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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: WU3Y

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00149

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/11/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With
X Program Requirements Compliance Based On:
___1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Stephanie Powers, HFE NE II 05/21/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 05/21/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

CCN: 24-5223

Life safety code waivers were forwarded to the CMS Region V Office for final review and determination: K521. Approval of the waivers was recommended.

Refer to the facility's plan of correction and K84 justification page detailing the waiver request.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245223

May 21, 2018

Mr. Dennis Decosta, Administrator
Red Wing Health Center
1412 West Fourth Street
Red Wing, MN 55066

Dear Mr. Decosta:

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 May 5, 2018 the above facility is certified for:

130 Skilled Nursing Facility/Nursing Facility Beds

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

Your request for waiver of K521 has been recommended based on the submitted documentation. You will receive notification from CMS only if they do not concur with our recommendation.

If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for this deficiency or renew your request for waiver in order to continue your participation in the Medicare Medicaid Program.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

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

Please contact me if you have any questions.

Sincerely,

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

cc: Licensing and Certification File

Electronically delivered

May 21, 2018

Mr. Dennis Decosta, Administrator
Red Wing Health Center
1412 West Fourth Street
Red Wing, MN 55066

RE: Project Numbers S5223028, H5223102

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

Dear Mr. Decosta:

On February 22, 2018, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective February 27, 2018. (42 CFR 488.422)

In addition, on February 22, 2018, we recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedies be imposed:

- Civil money penalty (CMP) for the deficiencies cited at F692, F741. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for a standard survey completed on February 6, 2018. The most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On April 6, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on March 27, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 6, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 18, 2018. Based on our visit, we determined that your facility had not corrected the deficiencies issued pursuant to our standard survey, completed on February 6, 2018.

As a result of the revisit findings, we notified you that the Category 1 remedy of state monitoring would remain in effect.

In addition, as authorized by the Centers for Medicare and Medicaid Services(CMS), this Department imposed the following enforcement remedies:

- Civil money penalties (CMP) for the deficiencies cited at F692, F741. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective May 6, 2018. (42 CFR 488.417 (b))

On May 11, 2018, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on April 6, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 5, 2018. Based on our visit, we determined that your facility had corrected the deficiencies issued pursuant to our PCR, completed on April 6, 2018.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective May 5, 2018.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of April 17, 2018:

- Civil money penalty will remain in effect. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 6, 2018 be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective May 6, 2018 is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective May 6, 2018, is to be rescinded.

In our letter of April 17, 2018, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 6, 2018, due to denial of payment for new admissions. Since your facility attained substantial compliance on May 5, 2018, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Your request for a continuing waiver involving the deficiency(ies) cited under F521 at the time of the February 6, 2018 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: WU3Y

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00149

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

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

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

10.THE FACILITY IS CERTIFIED AS:
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 __ 6. Scope of Services Limit
__ 3. 24 Hour RN __ 7. Medical Director
__ 4. 7-Day RN (Rural SNF) __ 8. Patient Room Size
X 5. Life Safety Code __ 9. Beds/Room

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Jennifer Kolsrud, HFE NE II 05/15/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/06/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

CCN: 24-5223

Life safety code waivers were forwarded to the CMS Region V Office for final review and determination: K521. Approval of the waivers was recommended.

Refer to the facility's plan of correction and K84 justification page detailing the waiver request.

Electronically delivered
April 27, 2018

Mr. Dennis Decosta, Administrator
Red Wing Health Center
1412 West Fourth Street
Red Wing, MN 55066

RE: Project Numbers S5223028, H5223102, H5223103

Revised Letter

Revisions have been made to this letter for clarification regarding the CMP's.

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

Dear Mr. Decosta:

On February 22, 2018, we informed you that the following enforcement remedies were being imposed:

- State Monitoring effective February 27, 2018. (42 CFR 488.422)

- Civil money penalty (CMP) for the deficiencies cited at F692, F741. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for a standard survey completed on February 6, 2018. The most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On April 17, 2018 we informed you that compliance with the health deficiencies issued pursuant to the February 6, 2018 standard survey has not yet been verified. As a result of the findings we notified you of the following remedy was being imposed:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective May 6, 2018. (42 CFR 488.417 (b))

On April 6, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies

issued pursuant to a standard survey, completed on February 6, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 18, 2018. Based on our visit, we determined that your facility had not corrected the deficiencies issued pursuant to our standard survey, completed on February 6, 2018. In addition, at the time of the April 6, 2018 PCR the Minnesota Department of Health completed an investigation of complaint number H5223102, that was found to be substantiated and H5223103 that was unsubstantiated.

The deficiencies not corrected are as follows:

F0688 -- S/S: D -- 483.25(c)(1)-(3) -- Increase/prevent Decrease In Rom/Mobility
F0791 -- S/S: D -- 483.55(b)(1)-(5) -- Routine/emergency Dental Srvcs In NFS
F0690 -- S/S: D -- 483.25(e)(1)-(3) -- Bowel/bladder Incontinence, Catheter, UTI

In addition, at the time of this revisit, we identified the following deficiencies:

F0609 -- S/S: D -- 483.12(c)(1)(4) -- Reporting Of Alleged Violations
F0686 -- S/S: G -- 483.25(b)(1)(i)(ii) -- Treatment/svcs To Prevent/heal Pressure Ulcer
F0726 -- S/S: G -- 483.35(a)(3)(4)(c) -- Competent Nursing Staff
F0760 -- S/S: D -- 483.45(f)(2) -- Residents Are Free Of Significant Med Errors

The most serious deficiencies in your facility were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

As a result of the revisit findings, the Category 1 remedy of state monitoring will remain in effect.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in our letters of February 22, 2018 and April 17, 2018:

- Civil money penalty (CMP) for the deficiencies cited at F692, F741, be imposed. (42 CFR 488.430 through 488.444)

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective May 6, 2018. (42 CFR 488.417 (b))

Based on the findings of this visit, we recommended to the CMS Region V Office the following additional remedies:

- Civil money penalty (CMP) for the deficiencies cited at F686, F726. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

made timely. The plan of correction will serve as the facility's allegation of compliance; and,

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

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

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

Failure to submit an acceptable 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 ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC and CMS approval, a revisit of your facility may be conducted to verify that substantial compliance with the regulations has been attained. The revisit would 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the fourth revisit.

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

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 August 6, 2018 (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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to: Tamika.Brown@cms.hhs.gov. Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900

St. Paul, Minnesota 55164-0900

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable 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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING _____ B. WING _____	R-C 04/06/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS Red Wing Health Center is a Special Focus Facility (SFF). An onsite post certification revisit (PCR) was completed on April 2, 3, 4, 5 and 6, 2018, and found to have NOT corrected all the citations issued on the survey exited February 6, 2018. In addition, an investigation of complaints H5223102 and H5223103 was completed at the time of the revisit. H5223103 was found not to be substantiated. H5223102 was substantiated at F760 scope/severity-D-a significant medication error. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	{F 000}		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and	F 609		5/5/18

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

Electronically Signed | 05/03/2018

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 _____	R-C 04/06/2018

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F 609	Continued From page 1 adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to report alleged violations of mistreatment to the State Agency (SA) for 3 of 3 incidents involving two residents (R21, R185) reviewed for medication and/or treatment errors. Finding include: A Medication Error Report (#1) dated 3/2/18, identified an incident in which registered nurse (RN)-A pushed the tip of an enema bottle into R21's healing pressure ulcer located on the left hip. R21 expressed pain when RN-A accidentally pushed the enema tip into a wound opening during the administration of an enema, resulting in bleeding to the healing wound located on the left ischium (hip area). The Medication Error Report dated 3/2/18, identified the physician was notified and the director of nursing (DON) signed acknowledgement of the error. Review of RN-A's personnel file identified a form titled "Internal Investigation Form"; on page 7 the administrator's signature dated 3/5/18, revealed acknowledgment of the violation.	F 609	F609 Reporting of Alleged Violations Immediate Corrective Action: 1. All Medication Errors that require reporting were reported on 4/6/18. 2. R21□s area was resolved on 3/29/18. 3. R185 had no adverse outcomes. 4. RN-A and the previous DON are no longer employed at the facility. Action as it applies to others: 5. All events that require reporting have been reported to the department. 6. Education was completed with staff on reporting requirements. Date of Completion: 5/5/18 Recurrence will be prevented by: 7. The Administrator/designee will audit reportable events each week to ensure reporting requirements have been met.	

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F 609	Continued From page 2 A Medication Error Report (#2) was documented on 3/16/18, when RN-A placed wound dressing material into R21's rectum, causing pain; (interview with R21 and nursing assistant (NA)-D stated the wound dressing material entered the vagina not the rectum as documented on the report). The Medication Error Report dated 3/16/18, identified the physician/Medical Director was notified and signed the form on 3/16/18, as well as the DON. A Medication Error incident (#3) occurred on 3/2/18 to 3/5/18, when the DON received a verbal medication change from the hospice nurse for R185 on 3/1/18, to discontinue MS Contin (opioid·narcotic analgesic) 75 milligrams (mg) (60 mg tablet plus 15 mg tablet) every 8 hours and start Methadone (opioid·narcotic analgesic) 10 mg every 8 hours upon arrival from pharmacy. The Methadone medication arrived from the pharmacy in time to administer the third dose at 4:00 p.m. on 3/2/18, to R185. However, from 3/2/18 until 3/5/18, R185 was administered concurrently, the MS Contin and the Methadone (total of 11 errors) and a medication error was identified. The Medication Error Report was filled out by the DON dated 3/5/18, with the physician/medical director signature dated 3/9/18. Interview on 4/5/18, at 1:30 p.m. with interim DON (IDON) regarding this event (#3), it was verified no other information was available for review. The IDON verified this should have been reported as a vulnerable adult (VA) report but had not been. On 4/5/18, at 4:00 p.m. the IDON submitted additional information for Medication Error Reports (#1, #2), which included a disciplinary	F 609	Audits will occur weekly for the next 90 days. The results of these audits will be shared with the facility□s QAPI Committee for input on the need to increase, decrease, or discontinue the audits based off of the findings. The Correction will be monitored by: Administrator/Designee	

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F 609	Continued From page 3 report for RN-A. However, the IDON was unable to locate the VA reports for both of these violations (#1, #2). The company's area administrator was present at this time and voiced he was aware of the violations but was unsure whether reported to the State Agency. During policy review dated 11/16, and titled Abuse Prevention Plan-MN the following was noted: (1) The Administrator, DON, or nursing supervisor will make sure that a report is filed , that the internal investigation begins immediately, the appropriate reporting takes place and that interventions are implemented to provide the vulnerable adult with a safe living environment. (2) Mistreatment meals (means) inappropriate treatment. (3) Reportable incidents-Medications errors, which have an adverse or potential for adverse outcome.	F 609		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	F 686		5/5/18

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F 686	Continued From page 4 Based on observation, interview and document review the facility failed to ensure treatments were implemented in a manner which promotes healing and prevents injury for 1 of 1 resident (R21) reviewed with a Stage 4 pressure ulcer. R21 sustained harm when registered nurse (RN)-A inserted an enema tip into a healing pressure ulcer. Findings include: R21 was admitted on 1/7/16, with diagnoses of a contiguous (sharing a common border; touching) back, buttock and hip Stage 4 pressure ulcers (PU), cervical spinal cord injury and quadriplegia (paralysis of all four limbs). The quarterly Minimum Data Set (MDS) for R21 dated 1/29/18, identified a Brief Interview of Mental Status (BIMS) score of 15/15, indicating intact cognition. No behaviors were identified on the quarterly MDS. The care plan identified problems related to constipation and incontinence of bowel, and indicated R21 required staff assistance with personal hygiene. In addition, it identified R21 had a history of chronic pressure ulcers located on the left ischium and coccyx with wounds that open/closes. The care plan indicated the need for wound assessment and treatment. Wound documentation dated 3/6/18, identified R21 had a Stage 4 pressure ulcer measuring 0.5 cm (centimeters) length, 0.3 cm width and 0.8 cm depth. Treatment included: Pack with Maxorb extra Alginate, cover with ABD (a type of dressing) and change daily. An order from the wound clinic dated 2/23/18, indicated R21 was to have an Alginate dressing once per day.	F 686	F686 Treatment/Services to Prevent/Heal Pressure Ulcer Immediate corrective action: 1. R21□s area was healed on 3/29/18. 2. RN-A are no longer employed at the facility. Action as it applies to others: 3. A complete review of all residents with pressure ulcers to ensure treatments are in place and are completed per order. 4. The licensed nursing staff have been educated on completing treatment orders per order. Date of completion: 5/5/18 Recurrence will be prevented by: 5. The DON/designee will audit weekly to ensure treatments are completed per physician orders. Audits will occur weekly for the next 90 days. The results of these audits will be shared with the facility□s QAPI Committee for input on the need to increase, decrease, or discontinue the audits based off of the findings. The correction will be monitored by: DON/Designee	

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F 686	Continued From page 5	F 686		

A 1/22/17 physician order for R21 indicated: Fleets Enema 7-19 grams (GM) 1 18 milliliters(ML) (Sodium Phosphates) Insert 1 each rectally one time a day every 2 day(s) for constipation, to be given at 9 a.m. A Medication Error Report dated 3/2/18, indicated RN-A had inserted an enema tip into a wound located on R21's left hip rather than the resident's rectum. A nursing progress/assessment note dated 3/2/18, documented that R21 experienced pain and bleeding when the error had occurred.

