiled tracheostomy dressing. LPN-C cleansed around the stoma with normal saline and then placed a clean tracheostomy gauze pad. LPN-C wiped away thick sputum from the tracheostomy site after R146 had several deep coughs . LPN-C threw away the tissue and removed gloves. LPN-C then picked up the remaining 4 x 4 gauze and scissor, left the room, and placed the items on the medication cart. LPN-C then went into the medication room and washed her hands. At approximately 9:07 a.m. LPN-C reported not being trained to change gloves after removal of soiled items because it was not a sterile technique. On 8/22/13 at 2:15 p.m., the dressing change procedure observed with LPN-C, was reviewed with the Infection Control Nurse (RN)-H. RN-H stated he was not sure what the nurse should of done as he did not observe the dressing change. RN-H indicated he would locate the policy/procedure. On 8/22/13 at approximately 2:45 p.m., the director of nursing provided the policy/procedure for application of dry, clean dressings. The Policy/Procedure, dated 12/11, directed staff to: " Wash and dry your hands thoroughly...Put on clean gloves. Loosen tape and remove soiled dressing....Pull glove over dressing and discard into plastic or biohazard bag...Wash and dry your hands thoroughly...Open dry, clean dressing (s) by pulling corners of the exterior wrapper	F 441		

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F 441	Continued From page 34 outward... Put on clean gloves...Assess the wound...Cleanse the wound...if using gauze, use a clean gauze for each cleansing stroke...Use dry gauze to pat the wound dry...Apply the ordered dressing...Discard disposable items...Remove disposable gloves and discard into designated container...Wash and dry your hands thoroughly...Clean the bedside stand...Wash and dry your hands thoroughly."	F 441		
F 469 SS=E	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to maintain an effective pest control program to prevent flies from entering the building. This specifically affected 2 residents (R29, R83) observed and had the potential to affect multiple residents of the 120 residents residing in the facility. Findings include: During interview and observation on 8/20/13 at 2:00 p.m. in room 2-001, two flies were observed flying throughout the room, landing on the drinking glasses, cookies, and R29's personal items. A sticky trap for pests was observed to be hanging on the wall and interview with R29 stated his wife brought in the trap because of the fly problem in the bedroom.	F 469	F 469 It is now facility policy that staff and delivery personnel not block the doors open. The Administrator is responsible for the implementation of this policy. Light traps have been installed to trap flying insects as they enter the building. The Maintenance Director will ensure the maintenance of the light traps is carried out. The Housekeeping Director or designee will monitor for the presence of flies and complete weekly audits x3 of the cited residents rooms plus 5 random rooms from each floor and a dining room during one of the daily meals until the November Quality Assurance (QA) meeting then report the results to the QA committee for further review. The Maintenance Director, Housekeeping Director or designee, and Administrator are responsible for monitoring this correction. Date of completion 9/29/2013	9/29/13

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 08/22/2013

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 469	Continued From page 35	F 469		

On 8/21/13, at 2:00 p.m. in room 1-077, a family member (F)-Y was observed to use a fly swatter to get rid of the flies in the room. During interview with F-Y, the family member stated there was a fly problem at the facility. A fly was observed on the spout of the sippy cup used for R83's thickened liquid beverages.

During interview on 8/22/13, at 2:15 p.m., the director of housekeeping (DH) stated there was a problem with flies getting into the facility and said the food delivery people have been known to leave the doors open, which could be thirty minutes. DH also stated that during outdoor activity events the facility door has been left open to make it easier for the residents to go in and out of the building. The DH stated this information would be presented to the administrator.

Although document review of the facility pest control program indicated the facility had a routine and consistent intervention with a pest control company, the DH replied that it can't be effective when the doors are left open.

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

F5223021

PRINTED: 09/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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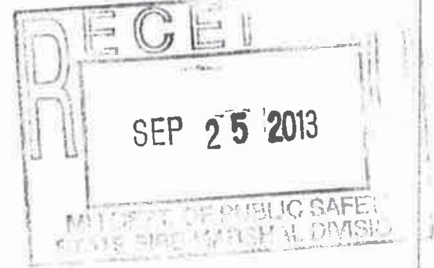
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Red Wing Health Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K 000	 POC ok w/ AW for K67 10-22-13	

DC: 10.01.2013

EXIT: 08.22.2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 9/23/2013

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	08/22/2013

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	08/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 census of 121 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at 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. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to assure fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 19.7.1.2. This deficient practice could affect all 121 residents. Findings include: On facility tour between 1:00 PM and 4:30 PM on 08/22/2013, the review of the fire drill documentation for the past 12 months (August 2012 to July 2013) revealed the drills for the following shifts were completed but did not	K 050	K 050 Fire Drills will vary in times at least 1.5 hours apart every quarter for each shift. The Maintenance Director has established a fire drill calendar which will be used to schedule fire drills and ensure compliance. Date Completed 9/29/2013	

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	245223	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	08/22/2013