Interview with nursing assistant (NA)-E on 4/5/18, at 3:40 p.m. recalled the incident and remembered feeling R21's body jerking while on her side and observed RN-A pushing the enema tip until R21 screamed out in pain. NA-E observed RN-A had tip of enema in wound and not anal opening.

Weekly wound documentation dated 3/13/18, identified a Stage 4 pressure ulcer measuring 0.5 cm length, 0.3 cm width and 0.8 cm depth. Current treatment included: Cleanse with wound cleanser, Apply Puracol. Change daily.

A Medication Error Report dated 3/16/18, identified that RN-A had placed a wound dressing [Puracol] into R21's anal opening in lieu of packing the stage four pressure ulcer on the resident's "bottom". A progress note dated 3/16/18, indicated the wound dressing for R21 was placed into the anal cavity with resident stating, "That doesn't feel right."

Interview with NA-D on 4/5/18, at 4:00 p.m. recalled the above incident and stated it was the vagina not the rectum (anal opening) that was

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F 686	Continued From page 6 packed with the wound dressing. NA-D indicated R21 called out in pain and NA-D had to identify the location of the wound to RN-A . When interviewed on 4/5/18, at 3:07 p.m. R21 stated she can still experience pain in these areas, and had no abnormal anatomy. She verified the incidents occurred approximately a month ago and explained that NA-D and NA-E had to tell R21 treatments were not completed correctly. Both NA-D and NA-E were present during the time of the described incidents. During an observation on 4/6/18, at 3:00 p.m., it was noted the location of the pressure ulcer, rectum, and vaginal areas were easily identified.	F 686		
{F 688} SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced	{F 688}		5/5/18

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{F 688}	Continued From page 7 by: Based on observation, interview, and document review, the facility failed to ensure hand splint was applied for 2 of 3 resident (R66, R55) reviewed for range of motion. Findings include: According to the admission record, R66 had been admitted to the facility on 9/22/16. R66's care plan, dated 1/17/18, identified diagnoses of traumatic subdural hemorrhage, cognitive communication deficit, unspecified intracranial injury, and unspecified lack of coordination. In addition, it identifies the R66 requires the assist of 1 staff for all cares including, putting on left cylinder splint at bed time as resident allows and staff to remove during AM cares. 4/4/18 9:40 am noted to be lying in bed with fall matt on floor next to bed, no splint on at this time, with blue hand splint noted to be on table next to door. On 4/4/18 at 11:30 a.m., Nursing assistant (NA)-A stated that R66 only wears her hand splint at night and are off during the day. On 4/4/18, at 2:25 p.m. LPN - A stated that R66 did not have hand splint on the morning; it was passed through report that we need to make sure splints are on. Review of medication and treatment administration record (MAR/TAR) for the months of March and April showed no documentation as to when splint to left arm is to be applied. In addition, no documentation was noted in nursing assistant documentation.	{F 688}	F688 Increase/Prevent Decrease in ROM/Mobility Immediate corrective action: 1. R66 had no adverse reactions noted. A wearing schedule has been obtained and resident wears per order. 2. R55 had no adverse reactions noted. A wearing schedule has been obtained and resident wears per order. Action as it applies to others: 3. All residents who have hand splints have been audited and have a wearing schedule. 4. Education was provided to staff on application and wearing schedules of hand splints. Date of completion: 5/5/18 Recurrence will be prevented by: 5. The DON/designee will audit residents who wear hand splints to ensure they are placed on per order. Audits will occur weekly for the next 90 days. The results of these audits will be shared with the facility□s QAPI Committee for input on the need to increase, decrease, or discontinue the audits based off of the findings. The correction will be monitored by: DON/Designee	

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{F 688}	Continued From page 8	{F 688}		

According to the admission record, R55 had been admitted to the facility on 4/15/15. R55's care plan, dated 3/29/18, identified diagnosis of anoxic brain damage (brain damage due to lack of oxygen) indicating staff to assist R55 with all cares including: right wrist /hand orthotic to be applied by nursing and worn at all times as resident allows.

Review of the March and April 2018 medication administration record (MAR), and treatment administration record (TAR), revealed no documentation as to when the splint to R55's left arm was to be applied. In addition, documentation beginning 3/18/18, indicated no documentation nor non applicable code. The April 2018 task documentation indicated only one incidence of documented splint use, 4/4/18, otherwise the April 2018 documentation was also blank.

On 4/4/18 during continuous observation of R55 from 9:40 a.m. to 11:20 a.m., staff did not offer or attempt to apply the right wrist /hand splint. At 9:40 a.m. R55 was observed sitting in a Broda (special wheelchair) chair at the dining room table. There were no hand splints on at that time. At 10:11 a.m., R55 was still sitting in the Broda chair in the 3E dining room. NA-A was observed to approach and ask R55 if he wanted his socks back on as R55 had removed both socks and shoes, the resident declined. At 10:26 a.m., NA-A asked R55 if wanted to go for a walk. R55 stated no, but requested to make a phone call to his dad. NA-A brought R55 to the staff charting room, and assisted with making the call. At 10:40 a.m., R55 was observed sitting in the lobby area outside the nurses' charting room with NA-A, who

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{F 688}	Continued From page 9	{F 688}		

was charting on the computer. At 10:44 a.m., R55 was observed sitting in his room, NA-A turned on the radio for R55. At 10:55 a.m. R55 told NA-A he needed to go to the bathroom, and NA-A assisted the resident. At 11:20 a.m., R55 was observed seated in the lobby again. At no time during these continuous observations was a splint offered or applied to the right hand/wrist area.

On 4/4/18 at 11:32 a.m., NA-A was interviewed regarding how often R55's hand splint was used. NA-A said the hand splint was supposed to be worn daily, but that it had been broken for about a week, and OT (occupational therapy) was working on a new splint.

On 4/4/18 at 1:35 p.m., NA-F was interviewed regarding R55's hand splint. NA-F said the splint was "in the cart, I have not taken it yet." When asked what NA-F did to help keep R55's hand from becoming more contracted while the splint was not in use, NA-F stated she had attempted to stretch and straighten the hand this morning. NA-F stated R55 was able to open the hand, but the middle finger was contracted. NA-F was then observed to take the splint to OT and returned stating that OT staff had stated the splint looked fine, but wanted to reviewed R55's chart to see if there was a picture of the splint to verify, so the OT would look into it more. NA-F stated she would place the splint in R55's hand. At 1:45 p.m., R55 was observed to have the right hand splint on.

On 4/5/18 at 9:30 a.m., NA-B stated the only splints being used in the facility at that time were for R66 who wore one at night, and for R55 whose splint was broken, and required a new center piece which OT had ordered for him.

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{F 688}	Continued From page 10 On 4/5/18 at 10:32 a.m., the interim director of nursing (IDON) was interviewed about documentation of when hand splints should be applied and removed. The IDON stated, "You probably won't find any [documentation] as I notice it was under the tasks for the NA's to document and it was not being completed. It should have been on the MAR/TAR for the nurse/TMA (trained medication aide) to sign and check that was in place." The IDON verified there had been no documentation of R66's splint use, and verified the facility had conducted range of motion audits, but had not conducted audits to ensure hand splints were utilized as prescribed. The IDON stated, "I would expect that it would be on the MAR/TAR so the nurses can be making sure the splints are on/off and applied correctly per OT recommendations." Although the facility policy regarding splints was requested, none was received.	{F 688}		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an	F 690		5/5/18

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F 690	Continued From page 11 indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure timely toileting services were provided for 1 of 4 residents (R30) reviewed for incontinence care. Findings Include: R30's quarterly Minimum Data Set (MDS) dated 2/21/18, indicated R30 had severe cognitive impairments, required two person extensive assistance with toileting and always incontinent of bowel and bladder. R30's care plan print dated 4/5/18, included diagnoses of personal history of traumatic brain injury, non-traumatic chronic subdermal hemorrhage, adjustment disorder with anxiety and bipolar disorder.	F 690	F690 Bowel/Bladder Incontinence, Catheter, UTI Immediate corrective action: 1. R30 receives toileting needs as directed in the care plan. Action as it applies to others: 2. All residents who require assistance with toileting needs will be reviewed to ensure their care plans accurately reflect their needs. 3. Education was provided to nursing staff on the ensuring resident□s toileting needs	

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	245223	A. BUILDING _____ B. WING _____	R-C 04/06/2018

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F 690	Continued From page 12 During continuous observation of R30 on 4/4/18, at 1:31 p.m. R30 was lying in bed, awake and stated he was trying to roll over. Nursing assistant (NA)-A asked R30 whether he needed any assistance/help with anything. R30 responded and screamed "get out of here." NA-A stated staff members approach with two staff to provide any cares for R30 when in his room. NA-A stated R30 had been in his bed all day, refusing to get up and/or to leave his room. NA-A did not ask R30 whether she could check/change him related to incontinence cares. The following observations continued on 4/4/18: -1:40 p.m. R30 remained in his room with the door shut. No staff have entered resident's room. -2:05 p.m. R30 remained in his room with the door shut. No staff have entered resident's room. -2:16 p.m. R30 remained in his room with the door shut. No staff have entered resident's room. -2:55 p.m. licensed practical nurse (LPN)-A delivered R30 juice and left it in his room. LPN-A stated R30 was sleeping and confirmed she did not offer to complete any cares at this time. -3:24 p.m. R30 remained in his room with the door shut. No staff have entered resident's room. -3:39 p.m. R30 remained in room with the door shut. No staff have entered resident's room. -3:47 p.m. NA-C delivered linens, knocked, opened R30's door, greeted, set down the linens and exited the room. NA-C did not offer to	F 690	are provided per their plan of care. Date of completion: 5/5/18 Recurrence will be prevented by: 4. The DON/designee will audit random residents to ensure their toileting needs are provided per their plan of care. Audits will occur weekly for the next 90 days. The results of these audits will be shared with the facility□s QAPI Committee for input on the need to increase, decrease, or discontinue the audits based off of the findings. The correction will be monitored by: DON/Designee	

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F 690	Continued From page 13	F 690		

check/change R30.

-3:55 p.m. R30 remained in his room with the door shut. No staff have entered resident's room.

-4:16 p.m. R30 remained in his room with the door shut. No staff have entered resident's room.

During the continuous observation period from 1:31 p.m. to 4:16 p.m. (2 hours, 45 minutes) R30 was not provided nor offered cares related to toileting needs.

During an interview on 4/4/18, at 4:16 p.m. NA-C reported that R30 required a check/change every two hours. NA-C stated R30 was in a good mood, very pleasant and she had the ability to provide cares.

During an observation on 4/4/18, at 4:20 p.m. NA-C entered R30's room to check and change, which R30 granted permission for writer to observe cares. Upon checking the brief, NA-C stated R30's incontinent pad was medium urine soaked and the bottom of his shirt was also wet. R30 was cooperative while NA-C changed the wet brief and shirt.

R30's Bowel and Bladder assessment dated 12/5/17, included, "Resident has a DX [diagnoses]: TBI [traumatic brain injury] and most likely the reason why he is incontinent. Resident's BIMS [Brief Interview for Mental Score] score is 3 indicating severe cognitive impairment ...Analysis (Include 3 day bladder summary) Resident has a TBI [traumatic brain injury] and is unable to recognize the urge to void or defecate. Is not a candidate for bladder retraining r/t [related to] his cognitive issues. Resident is always incontinent of

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F 690	Continued From page 14	F 690		

bowels and bladder. Wears incontinent briefs and staff check and change q [every] 2-2.5 hrs and PRN."

R30's toileting care plan dated 12/5/17, included, "Toileting: I need assistance with my toileting. I am incontinent of both bowel and bladder. Interventions included: I need extensive assistance of 1 staff in toileting. I will at times refuse to allow staff to do cares after I have been incontinent. I may strike out or attempt to pull their hair if they get close to me."

R30's undated, facility document, Visual/Bedside Kardex Report, indicated "I need extensive assistance of 1 staff in toileting. I will at times refuse to allow staff to do cares after I have been incontinent. I may strike out or attempt to pull their hair if they get close to me."

During an interview on 4/4/18, at 4:35 p.m. NA-C stated actually the first time she checked and changed R30 during her shift was at 4:20 p.m. this afternoon.

During an interview on 4/4/18, at 4:43 p.m. the interim director of nursing (IDON) stated it was standard of practice to check and change incontinent residents every two hours. The IDON verified R30's bladder assessment dated 12/5/17, indicated R30 should be toileted every 2--2.5 hours and verified this had not been carried through to the care plan for this resident. The IDON stated her expectation was that residents be toileted according to their assessed needs and for care plan to indicate how often residents should be toileted.

The ADL Assistance Provided Per Care Plan

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F 690	Continued From page 15 dated 11/2016, included, "Based upon resident/resident representative desires, assessment and care plan, ADL assistance will be provided to any residents deemed necessary."	F 690		
F 726 SS=G	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced	F 726		5/5/18

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F 726	Continued From page 16 by: Based on interview and record review, the facility failed to ensure treatments were implemented in a safe manner by registered nurse (RN)-A who inserted an enema tip into a healing pressure ulcer and implemented improper wound treatment for 1 of 1 resident (R21) reviewed with a Stage 4 pressure ulcer. R21 sustained harm when registered nurse (RN)-A inserted an enema tip into a healing pressure ulcer. Findings include: RN-A repeatedly performed unsafe nursing care for R21, who required wound treatment to a pressure ulcer and administration of a Fleet enema for bowel management. R21 was admitted on 1/7/16, with diagnoses of a contiguous (sharing a common border; touching) back, buttock and hip Stage 4 pressure ulcers (PU), cervical spinal cord injury and quadriplegia (paralysis of all four limbs). The quarterly Minimum Data Set (MDS) for R21 dated 1/29/18, identified a Brief Interview of Mental Status (BIMS) score of 15/15, indicating intact cognition. No behaviors were identified on the quarterly MDS. The care plan identified problems related to constipation and incontinence of bowel, and indicated R21 required staff assistance with personal hygiene. In addition, it identified R21 had a history of chronic pressure ulcers located on the left ischium and coccyx with wounds that open/closes. The care plan indicated the need for wound assessment and treatment. Wound documentation dated 3/6/18, identified	F 726	F726 Competent Nursing Staff Immediate corrective action: 1. R21□s area was healed on 3/29/18. 2. RN-A are no longer employed at the facility. Action as it applies to others: 3. The licensed nursing staff have been educated on completing treatment orders per order Date of completion: 5/5/18 Recurrence will be prevented by: 4. The DON/designee will audit weekly to ensure treatments are completed per physician orders. Audits will occur weekly for the next 90 days. The results of these audits will be shared with the facility□s QAPI Committee for input on the need to increase, decrease, or discontinue the audits based off of the findings. The correction will be monitored by: DON/Designee	

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F 726	Continued From page 17	F 726		

R21 had a Stage 4 pressure ulcer measuring 0.5 cm (centimeters) length, 0.3 cm width and 0.8 cm depth. Treatment included: Pack with Maxorb extra Alginate, cover with ABD (a type of dressing) and change daily.

A 1/22/18, physician order for R21 indicated: Fleets Enema 7-19 grams (GM) 1 18 milliliters(ML) (Sodium Phosphates) Insert 1 each rectally one time a day every 2 day(s) for constipation, to be given at 9 a.m. A Medication Error Report dated 3/2/18, indicated RN-A had inserted an enema tip into a wound located on R21's left hip rather than the resident's rectum. A nursing progress/assessment note dated 3/2/18, documented that R21 experienced pain and bleeding when the error had occurred.

Interview with nursing assistant (NA)-E on 4/5/18, at 3:40 p.m. recalled the incident and remembered feeling R21's body jerking while on her side and observed RN-A pushing the enema tip until R21 screamed out in pain. NA-E observed RN-A had tip of enema in the wound and not the anal opening.

Weekly wound documentation dated 3/13/18, identified a Stage 4 pressure ulcer measuring 0.5 cm length, 0.3 cm width and 0.8 cm depth. Current treatment included: Cleanse with wound cleanser, Apply Puracol. Change daily.

A Medication Error Report dated 3/16/18, identified that RN-A had placed a wound dressing [Puracol] into R21's anal opening in lieu of packing the stage four pressure ulcer on the resident's "bottom". A progress note dated 3/16/18, indicated the wound dressing for R21 was placed into the anal cavity with resident

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F 726	Continued From page 18	F 726		

stating, "That doesn't feel right." Review of the progress notes identified that RN-A worked the remainder of the shift as RN-A entered a progress noted dated 3/16/19, at 3:09 p.m. which stated: at approx. 10:45 a.m., wound drsg [dressing] was placed in anal cavity, then removed and disposed of. New dressing acquired and placed in wound. Resident stated, "That doesn't feel right".

Interview with NA-D on 4/5/18, at 4:00 p.m. recalled the above incident and stated it was the vagina not the rectum (anal opening) that was packed with the wound dressing. NA-D indicated R21 called out in pain and NA-D had to identify the location of the wound to RN-A .

When interviewed on 4/5/18, at 3:07 p.m. R21 stated she can still experience pain in these areas, and had no abnormal anatomy. She verified the incidents occurred approximately a month ago and explained that NA-D and NA-E had to tell R21 treatments were not completed correctly. R21 verified that both NA-D and NA-E were present during the time of the described incidents.

During an observation on 4/6/18, at 3:00 p.m., it was noted the location of the pressure ulcer, rectum, and vaginal areas were easily identified.

Review of the personnel file for RN-A identified the following:
(1)-12/4/17- Medication Administration Policies- written warning;
(2)-2/3/18-Medication Administration error- written warning;
(3)- 3/2/18-Medication error occurred- review of policy related to "Ready to use Fleet Enema";

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F 726	Continued From page 19 (4) -3/17/18- Unacceptable performance-Termination after wound dressing inserted in wrong anatomy. Documentation was lacking to indicate the facility had conducted a performance audit/review of RN-A during treatments provided after warnings had been issued to ensure standards of practice had been followed. RN-A was suspended on 3/17/18, and terminated on 3/21/18.	F 726		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on document review and interview the facility failed to ensure physician orders were implemented as directed to prevent a significant medication error, concurrent administration of two narcotic medications, for 1 of 1 resident (R185) reviewed who concurrently eceived MS Contin and Methadone. Findings include: R185 had a change in pain medication on 3/1/18. Order documentation in R185's record, indicated the director of nursing (DON) had received a verbal order from a hospice nurse on 3/1/18, to discontinue MS Contin (opioid· narcotic analgesic) 75 milligrams (mg) every 8 hours [facility had been giving one 15 mg tablet and one 60 mg tablet to get to 75 mg], and to start	F 760	F760 Residents are Free of Significant Med Errors Immediate corrective action: 1. R185 had no adverse outcomes. 2. RN-A are no longer employed at the facility. Action as it applies to others: 3. Education was provided to the licensed nursing staff on medication management. Date of completion: 5/5/18 Recurrence will be prevented by:	5/5/18

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F 760	Continued From page 20 Methadone (opioid·narcotic analgesic) 10 mg every 8 hours upon arrival from pharmacy. The order change was communicated 3/1/18 to RN-B in the following manner: Discontinue MS Contin 60 milligrams (mg) every 8 hours and MS Contin 15 mg every 8 hours, Start Methadone 10 mg every 8 hours. The medication administration record (MAR) was reviewed for R185 for 3/1- 3/5/18. The MAR indicated R185 had received both MS Contin 75 mg every 8 hours, and Methadone 10 mg every 8 hours for that time period receiving both medications 11 times in error, when the facility failed to discontinue the MS Contin. A Medication Error Report verified R185 had recieved the two narcotics concurrently from 3/2/18 until 3/5/18. The Medication Error Report indicated R185 had concurrently received the MS Contin and the Methadone for a total of 11 medication error doses. The Medication Error Report had been completed by the previous DON 3/5/18, and had been sent to the physician/medical director who signed it 3/9/18. The facility's Physician Order Procedure policy dated 11/2016 included: "...all transactions of orders should be signed off by a nurse and double checked by a second nurse to assure that all steps have been carried out to avoid errors. Both will indicate the review of the order by signing in the medical record. The second nurse will run the Administration Record Report for the MAR/TAR to view for accuracy of the transcription."	F 760	4. The DON/designee will observe medication observation in med-pass weekly to ensure medication errors do not occur. Audits will occur weekly for the next 90 days. The results of these audits will be shared with the facility□s QAPI Committee for input on the need to increase, decrease, or discontinue the audits based off of the findings. The correction will be monitored by: DON/Designee	
{F 791}	Routine/Emergency Dental Srvcs in NFs	{F 791}		5/5/18

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{F 791} SS=D	Continued From page 21 CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and	{F 791}		

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{F 791}	Continued From page 22 §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to schedule ensure 1 of 4 residents (R21) reviewed for dental care, received dental services to meet their individualized needs. Finding include: During an interview with R21 on 4/4/18 at 10:48 a.m., the resident stated she'd had pain in her teeth and wanted to see her dentist in Wisconsin, but the facility staff had not assisted her with arranging an appointment. R21 stated it had been about four months since she'd indicated her desire to see the dentist. The health unit coordinator (HUC)-C was interviewed on 4/4/18 at 3:05 p.m.. HUC-C stated R21's dental services had to be provided in Wisconsin because the resident has Wisconsin medical assistance. HUC-C said she'd never been given a dentist's name, just the town and that she'd attempted to get R21 a visit. However, HUC-C was unable to provide any documented evidence of these attempts. In addition, HUC-C was unaware of R21's pain in her teeth. On 4/4/18 at 4:05 p.m., HUC-C stated she'd made a dental appointment for R21. On 4/4/18 at 4:42 p.m., the interim director of nursing (IDON) was interviewed about R21's dental concerns. The IDON stated an	{F 791}	F791 Routine/Emergency Dental Services in NFs Immediate corrective action: 1. R21 is scheduled for a dental appointment on 5-9-18. Action as it applies to others: 2. No resident is in need of emergency dental care. Dental services will be provided when needed to residents. 3. Education was provided to staff regarding dental services and needs. Date of completion: 5/5/18 Recurrence will be prevented by: 4. The DON/designee will audit random residents each week to ensure any dental needs are addressed and appointments made as needed. Audits will occur weekly for the next 90 days. The results of these audits will be shared with the facility□s QAPI Committee for input on the need to increase, decrease, or discontinue the audits based off of the findings. The correction will be monitored by: DON/Designee	

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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
{F 791}	Continued From page 23 appointment should have been made before now. HUC-C was interviewed again on 4/5/18 at 11:06 a.m., and verified she'd been aware of R21's desire to go to the dentist at least two weeks ago. HUC-C said, "I know I'm slow and should have made the appointment sooner. I just looked for the papers yesterday and found a name in the paper chart." The facility's policy Emergency Dental Care-Denture Replacement dated 3/18, included: "Will assist the resident in making an appointment and arranging transportation to and from the dental service location... If referral does not occur with 3 business days, the facility must document what adaptations were made to ensure the could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay."	{F 791}		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: WU3Y

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00149

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

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

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

4. TYPE OF ACTION: **2** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/06/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **130** (L18)

13.Total Certified Beds **130** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Jennifer Kolsrud, HFE NE II 03/12/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Debby Baker, Enforcement Specialist 03/26/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

CCN: 24-5223

On February 6, 2017 a standard survey was completed at this facility. The most serious deficiencies (F692 and F741) were cited at a S/S level of G. As a result of our findings, we are imposing the Category 1 remedy of State monitoring, effective February 27, 2018.