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

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K 050	Continued From page 3 sufficiently vary the times that the drills were conducted: Day - 1023, 1430, 0928 and 1340 hours Evening: 1551, 1600, 1530 and 2000 hours Nights: 0455, 0400, 0430 and 0500 hours This deficient practice was confirmed by the Plant Operations Director (MF) at the time of discovery.	K 050		
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation, the facility failed to install the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.5.2, 19.3.6.1 and 9.6. The deficient practice could affect 40 out 121 residents. Findings include: On facility tour between 1:00 PM and 4:30 PM on 08/22/2013, observation revealed, that the 3rd floor - family lounge that is now open to the	K 052	K 052 The 3rd Floor Family Lounge smoke detector was installed 9/20/2013 and is connected to the Fire Alarm Panel.	

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	245223	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	08/22/2013

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 052	Continued From page 4 corridor does not have automatic smoke detection interconnected to the building fire alarm panel. This deficient practice was confirmed by the Plant Operations Director (MF) at the time of discovery.	K 052		
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed maintain the fire alarm system in accordance with the requirement 1999 NFPA 72, Sections 7-3.2 and 7-3.2.1. The deficient practice could affect all 121 residents. Findings include: On facility tour between 1:00 PM and 4:30 PM on 08/22/2013, the review of the annual fire alarm system inspection / test was not completed in a 12 month period. The report from Henning indicated the 2012 was completed on 03/29/2012 and 2013 was completed on 04/16/2013 by Tech-One. This deficient practice was confirmed by the Plant Operations Director (MF) at the time of discovery.	K 054	K 054 Fire Alarm testing is on the Maintenance schedule to be preformed on or before the same date of the previous year's inspection. Vendors were also changed to ensure better service. The Maintenance Director will manage this process. Date complete 9/29/2013	
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are	K 062		

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	245223	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	08/22/2013

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

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K 062	Continued From page 5 continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1998 NFPA 25, section 5-3.2.1. This deficient practice could affect all 121 residents. Findings include: On facility tour between 1:00 PM and 4:30 PM on 08/22/2013, the review of the quarterly flow alarm test report revealed that there is no documentation for 2013 - 1st quarter flow alarm test. This deficient practice was confirmed by the Plant Operations Director (MF) at the time of discovery.	K 062	K 062 Quarterly flow tests are on the Maintenance schedule. The Maintenance Director will verify with the vendor one month previous to the scheduled test that the vendor has this on their schedule. Date Completed 9/29/2013	
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2	K 067	K067 A Life Safety Code Waiver is being applied for from CMS for the following reasons: I. There will be no adverse effect on the health and safety of the facility's residents and staff since:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**08/22/2013**

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

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K 067	Continued From page 6 This STANDARD is not met as evidenced by: Based on observations and staff interviews, it was verified that the facility's general ventilating and air conditioning system (HVAC) is not installed in accordance with the LSC, Section 19.5.2.1 and NFPA 90A, Section 2-3.11 and 3-4.7. A noncompliant HVAC system could affect all 121 residents. Findings include: On facility tour between 1:00 PM and 4:30 PM on 08/22/2013, observations revealed that the ventilation system on the 1st, 2nd, and 3rd floors in the 1965 addition utilizes the egress corridor as the return air for the resident rooms. There was no balancing report available. This deficient practice was confirmed by the Plant Operations Director (MF) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 067	a. The building is protected throughout by an addressable supervised automatic fire alarm system installed in accordance with NFPC 72 in corridors, hazardous areas, and spaces open to the corridor. b. The building has automatic shutdown of all ventilation fans upon detection of smoke or activation of the building fire alarm system. c. Annual service and maintenance contracts exist to service all the facility's fire protection systems (e.g. fire alarm system, sprinkler system, and portable extinguishers.) as applicable. d. The building fire alarm system is monitored to provide automatic fire department notification. e. Fire safety training is provided on an annual basis for all employees and during orientation for all new hires. f. Fire drills are conducted quarterly on each shift. g. The building is protected by a sprinkler system. II. Compliance with this provision will impose an unreasonable hardship on the facility since the cost to implement such a system is prohibitive.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 067		K 067	B. Compliance with this provision will impose an unreasonable hardship to the facility since: a. The $400,000 cost to implement such a system is prohibitive as evidenced by the losses of $288,816 shown on our most recent cost report which is from 2012 and is included for your reference. b. WHV estimates that the work will disrupt the normal use of patient areas for 6 months. c. There is only about one year left on the facility lease which means we would not be able to recover any meaningful portion of the cost. d. Since the building is leased there is no collateral to pledge for the needed financing. e. The lease on the building runs out in about one year making the remaining useful life of the building after the 6 month project less than one year.	