In addition, we are recommending the following enforcement action to the CMS RO for imposition:

- CMP for deficiencies cited at F692 and F741.

Furthermore, the following life safety code waivers were forwarded to the CMS Region V Office for final review and determination: K521. Approval of the waivers was recommended.

Refer to the CMS 2567 for both health and life safety code along with the facility's plan of correction and K84 justification page detailing the waiver request.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 22, 2018

Mr. Dennis Decosta, Administrator
Red Wing Health Center
1412 West Fourth Street
Red Wing, MN 55066

RE: Project Number S5223028

Dear Mr. Decosta:

On February 6, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

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

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

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

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

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

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

DEPARTMENT CONTACT

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

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

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

For all surveys completed after September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when one or more of the following circumstances exist:

- Immediate jeopardy (IJ) (scope and severity levels J, K, and L) is identified on the current survey; OR
- Deficiencies of Substandard Quality of Care (SQC) that are not IJ are identified on the current survey; OR
- Any G level deficiency is identified on the current survey in 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25 Quality of Care; OR
- Deficiencies of actual harm or above (level G or above) on the current survey as well as having deficiencies of actual harm or above on the previous standard health or Life Safety Code (LSC) survey OR deficiencies of actual harm or above on any type of survey between the current survey and the last standard survey. These surveys must be separated by a period of compliance (i.e., from different noncompliance cycles).; OR
- A facility is classified as a Special Focus Facility (SFF) AND has a deficiency citation at level "F" or higher on its current health survey or "G" or higher for the current LSC survey.

Note: the "current" survey is whatever Health and/or LSC survey is currently being performed, i.e., standard, revisit, or complaint.

Your facility meets one or more criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

- State Monitoring effective February 27, 2018. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

• Civil money penalty for the deficiency cited at F692 and F741. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

• 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 ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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 May 6, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 6, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING _____ B. WING _____	02/06/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on January 29, 30, 31, February 1, 3, 5, and 6, 2018, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements	E 000		
F 000	INITIAL COMMENTS Red Wing Health Center is a Special Focus Facility (SFF), and received a Certification survey on January 29, 30, 31, February 1, 3, 5 & 6, 2018. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure reasonable accommodation of needs in regards to call light in	F 558	F558 Reasonable Accommodations/Needs/Preferences	3/18/18

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

Electronically Signed | 03/03/2018

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 _____	02/06/2018

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F 558	Continued From page 1 reach for use for 1 of 1 resident (R51) and for comfortable table height for dining for 1 of 1 resident (R4) comfortable table height while eating. Findings include: R51 had been observed and interviewed on 1/29/18, at 9:58 a.m. as R51 was in bed at the time and during an interview with R51 the call light was placed at the top of the bed and behind R51 out of reach. During initial contact interview with R51, licensed practical nurse (LPN)-I came into the room and said that the call light was not in reach for R51 and proceeded to place the call light where R51 could easily access it if needed. R51 was interviewed again on 1/30/18, at 1:16 p.m., at which time R51 asked to have call light moved so it was in reach. The call light was noted to be located at the very top of mattress behind R51's head and no staff were in the room at this time. Following the request by R51 to have call light put in reach the Unit Manager (UM)-I had been informed R51 needed assistance including the call light request at 1:20 p.m. UM-I stated she would check on R51, stating, "You know R51 can reach it" in reference to the call light location. UM-I then went to R51's room and returned to nursing station and said, "You were right R51 was not able to reach call light." Received policy and procedure for "Answering Call Lights" with revision date of January 2014. Policy: The purpose of this procedure is to respond to the resident's requests and needs. Procedures: 5) When the resident is in bed or confined to a chair be sure call light is within easy reach of the resident.	F 558	Immediate Corrective Action: 1. Resident R51 had call light placed within reach at the time of the survey. Resident R4□s table height was adjusted to a comfortable level at the time of survey. Action as it applies to others: 2. The Policy and Procedure for Call lights and Reasonable Accommodation of Needs remains current. 3. A complete audit was performed at the time of survey to ensure resident call lights were in reach, as well as, call light accessibility is audited during the facility□s Guardian Angel rounds. A complete audit of dining rooms was conducted to ensure table heights were at an appropriate and comfortable level for residents. 4. The DON/designee will educate all staff no later than March 5, 2018 on the following: All residents must have their call light within reach; Residents should be seated at tables of the appropriate height to allow for a comfortable dining experience. If a resident seats self in dining room and table does not appear to be a proper height, please assist resident to another table. Those not in attendance at staff education due to illness, vacation or casual status will be educated prior their first shift worked. Date of completion: 3/18/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 558	Continued From page 2 LACK OF COMFORTABLE DINING EXPERIENCE DUE TO TABLE HEIGHT: R4'S admission form included an admission date of 9/1/15 and diagnosis of moderate intellectual disabilities. R4's quarterly Minimum Date Set date 11/2/17 an assessment, indicates a Brief Interview for Mental Status (BIMs) score of 9, indicating moderate impaired cognition. Also indicated R4 is independent with eating after setup. During dining observation on 1/29/18, at 12:59 p.m. R4 was seated in a wheelchair at the dining table. R4 received a food tray and it was set up by staff. After staff set up the meal it was noted that R4's chin was at the same height as the top of the table and R4 had difficulty reaching up and over her plate of food to reach and return the glass of juice and milk. Also had to lift arms up and over table to reach food using spoon and fork. On 2/1/18, at 12:14 p.m., during noon meal, R4 had taken drinks of juice and had elbows set on table top with elbows at same height as shoulders. During interview on 2/1/18, at 12:50 p.m., with nursing assistant (NA)-A regarding R4's eating comfort while seated at the dining table. NA-A stated it did not look as if R4 was eating comfortably with table being so high. NA-A did ask R4 if she would like table lowered and R4 shook head yes. Then NA-I attempted to lower table but was unsuccessful.	F 558	Recurrence will be prevented by: 5. The DON/designee will audit 10 random resident rooms at random times to ensure residents have their call lights within reach. Audits will be weekly for 4 weeks and then monthly for 3 months. Additionally, the DON/designee will audit dining services at random meals 5 times a week for 4 weeks and then monthly for 3 months to ensure resident□s table height is at an appropriate and comfortable height for dining. Results of audits will be discussed by the DON/designee at the monthly Quality Assurance Process Improvement (QAPI) meeting for further review and recommendations on continuing or discontinuing the audits based on the findings. The correction will be monitored by: DON/Designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 558	Continued From page 3 During interview on 2/2/18, at 4:15 p.m., DON stated, "I would expect the table to be at an appropriate height for resident" when asked about the high table surface for R4. Requested policy for reasonable accommodation of needs and none had been provided.	F 558		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.	F 561		3/18/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 561	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to honor an opportunity to choose an activity to go outside the facility for 1 of 1 resident (R36) reviewed for choices. Findings include: R36's admission Minimum Data Set (MDS) an assessment dated 9/5/17, for preferences and customary routines indicated when R36 was interviewed for activity preferences, it is very important to do your favorite activities and to go outside and get fresh air when the weather is good. R36's quarterly MDS dated 11/29/17, indicated R36 had unclear speech (slurred or mumbled words), usually makes self-understood, and usually has the ability to understand others, with a moderate cognitive impairment and mild depression. Psychosis, behavior symptoms, rejection of care, and wandering were not exhibited. R36 needs 1 person extensive assist with locomotion on and off the unit. Walking in room and in the corridor did not occur. Diagnoses include: Aphasia (loss of ability to understand or express speech, caused by brain damage), depression, and anoxic brain damage (is injury to the brain due to a lack of oxygen). Wander/elopement alarm not used. Active discharge planning already occurring to return to the community. R36's Care Plan dated 9/12/17, indicated under quality of life, continuing these activities I did prior to admission are important to me: being outside when weather is good. Further indicated under	F 561	F561 Self-Determination Immediate Corrective Action: 1. Resident R36 is being assisted outside as he desires and weather permitting. Action as it applies to others: 2. All Resident care plans will be reviewed to identify any residents who enjoy going outside to ensure these residents are offered this opportunity. 3. The Policy and Procedure for Quality of Life, Self-Determination remains current. 4. The Regional Clinical Director/Designee will educate the DON and ADON who will then educate all staff on resident rights and preferences, including assisting residents to go outside when they require supervision for safety. Education will occur no later than March 5, 2017 and those not in attendance at staff education due to illness, vacation or casual status will be educated prior their first shift worked. Date of Completion: 3/18/18 Recurrence will be prevented by: 5. The DON/designee will audit 10 residents each week to ensure resident rights and preferences are being honored	

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F 561	Continued From page 5 quality of life, activities I pursue independently include outdoor activities like gardening and sitting in the sunshine. Goal indicated I would like to sit in the lobby/yard/dayroom and "people watch." I would like to continue this activity in my leisure time as able. Staff to monitor if I become restless/agitated, and ask if I want/need to do something differently. I (R36) would like my life to continue to be meaningful, and to be kept "busy" even though it appears I do not understand or participate like others do. I may need additional time to communicate my preferences and may not effectively respond to stimulus in my environment. I would like staff to anticipate and help to meet my leisure time needs, and to invite me to /from groups of potential enjoyment. R36's , Associated Clinic of Psychology summary dated 10/24/17, recommendations related to aggressive behaviors are, "client may benefit from staff moving slowly, speaking in a calming voice, and reproaching client as needed, when increased agitation is noted, rather than trying to complete a care when resident is agitated. Recommendations to treat mood symptoms are client will continue to benefit from staff support, kindness, patience, and reminders that client is well liked, appreciated and respected. R36's, Associated Clinic of Psychology summary dated 11/21/17, recommendations are: staff are to consider using a communication board with (R36). Due to his aphasia it is challenging for him to fully articulate his needs, and having a communication board may decrease his frustration. Staff are encouraged to get (R36) out of his room on a regular basis keeping him engaged in activities at the facility is helpful for his continued mood enhancement.	F 561	per their plan of care. Audits will include interview and observation. Audits will continue for 4 weeks and then monthly for 3 months. Results of audits will be discussed by the DON/designee at the monthly QAPI meeting for further review and recommendations on continuing or discontinuing the audits based on the findings. The correction will be monitored by: DON/Designee	

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Care plan dated 12/6/17, indicated for communication, the goal is: I (R36) would like staff to be patient with me and actively listen when I speak, even though it may take more time for me to express myself. I communicate best by words/gestures/facial affect. I have difficulty understanding others when they are not making direct eye contact with me, and allowing me ample time to respond. Intervention: Staff speak clearly and actively listen during conversations with R36. Staff validate communication when needed to ensure messages are clearly understood. I may become frustrated with staff and others if I feel I am not being understood. Please redirect me as able, and spend the time needed to communicate-including picture/letter/number board.

Review of progress notes from time of admission 8/29/17 to 1/31/18, shows resident was taken outside twice from admission.

Progress note on 9/25/17, 1:14 p.m., Behavior Note Text: Wandering about unit, attempting to get out of 3 E, sticking foot in door, became combative when staff attempted to redirect. Scratching & spitting. Taken outside with Speech for his session. Wandered down elevator to 1st floor kitchen attempting to shut door on foot. 3 staff to redirect & return to unit.

Progress note on 1/26/18, at 7:46 p.m. Behavior Note Text: R36 had received a phone call from family & that upset him. He left the 3 east unit and refused to come back. Unit manager attempted to calm him down. Wanted to leave. Became very upset when he was told he could not go home just yet. Unit manager took him outside to get

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some fresh air. He calmed down and allowed me to feed him supper. Consumed 75%. He has not been agitated since before supper.

Progress note dated 1/30/18, at 8:30 p.m., Behavior Note Text: Late Entry: Writer was alerted that resident was on the elevator. Resident came off the elevator and sat with writer in the 2 west common area for approximately 30-45 min. Resident continued to want to go outside despite the explanation that it was cold and he was not dressed to be outside. Resident was eventually escorted back to 3 east unit with much difficulty and protest, being physically aggressive towards staff. Once back on the unit, resident calmed down within 10-15 minutes. He took his medications without difficulty.

During observation on 3 east Unit on 1/31/18, at 11:14 a.m., R36 had wheeled self in Broda chair towards the exit doors which were closed and when activated by a sensor would sound an alarm. Licensed practical nurse (LPN)-B observed as R36 opened the unit door himself, the alarm went off, and he wheeled self out of unit. Nursing assistant (NA)-B went with R36 down the hallway from the unit towards 3 West unit to have a weight completed. Then R36 saw the elevator and started wheeling toward the elevator, R36 grabbed onto the handrail by the elevator while yelling and moaning trying to get in the elevator. NA-B attempted to redirect R36 to the 3 west unit to obtain a weight, without success. R36 has his feet on the floor, pushing against the floor to back into the 3 west elevator. R36 this whole time is yelling and moaning. Once inside the elevator, NA-B looked R36 in the eyes and in a calm voice stated, "Ok we will go downstairs." R36 stopped moaning and yelling,

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was quiet for the ride to the second floor main street entrance. At 11:19 a.m., R36 wheeled self out of the elevator straight for the front doors. NA-B directed R36 to the right of the doors to offer an opportunity to look at the birds. R36 at this time used his feet and pushes them off the floor to back up to get back to the entrance doors. As R36 is closer to the front door he reached for the handles of the door that lead out near the street. NA-B is talking quietly in a calm voice to R36 and told R36 it was cold outside and that he would need a jacket and a hat. R36 was offered a drink of water and he started yelling and moaning again, reaching for the door handles to get outside. Assistant director of nursing (ADON) arrives and tried to talk to R36 to encourage him to go back to the 3 east unit. NA-B leaves the area to go back to the 3 East unit. R36 continues to reach for the handles on the front door. ADON is trying to move R36 away from the doors and R36 starts arching his back in his chair and pushing his feet off the floor to stay near the door handles. Then the Unit manager (UM)-I and director of nursing (DON) are now at the scene to assist with redirecting the resident away from the front doors. At 11:48 a.m., R36 was observed leaving the elevator on the third floor which was close to 3 east unit along with DON, ADON, and UM-I. LPN-F arrives on the scene with a chocolate pudding and attempts to give R36 a bite of the chocolate pudding and R36 moves his head away from the spoon of pudding. R36 continues to scream and cry as he is being pushed into the 3 east unit.

During interview on 1/31/18, at 12:49 p.m., NA-B verified when R36 was down on 2nd floor earlier he wanted to go outside. Further verified she was the only nursing assistant working the 3 east

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unit, and could not leave the rest of the residents to go get a jacket and hat to take R36 outside. NA-B stated, "This is why we need two aides on this floor." Further stated we do not have time to do 1:1 with these residents when they need to be redirected for their behaviors, it's impossible. "I am doing the best that I can."

During interview on 2/1/18, at 12:42 p.m., LPN-B stated yesterday would have been a great day to take R36 outside, the weather was nice, if we would have had the staff to do it, and we could have done that. LPN-B further stated, "We should be accommodating [R36's] preferences, if he wants to go outside and the weather is nice, he should be able to go outside."

During interview on 2/5/18, at 12:54 p.m., ADON stated any resident could go outside with a staff that had exit seeking behaviors safely; the 2 east doors to go outside has a safe fenced in area. There is also a safe fenced in area on 1 east unit to go outside.

During interview on 2/6/18, at 2:31 p.m. director of nursing (DON) verified no one offered R36 to go outside and that R36 has a right to make choices.

Facility Policy, "Quality of Life-Self Determination," dated 2010, revised Jan 2014, revealed, "our policy respects and promotes the right of each resident to exercise his or her autonomy regarding what the resident considers to be important facets of his or her life." 2. In order to facilitate resident choices, staff shall: a. inform (and regularly remind) the resident and family members of the resident's right to self-determination and participation in preferred

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F 561	Continued From page 10 activities; b. Gather information about the resident's personal preferences on initial assessment and periodically thereafter, and document these preferences in the medical record; c. include information gathered about the residents preferences in the care planning process; and d. document and communicate any medical conditions or limitations that may inhibit or interfere with participation in preferred activities.	F 561		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.	F 565		3/18/18

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F 565	Continued From page 11 §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to timely act upon voiced concerns during resident council for 10 of 10 residents (R11, R31, R46, R53, R71, R47, R67, R24, R53, & R21) identified to have attended resident council meetings. Findings include: R11, R31, R46, R53, R71, R47 and R67 were attendees during the resident council meeting dated 12/4/17, according to the council meeting minutes with granted permission from one of the residents to review. The minutes identified a concern of, "Would like follow through on grievances." The concern was identified under the heading of administration. Another request stated, "would like another nurse on 2 W [west]" and this concern was identified under the heading of nursing. Resident council meeting minutes for 1/8/18, meeting again included R11, R31, R46, R53, R71, R47 and R67 attended the meeting. The minutes lacked any identified action or follow-up to the councils presented concern of grievances or nursing from the 12/14/17, resident council meeting. The minutes listed a section labeled	F 565	F565 Resident/Family Group and Response Immediate Corrective Action: 1. All outstanding grievances have been addressed. Action as it applies to others: 2. A Resident Council meeting will be held no later than March 5, 2018 to review grievances/concerns and to see if any other issues remain unresolved. 3. The Grievance/Concern Policy remains current. The Administrator/designee will review the Grievance/Concern Policy with the Interdisciplinary Team (IDT) no later than March 5, 2018 to assure team members understand the Grievance/Concern Policy requirements for timely and satisfactory resolutions. Date of Completion: 3/18/18 Recurrence will be prevented by:	

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F 565	Continued From page 12 "Agenda & Minutes, 2. 'old business', review concerns from the last meeting:" only addressed concern had been the temperatures of food and food running out. On 1/31/18, at 10:04 a.m. a group meeting was held with wight residents from the facility, which included R24, R53 & R21 who did not often attend the monthly resident council meeting. Also R46, R53, R67, R11, R47 who were frequent attendees during the resident council meetings were also in attendance today. R46 explained the council group met on a monthly basis and specific departments attend but do not always follow through with concerns or questions the residents present. R21 said that she had copies made of her grievances and R21 grievances are not responded to by administration. R11 has had to wait 2 hours to have cares completed, R46, R53, R67, R24, R28, R11, R21, R47 all in agreement that cares are rushed and not done properly or thoroughly, adding there is supposed to be two nurses and two aides but they only have one nurse and one aide. R21 and R67 confirmed their unit only has one aide. R21 added there is supposed to be a restorative aide (for range of motion (ROM)) but gets pulled to other areas. R21 voiced concern they had not had consistent restorative services in the past three months. All residents stated they sometimes feel staff retaliate against them for making comments, grievances and bringing up concerns. Review of 20 grievance/concern report forms from 10/1/17 to 2/5/18 included, not enough staff, nursing cares, long wait times for call lights being answered and no range of motion provided. The reports identified, no 72 hour follow on two reports, four were not satisfied and three reports	F 565	4. The Administrator/designee will audit all grievances/concerns each week to ensure response is timely and the resolution is to the resident□s satisfaction. Audits will continue for 4 weeks and then will be 10 random monthly for 3 months. Results of audits will be discussed by the Administrator/designee at the monthly QAPI meeting for further review and recommendations on continuing or discontinuing the audits based on the findings. The Correction will be monitored by: Administrator/Designee	

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F 565	Continued From page 13 had no response on resident satisfaction. Some grievances note "already addressed", but the residents still are not getting satisfied. Triggering the residents to file another grievance sometimes the same concerns. During an interview with the DON on 2/5/18, at 12:46 p.m. stated when no restorative aide is on to complete ROM services the expectation is all aides (nursing assistants) are trained and educated and can complete the ROM services. A facility Grievance/concern policy dated 7/15, identified a meeting with the resident/representative will occur to review the findings and action(s) taken and /or those that will be taken. It they are not satisfied with the results, other actions will be developed as needed. If the resident/representative are still not satisfied with the results of the investigation/actions they may file a report with Chief Operations Officer of Welcov Healthcare. A written response will be returned to resident/representative within 10 (ten) days. The resident/ representative also has the right to file a written grievance/concern with the local Ombudsman or survey agency for the State.	F 565		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;	F 582		3/18/18

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F 582	Continued From page 14 (B) 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 (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) 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/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.	F 582		

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F 582	Continued From page 15 (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide 48-hour notice for the end of Medicare coverage for 2 of 3 residents (R70 and R181) reviewed for liability notices. Findings include: R70 received Medicare Part A services from 11/21/17, to 12/17/17, even though benefit days were not exhausted. However, R70 was not provided the appropriate notice of non-coverage to indicate the resident or legal representative could request a reconsideration, Demand Bill, once Medicare services were no longer being received or necessary. R181 received Medicare Part A services from 7/13/17, to 8/23/17, and benefit days were not exhausted. However, R181 had not received the appropriate notice of non-coverage to indicate the resident or legal representative could request a reconsideration, Demand Bill, once Medicare services were no longer being received or necessary. On 2/5/18, at 12:22 p.m. in response to question regarding beneficiary notices when services were stopped for R70 & R181 he said there is no good reason why they were missed We had a change of staff and now the previous staff member is back completing the process of providing the correct notices to our residents.	F 582	F582 Medicaid/Medicare Coverage/Liability Notice Immediate corrective action: 1. A new process was implemented in January 2018 regarding issuing of denials. Failure to issue the denials for R70 and R181 occurred prior to this process update and cannot be corrected for these residents. Action as it applies to others: 2. The non-coverage notices are being administered by a staff member who is knowledgeable of the non-coverage notification requirements, a change in process in prior to survey and no notices have been missed since she has taken over the process in January 2018. Additional education will be provided to a second staff member by the first staff member in charge of the process to provide back-up in her absence. Date of completion: 3/18/18 Recurrence will be prevented by: 3. The Administrator/designee will audit all residents whose coverage has ended to ensure they received the 48 hour notice	

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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
F 582	Continued From page 16	F 582	for the end of Medicare coverage. Audits will be weekly for 4 weeks and then 10 random residents monthly for 3 months. Results of audits will be discussed by the Administrator/designee at the monthly QAPI meeting for further review and recommendations on continuing or discontinuing the audits based on the findings. The correction will be monitored by: Administrator/Designee	
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for	F 604		3/18/18

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	245223	A. BUILDING _____ B. WING _____	02/06/2018

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F 604	Continued From page 17 purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to do a comprehensive assessment to determine if the least restrictive device (leg straps) was used and an ongoing need for the leg straps, also provide cares/services regarding the use of leg straps as a restraint device to minimize the time worn due to being short staff on this unit and the need to remove the leg straps every two hour or more often as care planned for 1 of 1 resident (R36) who was assessed to need the leg straps to prevent sliding out of the chair. Findings include: R36's quarterly Minimum Data Set (MDS) an assessment dated 11/29/17, indicated R36 had unclear speech (slurred or mumbled words), usually makes self-understood, and usually has the ability to understand others, with a moderate cognitive impairment and mild depression. Psychosis, behavior symptoms, rejection of care, and wandering were not exhibited. R36 needs 1 person extensive assist with locomotion on and off the unit. Walking in room and in the corridor did not occur. Diagnoses include: Aphasia (loss of ability to understand or express speech, caused by brain damage), depression, and anoxic brain damage (is injury to the brain due to a lack of oxygen). Limb restraint used daily.	F 604	F604 Right to be Free from Physical Restraints Immediate corrective action: 1. Resident R36 had a Physical Device Assessment on 3/1/18 outlining the need for thigh straps. Staff verbally educated at the time of survey on the requirement to check resident every 30 minutes and remove device every 2 hours. Action as it applies to others: 2. All residents were reviewed to ensure any restrictive devices that are used have a current comprehensive assessment and care plan interventions are in place. 3. The Policy and Procedure for Restraint Use remains current. 4. The DON/designee will educate all nursing staff no later than March 5, 2018 on the assessment requirement, as well as, the requirement that residents with restrictive devices be checked at least every 30 minutes and the device be removed every 2 hours. Those not in attendance at education sessions due to	