Winona Office
374 East Second St.
P.O. Box 77
Winona, MN 55987
Phone 507.452.2064
Fax 507.452.6320

Rochester Office
1712 Third Ave. SE
Rochester, MN 55904
Phone 507.280.4201
Fax 507.281.7694

La Crosse Office
1202 Caledonia St.
La Crosse, WI 54603
Phone 608.782.6550
Fax 608.782.1219

Iowa Office
2400 86th St., Suite 10
Des Moines, IA 50322
Phone 515.270.4811
Fax 515.331.8037

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June 21, 2011

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

Attn: Doug Hauschild

Subject: Return Air

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

The duct is currently returned from the hallways. 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 $400,000.00. However, this is based on being-able to do the work, of which is not even established as possible do to the above.

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

Sincerely,

Joe Ruff

Sheehan, Pat (DPS)

From: Sheehan, Pat (DPS)
Sent: Tuesday, October 22, 2013 4:04 PM
To: 'rochi_lsc@cms.hhs.gov'
Cc: Schroeder, Gary (DPS); 'tony.linn@welcov.com'; 'Colleen Leach'; 'Jim Loveland'; 'Mark Meath'; 'Mary Henderson'; 'Nicole Steege'; 'Shellae Dietrich'; Whitney, Marian (DPS)
Subject: Red Wing Health Center (245223) K67 Annual Waiver Request - Previously Approved - No Changes

This is to inform you that Red Wing HC is requesting an annual waiver for K67, corridors as a plenum. The exit date was 8-22-13.

I am recommending that CMS approve this waiver request.

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

Name of Facility: Red Wing Health Center

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

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

PROVISION NUMBER(S)	JUSTIFICATION
K84 K067 1 of 2	An annual waver is requested for the following reasons: A. There will be no adverse effect on the health and safety of the facility's residents and staff since: a. The building is protected throughout by an addressable supervised automatic fire alarm system installed in accordance with NPFA 72 in corridors, hazardous areas and spaces open to the corridor. b. The building has automatic shutdown of all ventilation fans upon detection of smoke or activation of the building fire alarm system. c. Annual services and maintenance contracts exist to service all the facility's fire protection systems (e.g. fire alarm system, sprinkler system, portable extinguishers, as applicable). d. The building fire alarm system is monitored to provide automatic fire department notification. e. Fire safety training is provided for all employees on an annual basis and during orientation for all new hires. f. Fire drills are conducted quarterly on each shift. g. The building is protected by a sprinkler system. Continued on the next page...

Surveyor (Signature)	Title	Office	Date
Fire Authority Official (Signature) [signature]	Title: Fire Safety Supervisor	Office: State Fire Marshal	Date: 10-22-13

Name of Facility	Red Wing Health Center

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

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

PROVISION NUMBER(S)	JUSTIFICATION
K84 K067 2 of 2	B. Compliance with this provision will impose an unreasonable hardship to the facility since: a. The $400,000 cost to implement such a system is prohibitive as evidenced by the losses of $288,816 shown on our most recent cost report which is from 2012 and is included for your reference. b. WHV estimates that the work will disrupt the normal use of patient areas for 6 months. c. There is only about one year left on the facility lease which means we would not be able to recover any meaningful portion of the cost. d. Since the building is leased there is no collateral to pledge for the needed financing. e. The lease on the building runs out in about one year making the remaining useful life of the building after the 6 month project less than one year.

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

Client: ***053-01483500 - Red Wing Health Center***
Engagement: ***MD 2012 - Red Wing Health Care, LLC***
Period Ending: ***9/30/2012***
Trial Balance: ***T-01 - TB***
Workpaper: ***T-02 - Medicaid TB Grouping Report***

Account	Description	1st PP-FINAL 9/30/2011	FINAL 9/30/2012
675311	WORKERS COMPENSATION	200,146.00	144,226.00
Subtotal : None		**200,146.00**	**144,226.00**
Total [9024] Worker's Compensation Insurance		**200,146.00**	**144,226.00**
Group : [9026]	**Pension or Profit Sharing**		
Subgroup : None			
675316	401K	25,630.00	22,650.00
675318	DEFERRED COMPENSATION	1,948.00	1,771.00
Subtotal : None		**27,578.00**	**24,421.00**
Total [9026] Pension or Profit Sharing		**27,578.00**	**24,421.00**
Group : [9080]	**Other Employee Benefits**		
Subgroup : None			
675301	EMP PHYS/DRUG TEST/BACKGROUND	2,447.00	2,211.00
675302	FRINGE - ALLOWED	4,443.00	3,997.00
675310	FLEXIBLE BENEFITS	515.00	1,653.00
675314	UNIFORM ALLOWANCE	5,975.00	6,719.00
Subtotal : None		**13,380.00**	**14,580.00**
Total [9080] Other Employee Benefits		**13,380.00**	**14,580.00**
	Operating Expenses	**10,229,322.00**	**9,764,044.00**
	TOTAL EXPENSE	**10,229,322.00**	**9,764,044.00**
	NET (INCOME) LOSS	**(379,937.00)**	**288,816.00**
	Sum of Account Groups	**0.00**	**0.00**

Complete report on file
FS