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F 604	Continued From page 18 R36's care plan dated 9/17/17, indicated risk of falls related to being totally dependent on staff for activities of daily living (ADL) and mobility. 12/13/17, I have thigh straps in my broda chair due to my impulsive behavior. Staff check thigh straps every 30 minutes then release. R36's signed medication review report dated 12/18/17, identified on 9/13/17, to start, "Thigh straps while on broda wheel chair for safety per OT [occupational therapy]." Physical device assessment dated 2/8/18, indicated R36 poor balance. Factors possibly contributing to the need for a device is impaired mobility and impaired judgement. The medical symptoms for the use of a device is R36 has poor trunk control and will slide out of chair without the use of thigh straps. Suggested device is a thigh strap. Device will be used when in broda chair and will be checked every 30 minutes and released every 2 hours. Thigh Strap is considered a device to help keep body in alignment, positioning and used for fall prevention. R36 is unable to demonstrate an ability to use the device, and is unable to remove device upon command. Risk factors associated with thigh straps are bruising and skin integrity. During continuous observation of R36 on 1/30/18, at 1:14 p.m., R36 was seated in a Broda chair with his eyes closed in the lobby parked next to the medication cart. R36 was dressed and thigh straps for each leg were in place. At 2:21 p.m., R36 remains in chair and no one has checked his thigh straps. Trained medication aide (TMA)-A and nursing assistant (NA)-C were working the unit this shift and are in the office. At 2:50 p.m.,	F 604	illness, vacation, or casual work status will be educated prior to their next shift worked. Date of Completion: 3/18/18 Recurrence will be prevented by: 5. The DON/designee will audit all residents with restrictive devices in use to ensure the following: Assessment is current; care plan is current; Resident is being checked at least every 30 minutes and device removed at least every 2 hours. Audits will be weekly for 4 weeks and then monthly for 3 months. Results of audits will be discussed by the DON/designee at the monthly QAPI meeting for further review and recommendations on continuing or discontinuing the audits based on the findings. The correction will be monitored by: DON/Designee	

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F 604	Continued From page 19 R36 remains in his broda chair in the same location with his eyes closed with thigh straps secured, no one has attempted to check his thigh straps as care plan identified, to check every 30 minutes. During interview on 2/1/18, at 11:05 a.m., director of nursing (DON) stated my expectation is for staff to follow the care plan and check R36's thigh straps every 30 minutes and release every 2 hours. Policy for Physical restraints, dated Aug 2006, and last revised on April 2016, identified a restraint is used only when assessed as necessary to treat a medical condition and/or an appropriate measure to be used to provide resident safety. Facility will complete an assessment prior to use of the device and quarterly thereafter. Least restricted device will be the goal. Consent to use the restraint must be obtained from the resident, family, or legal representative prior to using the restraint.	F 604		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the	F 637		3/18/18

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F 637	Continued From page 20 care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to identify a significant change in status assessment in a timely manner for 1 of 1 resident (R36) reviewed for activities of daily living (ADL) decline. Findings include: R36's quarterly Minimum Data Set (MDS) an assessment, dated 11/29/17, identified R36 was admitted on 8/29/17 with multiple diagnoses of anoxic brain damage (is injury to the brain due to a lack of oxygen), aphasia (loss of ability to understand or express speech, caused by brain damage), and depression. Required an assist of 1 person total dependence with eating. Weight is 173 pounds with no weight loss in the last 6 months and has a feeding tube. Does not have a wanderguard/elopement device. R36's care plan dated 9/19/17, indicated R36 was working on my chewing/swallowing ability, not able to feed self. After comprehensive care plan had been developed on 12/19/17, Intervention were: staff of 1 provides an escort to dining room meal setup/assistance to apply condiments, pour liquids, season food, and identify foods on plate/available as alternates. Staff of 1 totally feed me, providing small bites, alternating with sips of liquids. Staff allow adequate time for me to swallow and clear my mouth. R36's signed medication review report dated 12/18/17, indicated enteral feed order one time a day Isosource 1.5, 130 ml/hour x 12 hours via j-tube. Flush with 60 cc water before and after	F 637	F637 Comprehensive Assessment After Significant Change Immediate corrective action: 1. Resident R36 has had a significant change MDS completed. Action as it applies to others: 2. All MDS□s submitted this month will be reviewed for accuracy/missed significant change. 3. The Director of Reimbursement will educate the IDT team no later than March 5, 2018 on ensuring significant change assessments are completed as the significant change is identified and the RAI Manual regarding significant change is followed. Date of completion: 3/18/18 Recurrence will be prevented by: 4. The DON/designee will audit 5 random residents each week to ensure that a significant change has not occurred without the completion of the signification change assessment. Audits will be weekly for 4 weeks and then monthly for 3 months. Results of audits will be discussed by the DON/designee at the monthly QAPI meeting for further review and recommendations on continuing or	

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F 637	Continued From page 21 tube feeding administration. Progress note on 1/9/18, at 8:47 p.m., revealed, R36 had pulled g-tube out. Attempted to reinsert without success. R36 took all his meds orally. Dr. Sierra was notified. Refused supper tonight. Unsigned, physician's telephone order dated 1/12/18, indicated to discontinue g-tube and all treatments related to g-tube. Review of weights in R36's medical record identified on 11/22/17 weight was 173.4 pounds and weight on 2/1/18 was 160.6 pounds. During interview on 2/5/18, at 4:19 p.m., registered nurse (RN)-B Verified that R36 has had his feeding tube out since 1/9/18, and has had weight loss. RN-B stated when a resident has a change in 2 or more areas, a significant change assessment needs to be completed and verified one had not been completed for R36. During interview on 2/5/18, at 5:23 p.m., RN-D Ellen verified R36 has a wanderguard on, had his g-tube removed since 1/9/18, has not been receiving his tube feeding and now a weight loss. RN-D stated a significant change assessment should have been completed. RN-D said, "I will be putting in a significant change assessment for R36." Facility policy dated Aug 2006, last revised May 2017, titled, "Change of Condition or Status," identified to assure all necessary parties are notified promptly when a resident has had a change in condition which may necessitate orders form the physician and maintain accuracy with the resident's overall care. A. If the resident	F 637	discontinuing the audits based on the findings. The correction will be monitored by: DON/Designee	

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F 637	Continued From page 22 experiences a significant change, in physical or mental condition, an Interact change in condition assessment of the resident's conditions will be conducted as required by current regulations governing resident assessments and as outlined in the MDS RAI instruction manual. Facility policy dated October 2010, revised June 2013, titled, "Comprehensive Assessment Schedules," identified if a change has occurred, however, the Comprehensive Assessment will be redone, written in the progress notes. This is true also if a change takes place in between MDS's.	F 637		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to accurately code the Minimum Data Set (MDS) for 1 of 1 residents (R66) reviewed for falls. Findings include: R66's quarterly Minimum Data Set (MDS) an assessment dated 1/8/18, indicated under section J: one fall since admission on 9/22/16. Facility document titled, "fall," indicated R66 fell to the floor on 10/21/17. Progress note dated 12/4/17, at 12:36 p.m., indicated R66 was found on the mat next to her bed between the bed and the window.	F 641	F641 Accuracy of Assessments Immediate corrective action: 1. Resident R66 MDS has been modified to include the correct number of falls. Action as it applies to others: 2. All MDS□s submitted this month will be reviewed for accuracy/missed significant change. 3. The Director of Reimbursement will educate the IDT team no later than March 5, 2018 on ensuring coding of the MDS is accurate and the RAI Manual is followed.	3/18/18

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F 641	Continued From page 23 During interview on 2/1/18, at 4:25 p.m., registered nurse (RN)-C stated she was unable to find an incident report for R66's fall for 12/4/17, but verified the fall was noted in the progress note. "I see the progress note, but no incident report that goes with that." During interview on 2/3/18, at 11:41 a.m.,RN-B verified 2 falls since R66's admission occurred on 10/21/17, and 12/4/17. Further verified on 1/8/18, quarterly MDS assessment only one fall was captured. RN-B stated it might have been missed because the electronic incident report for the 12/4/17, fall was not filled out and it was in the progress notes. A facility Assessment (MDS) policy dated 11/22/16, identified a purpose to insure the timeliness and accuracy of all MDS.	F 641	Date of completion: 3/18/18 Recurrence will be prevented by: 4. The DON/designee will audit 5 random residents each week to ensure the MDS is coded accurately. Audits will be weekly for 4 weeks and then monthly for 3 months. Results of audits will be discussed by the DON/designee at the monthly QAPI meeting for further review and recommendations on continuing or discontinuing the audits based on the findings. The correction will be monitored by: DON/Designee	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and	F 656		3/18/18

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F 656	Continued From page 24 (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement the care plan for 1 of 6 residents (R36) reviewed who were dependent upon staff assistance with activities of daily living (ADL) and failed to implement care plan interventions for dental care and nutrition for 1 of 1 resident (R281) reviewed for dental/nutrition. Findings include: LACK OF EATING ASSISTANCE AS CARE	F 656	F656 Develop/Implement Comprehensive Care Plan Immediate corrective action: 1. Residents R36 and R281 have had their care plan reviewed/updated and care plan is being followed. Action as it applies to others: 2. Care plan reviews will be conducted on	

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F 656	Continued From page 25 PLANNED: R36's quarterly Minimum Data Set (MDS) and assessment, dated 11/29/17, identified R36 was admitted on 8/29/17, with diagnoses of anoxic brain damage (is injury to the brain due to a lack of oxygen), aphasia (loss of ability to understand or express speech, caused by brain damage), and depression. Required an assist of 1 person total dependence with eating. Weight is 173 pounds with no weight loss in the last 6 months and has a feeding tube. Receives 51 percent or more of total calories through tube feeding. R36's care plan dated 9/19/17, indicated R36 needed assistance to eat and to bring to dining room and set up meal with staff assist of one. During observation on 1/29/18, at 12:20 p.m., R36 is lying in bed dressed. At 12:31 p.m., R36's lunch tray remains covered in the lunch tray cart. At 12:34 p.m., Nursing assistant (NA)-B brought R36 out of his room to the common area, R36 then wheeled self down hall to exit doors of the unit. At 12:36 p.m., R36's lunch tray still remains covered in the cart and not offered to R36. At 12:39 p.m., R36 remains in his broda chair sitting in the hallway looking at the exit doors. At 12:45 p.m., R36 is sitting in his broda chair by the exit door. The cart holding R36's tray was taken out of the unit and no staff had offered to assist R36 to eat his meal. During observation on 1/30/18, at 5:08 p.m., supper trays are delivered and all covered in the cart next to the dining room. At 5:30 p.m., R36 is wheeled self-down the hallway next to his room towards the exit doors. At 5:38 p.m., R36 remained in Broda chair in the hallway next to his	F 656	all residents to ensure plans of care are up to date to reflect eating assistance, oral care needs, and obtaining weights. 3. The Policy and Procedure for Care Planning remains current. 4. The DON/designee will educate the IDT team on ensuring plans of care are updated at resident changes occur and will educate nursing staff on ensuring the plans of care are followed. Education will occur no later than March 5, 2018. Those staff not in attendance in education sessions due to vacation, illness or casual work status will be educated prior to their next shift worked. Date of completion: 3/18/18 Recurrence will be prevented by: 4. The DON/designee will audit 5 random care plans each week to ensure they are accurate and staff are following the plan of are. Audits will be weekly for 4 weeks and then monthly for 3 months. Results of audits will be discussed by the DON/designee at the monthly QAPI meeting for further review and recommendations on continuing or discontinuing the audits based on the findings. The correction will be monitored by: DON/Designee	

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room. At 5:40 p.m., R36's supper tray was moved from cart to his room bedside table. At 5:44 p.m., nursing assistant (NA)-I stated to R36 are you hungry or thirsty? R36 did not respond. NA-I then walks back towards the lobby. At 5:49 p.m., NA-I returned with thickened chocolate milk and stood over R36 in the hallway and assisted with 2 spoons of the thickened milk. Then NA-I walks away. At 5:54 p.m., NA-C stood in hallway over R36 and offered a spoonful of the thickened chocolate milk. NA-I asks R36, you all done? R36 did not respond and NA-I walks away. At 5:59 p.m., untouched food tray remained covered sitting on bedside table in R36's room. Shortly after this the tray was removed from his room and no one brought R36 to the dining room or encouraged him to eat his meal from the food tray.

During observation on 2/1/18, at 7:43 a.m., the lunch cart with trays is delivered next to the dining room. At 8:27 a.m., R36's breakfast tray remains covered in the cart. At 8:43 a.m., NA-D puts R36's breakfast tray on the counter in the dining room. At 10:49 a.m., R36 continues to be lying in his bed awake. The cart was removed from the room and no staff had encouraged R36 to eat the food provided. Both NA-D and licensed practical nurse (LPN)-B were interviewed shortly after R36's tray was removed from the unit and they both verified R36 has not eaten breakfast.
LACK OF ORAL CARE AS CARE PLANNED:
R281's face sheet included an admission date of 1/6/18, also a diagnosis of altered mental status, urinary tract infection, type 2 diabetes, dementia, and Alzheimer's disease.

R281's oral assessment dated 1/23/18, indicated R281 had a sore area in her mouth and

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encouraged dentures to be removed at night.

On 1/30/18, at 5:55 p.m., during an interview with a family member (FM)-K, stated she had told R281's social worker (SW)-A that R281 had complained about a sore in her mouth. She had been unaware if the facility had addressed the problem.

During an observation on 2/1/18, at 7:11 a.m., R281 was observed to be in bed with her dentures in her mouth. Licensed practical nurse (LPN)-E verified that R281's dentures were not in her denture cup and remained in R281's mouth. LPN-E stated when she was a nursing assistant (NA) the expectation was that the teeth would be brushed and stored overnight unless the care plan indicated not to do this per resident request.

On 2/1/18, at 2:46 p.m., during an interview with the director of nursing (DON), stated that her expectation would be to provide oral care according to the facility policy.

Facility policy dated 1/2014, states that the purpose of the policy included storing the dentures at bedtime.

LACK OF WEIGHTS AS ORDERED:

On 1/13/18 physician orders were received to weigh R281 every Saturday for four weeks.

In a review of R281's electronic health record no weight was recorded during R281's stay at the facility.

On 2/1/18 at 7:18 a.m., LPN-E stated that she was aware of the order for weights. On 1/27/18,

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	245223	A. BUILDING _____ B. WING _____	02/06/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 28 LPN-E was unable to recall why the weights was not completed. LPN-E asked NA-H where the sheet for weights in January are located. NA-H stated she did not know where the sheet was located and cannot recall when it went missing. 2/1/18, at 9:14 a.m., in an interview with nursing assistant (NA)-G she stated she was unable to locate a weight in her nursing assistant electronic health record. During an interview on 2/1/18 at 2:48 p.m., with the DON stated her expectation would be for the staff to weigh residents as ordered. Facility policy, "Care Planning," dated 2009, revised last on Nov 2017, indicated policy: Individual, resident centered care planning be initiated upon admission and maintained by the interdisciplinary team (IDT) throughout the resident's stay to promote optimal quality of life while in residence. 1. Care Plans should be updated between care conferences to reflect current care needs of the individual resident as changes occur. When changes are made in the EHR care plan dates, time and name/initials are automatically entered. IDT members must confer with each other prior to changing interventions that involve multiple departments to avoid miscommunication.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that	F 657		3/18/18

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F 657	Continued From page 29 includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to act on family request for a speech evaluation to see if communication board would increase communication from resident to staff and family for 1 of 1 resident (R40) reviewed for care conference. Findings include: R40's admission form included an admission on 7/14/16 along with with diagnoses of intracranial injury without loss of consciousness, quadriplegia, traumatic brain injury, mild cognition and aphonia (loss of ability to speak through disease of or damage to the larynx or mouth.)	F 657	F657 Care Plan Timing and Revision Immediate corrective action: 1. Resident R40 has been assessed by Speech Therapy. Action as it applies to others: 2. A review of care conferences on all residents in this month will be conducted to ensure any requested services were addressed. The Policy and Procedure on Care Planning remains current. 3. The DON or designee will educate the IDT on ensuring requested services are	

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F 657	Continued From page 30 R40's care plan includes that R40 gestures for responses to questions will respond with a smiles for "yes" no smile means "no." R40's goal is staff to anticipate needs and address them with intervention staff will assist in decision-making as instructed by family or resident. Record review indicated R40 had a care conference on 1/5/18, attendance at the meeting was a registered nurse, social worker, family member(s) and R40. During an interview with family member (FM)-C on 1/30/18, at 5:09 p.m. FM-C voiced concern about last care conference stated they had asked the facility if they can look into other ways to communicate so R40 can voice own concerns as they did a test and found he can understand information. Care conference notes includes the family request to have R40 evaluated for assistive communication devices from therapy. During an interview with speech therapist on 2/1/18, at 2:00 p.m. who indicated the family requested communication device had not been completed. Speech therapy recalled the conversation to have R40 evaluated per family request and family had completed the proper procedure but the evaluation was missed and should have been completed as requested.	F 657	provided. Such services will be discussed at daily Quality Conference each morning and will require follow up by end of day at Quality Wrap up. Date of completion: 3/18/18 Recurrence will be prevented by: 4. The DON/designee will audit each care conference notes to ensure any requested services are obtained and care planned. Audits will be weekly for 4 weeks and then monthly for 3 months. Results of audits will be discussed by the DON/designee at the monthly QAPI meeting for further review and recommendations on continuing or discontinuing the audits based on the findings. The correction will be monitored by: DON/Designee	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced	F 677		3/18/18

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F 677	Continued From page 31	F 677		

by:
Based on observation, interview and document review, the failed to provide assistance with grooming for 1 of 1 resident (R22); provide oral care for 1 of 1 resident (R30); and dining assistance for 1 of 1 resident (R281) who were reviewed for activities of daily living (ADL's) and were assessed to need staff assistance to meet their needs.

Findings include:

LACK OF PERSONAL GROOMING:

R22's quarterly Minimum Data Set (MDS) and assessment dated 11/27/17, identified R22 as severely cognitively impaired and assessed to need 1 assist with personal hygiene.

R22's Medication Review Report dated 2/2/18, indicated diagnoses of traumatic brain injury, cognitive communication deficit, and mood disorder.

R22's care plan dated 10/13/16, identified staff assist of 1 to shave as requested.

During observation on 1/29/18, at 9:02 a.m., R22 was seated on the couch in the lobby of 3 West unit. Dressed in a black t-shirt and gray sweatpants, R22 is noted to have long unshaven facial hairs.

During observation on 1/30/18, at 1:09 p.m., R22 is sitting on the couch in the lobby dressed in a gray long sleeved shirt, green and blue plaid pants and continues to remain unshaved, with long facial hairs.

F677ADL Care Provided for Dependent Residents

Immediate corrective action:

1. Resident R22 was shaved at the time of survey. Resident R30 was provided oral care at the time of survey. No immediate correction could be taken for Resident R281 not receiving dining assistance. Res 281□s care plan has been update to reflect the assistance needed.

Action as it applies to others:

2. Daily Guardian Angel rounds will include checking for facial hair and oral care. The Kardex has been updated to reflect the needs for grooming, oral care, and dinning assistance for all residents.

3. The Policy and Procedure on ADL assistance remains current. The DON or designee will education all nursing staff no later than March 5, 2018 on ensuring residents are shaved, receive oral care and are assisted at meals per their plan of care. Education will include use of the Kardex. Those not in attendance at the education sessions due to vacation, illness or casual work status will have receive education prior to their next shift worked.

Date of completion: 3/18/18

Recurrence will be prevented by:

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F 677	Continued From page 32 During observation on 1/31/18, at 9:35 a.m., R22 is sitting on the couch in the lobby, dressed in a red, short, sleeved t-shirt, gray, blue, and orange plaid pajama pants and continues to be unshaven with long facial hairs noted. During observation on 2/1/18, at 7:19 a.m., R22 is sitting on the couch in the lobby drinking a cup of coffee. Dressed in a red t-shirt with grey long-sleeved shirt underneath, and blue, green, and white pajama pants and remains unshaven. During interview on 2/1/18, at 11:47 a.m., nursing assistant (NA)-D verified R22 needs assistance to be shaved and that she did not have time to do it today because she is the only nursing assistant on the floor. NA-D said R22 has his baths on Sundays and it should have for surely gotten done then. NA-D also said, "You can tell it's been awhile since he has been shaved, we need more staff, that's why things like this do not get done." During interview on 2/1/18, at 11:55 a.m., when asked if he likes to have his face shaved R22 stated, "I like to get shaved!" R22 is observed to rub his chin hairs as he stated this. During observation on 2/3/18, at 10:34 a.m., (two days after bringing the concern of no shaving) R22 is sitting on the couch dressed, hair uncombed and remains unshaven with long facial hairs. During interview on 2/3/18, at 10:43 a.m., licensed practical nurse (LPN)-B verified R22 needs help to be shaved daily and it should be offered daily. Further stated, "He definitely needs to be shaved!" It makes sense when there is only one nursing assistant on, they probably don't	F 677	4. The DON/designee will audit 5 random residents each week to ensure: resident is shaved, receives oral care, and feeding assistance per their plan of care. Audits will be weekly for 4 weeks and then monthly for 3 months. Results of audits will be discussed by the DON/designee at the monthly QAPI meeting for further review and recommendations on continuing or discontinuing the audits based on the findings. The correction will be monitored by: DON/Designee	

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F 677	Continued From page 33	F 677		

have time to shave him.

During interview on 2/3/18, at 2:47 p.m., assistant director of nursing (ADON) stated R22 should have had assistance with shaving if that is what R22 wanted.

During interview on 2/5/18, at 3:10 p.m., when R22 was asked if he got some help with shaving, R22 rubs his chin, smiling and stated, "Oh that looks a lot better, doesn't it? I like it!"

Facility Policy, "Shaving the Resident," dated 2010, revised Jan 2014, revealed the purpose of this procedure is to promote cleanliness and to provide skin care. Notify the supervisor if the resident refuses the procedure.

LACK OF ORAL CARE:

R30's annual MDS dated 12/5/17, identified R30 with an admissiont date of 3/3/16, indicated severe cognitive impairment, and needed 1 person limited assist with personal hygiene. Also indicated dental has obvious or likely cavity or broken natural teeth.

R30's care plan dated 3/5/16, indicated a diagnoses of traumatic brain injury, bipolar disorder and restlessness and agitation. Requires extensive staff assistance with personal hygiene.

R30's, Oral Health Screening Form, dated, 1/23/18, indicated missing most upper front teeth, swollen bleeding gums, and caries. Resident needs staff supervision with brushing teeth twice a day. Dental care referral recommendations indicate routine dental referral. Needs to see a dentist.

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F 677	Continued From page 34	F 677		

Undated Kardex indicated requires extensive assist of 1 staff with personal hygiene.

During observation on 1/29/18, at 3:08 p.m., R30 sitting in a wheelchair in his room and is noted to have several missing teeth.

During interview on 2/3/18, at 10:47 a.m., licensed practical nurse (LPN)-B verified she did not know how to get into R30's care plan and after being assisted to locate R30's care plan she verified that R30's care plan is not updated to reflect his need to have his teeth brushed twice daily with supervision and, "it should be." LPN-B said her expectation would be for R30 to have his teeth brushed twice a day and if it is refused, I would document in the progress notes the refusal.

During interview on 2/1/18, at 2:08 p.m., NA-D stated, "I did not have time to do [R30's] cares today, or brush his teeth, I didn't even attempt it with only me here." Further stated she has told the staff she refuses to go in R30's room by herself for any cares because on 1/4/18, NA-D reports she was the only nursing assistant on the floor that day and she was doing R30's cares and he grabbed her hair and shook her like a rag doll. NA-D added, "I am not having that happen again!" NA-D stated it is not safe to do his cares by yourself.

Facility policy for oral care was requested and was not provided.
LACK OF DINING ASSISTANCE:

R281's admission face sheet included admitted to the facility on 1/6/18. Also diagnosis of altered

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mental status, urinary tract infection, type 2 diabetes, dementia, and Alzheimer's disease.

R281's care plan dated 1/6/18, indicated independence in eating and staff was to observe for changes in ability to eat independently.

During an observation on 2/1/18, at 8:54 a.m., a tray with pancakes, sausage, hot cereal, and a glass milk was placed in front of R281. Staff puts syrup on the pancake and leaves the area. R281 sits with her head down. No attempt is made to feed self. At 9:00 a.m., the staff member comes back, cuts up her pancake, and gives her one bite of food then leaves the table. R281 picks up milk, takes a drink. At 9:02 a.m. staff tells R281 to take a bite and R281 takes a bite of her pancake. At 9:03 a.m., R281 takes a drink of milk. At 9:05 a.m. staff tell R281 to take a bite. R281 picks up her napkin and puts it on her plate. At 9:08 a.m.NA-G pulls R281 from the table and takes her to her room, stating to R281, it is time for you to lay down. NA-G does not ask R281 if she is finished eating or note that she had taken only two bites of food. R281 was at the table for 8 minutes and received verbal encouragement twice during this time.

On 1/30/18, at 5:47 p.m., during an interview with a family member (FM)-D, it was noted that the facility had identified R281 as eating independently. FM-D stated that technically that was true, R281 was physically able to eat independenetly herself but that she no longer did so without encouragement, likely due to her dementia. FM-D did state that there were concerns as R281 had a 13 pound weight loss prior to her being hospitalized. .

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F 688	Continued From page 36	F 688		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a restorative nursing program to include passive range of motion (PROM) was implemented for 1 of 2 residents (R66 and R21), and a hand splint was applied for 1 of 1 resident (R66), reviewed for range of motion. Findings include: R66's quarterly Minimum Data Set (MDS) an assessment dated 1/8/18, indicated R66 with an admit date of 9/22/16, severe cognitive impairment, total dependence for all areas of mobility and functional limitation on one side of upper extremity. Occupational therapy (OT) start date of 9/23/16, and end date of 1/12/17. MDS did not identify a restorative nursing program for	F 688	F688 Increase/Prevent Decrease in ROM/Mobility Immediate corrective action: 1. Residents F66 and R21 are receiving restorative services. No correction could be made for days when service was not provided. Action as it applies to others: 2. A complete review has been completed to ensure all residents needing restorative nursing will have the services provided. A restorative aide has been	3/18/18

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F 688	Continued From page 37 PROM or splint assistance. R66's care plan, dated 1/17/18, identified diagnoses of traumatic subdural hemorrhage, cognitive communication deficit, unspecified intracranial injury, and unspecified lack of coordination. Care plan lacked goals or interventions for PROM program or splint services. R66's physician's telephone order dated 1/12/17, revealed to discontinue OT services secondary to optimum level achieved. Restorative program in place for PROM and orthotic wear. R66's OT therapist progress and discharge summary dated, 1/12/17, revealed Clinical impression: functional progress this week has been significant due to functional maintenance restorative program in place with range of motion program for upper extremities specific to person served and daily hand and wrist orthotic wear for upper left extremity. Appropriate shifts (staff) have been educated on current programs and orthotic pictures for proper hand and wrist placement posted as well as written directions, visuals and daily care plan. Person served tolerates 8 hours for day wear. Summary of skilled services provided: skilled services provided since start of care included care giver education in orthotic wear, schedule, and passive range of motion, allowing for the patient to achieve this improved level of upper extremity skin integrity and contracture management. Facility document dated 1/12/17, "Therapy to Nursing communication," revealed R66 has a passive range of motion (PROM) program-gentle range to patient tolerance see attached instructions. Left hand splint on in the a.m. and off in the p.m. Important to wash hands in between fingers and check skin integrity. Note on the bottom of the document: Nursing please be	F 688	hired for the open position. 3. The Policies and Procedures for the Restorative Program remain current. The DON or designee will education all nursing staff on the requirement that restorative services be provided as described in their restorative plan. Restorative books with each resident receiving services are maintained at the corresponding nursing stations. Education will occur no later than March 5, 2018. Those not in attendance sessions due to illness, vacation or casual work status will be educated prior to their first shift worked. Date of completion: 3/18/18 Recurrence will be prevented by: 4. The DON/designee will audit all residents receiving restorative services to ensure the services are provided per their restorative plan and documented. Audits will be weekly for 4 weeks and then monthly for 3 months. Results of audits will be discussed by the DON/designee at the monthly QAPI meeting for further review and recommendations on continuing or discontinuing the audits based on the findings. The correction will be monitored by: DON/Designee	

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F 688	Continued From page 38	F 688		

sure changes are noted appropriately in care plan and care card.
Review of R66's medical record lacked a physician's order or documentation that the PROM exercises or left hand splint were being provided for R66.
During observation on 1/29/18, at 9:57 a.m., R66 is lying in bed on her back in her bed, dressed in a purple t-shirt, covered with a blanket. Right hand appears contracted.
During observation on 1/30/18, 2:53 p.m., R66 is lying in bed dressed in a red t-shirt, covered with a blanket and watching television.
During interview on 2/01/18, at 2:08 p.m., nursing assistant (NA)-D stated I have no idea who is supposed to get PROM services on this floor, we do not currently have a restorative aide. When we did have a restorative aide, they always got pulled to the floor to work as a nursing assistant because of call in's and short staffing.
During interview on 2/03/18, 10:43 licensed practical nurse (LPN)-B stated I am not sure where I go to figure out who on this floor needs range of motion or not, assistant director of nursing (ADON) should know."
During interview on 2/05/18, at 02:38 p.m., occupational therapy assistant (OTA)-H verified R66 should still have her left hand orthotic in place as well as her range of motion plan to her left upper extremity daily.
During interview on 2/05/18, at 2:59 p.m. trained medication aide (TMA)-B was not aware that R66 wears a left hand splint or receives a PROM program.
During interview on 2/05/18, at 4:32 p.m., physical therapist (PT)-L stated, we depend heavily upon the restorative aide to communicate with us if the residents restorative program is working or not and this is the basis we would use

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

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to reassess a resident for mobility. I heard they just hired a restorative aide, but I am not sure if she has started yet. The restorative aide they had was good, but she kept getting pulled to the floor because of short staffing so it was not getting done. If restorative program is not getting done, it is definitely a staffing issue. If I don't have a restorative aide, I have no one to communicate with in regards to it, so it is hard to assess a resident or to see a decline in someone.
During interview on 2/05/18 at 4:47 p.m., occupational therapist (OT)-F verified R66 should still have her left hand orthotic in place as well as her PROM program to her left upper extremity daily. OT-F stated this was implemented on 1/12/17, and it is needs to be done to maintain mobility and range of motion in her upper extremities. Further stated, "R66 is a vulnerable adult, if the splint is not being used on her left hand it should be documented and I should be notified." OT-F commented, "I can tell you the turnover rate at this building has been astounding!" The facility has not had a restorative aide for about a year, "I feel bad when this isn't getting done." At 5:00 p.m., OT reassessed R66's upper extremity and reports there has been no decline.
During Interview on 2/05/18, at 5:33 p.m., director of nursing (DON) verified order from OT that a PROM program and left splint device should be in place and is not on R66's care plan. DON stated, "If it is not on the care plan, the aides would not be able to do it, so it has not been done."
Facility policy, "Range of Motion Exercises," dated, 2010, revised Jan 2014, indicated the purpose of this policy is to exercise the resident's joints and muscles. Procedures include to verify that there is a physician's order and review the resident's care plan to assess for any special

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needs of the resident. Further indicated to document the date and time the exercises were performed, the name and the title of the individual who performed the exercise, the type of ROM exercise that was given, whether the exercise was active or passive, how long the exercise was conducted. Also indicated to notify the supervisor if the resident refuses the exercises.
Review of facility policy, "Casts, Splints, and other Immobility Devices Monitoring," dated November 2104, does not identify a purpose to wear them. Identified pressure monitoring of the device only.
Facility policy, "Restorative Nursing Program," dated 1/2010, revised January 2018, indicated Restorative Nursing Program refers to nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible. This concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning. Generally restorative nursing programs are initiated when a resident is discharged from formalized physical, occupational or speech therapy.
R21's admission form included a diagnosis of cervical spinal cord injury, quadriplegia and tracheostomy, and admitted 1/7/16.

During resident council meeting on 1/31/18 at 10:04 a.m. R21 voiced concerns she was not receiving her restorative therapies. R21 also said she had sent a grievance several times regarding the lack of nursing rehabilitation services and this was validated by three grievances filed with dates of 9/25/17 to 10/3/17 and 2/5/18.

R21 most current care plan (no date) provided by facility included nursing rehabilitation/restorative. R21 requires assistance/potential to restore function to maximum self-sufficiency and need for

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splints related to loss of muscle strength & flexibility. Goal is to maintain angle of joint contractures. Intervention includes passive left hand exercises daily three repetitions (reps) daily. Lower extremities range of motion done at least four times a week. Task to be completed by rehab/restorative aide or nursing assistant.

Review of restorative treatment record reads nurse to ensure that staff are following care plan; start date of 12/21/16.

R21 care plan intervention flow sheet reads: "NURSING REHAB-Active R [right] hand and passive L [left] hand exercises daily. 3 reps each, daily LE [lower extremities] ROM [range of motion] done at least 4 x a week."
Requested October 2017 restorative schedule and none was provided.
11/2017 scheduled to complete 22 times, 9 times completed.
12/2017 scheduled to complete 21 times, 9 times completed.
1/2018 received "none" (was in hospital 1/4/18-1/23/18)
2/1, 2, 3/2018 scheduled to complete 3 times, received once.

R21 was receiving therapy services on 11/7/17 to able to lean forward in wheel chair and a sit to stand transfer from wheelchair to bed. Therapy ended 1/2/18. A form titled "Therapy to Nursing Communication" dated 12/26/17 reads: Please assist patient with range of motion ex. To both LE x 15 x slowly for slight stretch. Donn (slip into/on)orthotics on both feet CAN BE DONE IN BED OR CHAIR. (A rectangle box outlined with the words "restorative aid", followed by: Please assist patient with range of motion x 15 and hold

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at the end of range with a count of 5. Hips/knees/ankles. Donn foot orthotics. ASSIST PATIENT TO LEAN FORWARD IN W/C AND HAVE HER HOLD FOR AS LONG AS POSSIBLE (AVG 2-3 MIN EACH TIME) X 3. papers attached of pictures showing the actions to be completed.
Therapy screening after return from hospital dated 1/23/18 reads; "pt is at functional baseline after return from hospital. Resume previous restorative nsg program for BLE [bilateral lower extremities] ROM." Unfortunately the newly dated recommendation from the therapy dated 12/26/17, was not updated in the records for nursing to complete.

Interview on 2/5/18 at 4:32 p.m. with Physical therapist (PT)-L stated therapy screens a resident periodically, screening completed by nursing is then updated with therapy to evaluate. Continues to add if a resident is on a restorative therapy for daily cares, the restorative aide would communicate to therapy if there has been any decline or not. Therapy depends heavily on restorative aide to communicate with therapy. Therapy will reassess if needed. PT-L stated the restorative aide gets moved from completing therapy for patients as they are pulled to help on the nursing units. An example is R21, no one has been doing restorative therapy with R21 consistently. PT-L stated, "I didn't know what to tell her when she asked me." PT-L added about a month ago, the director of nursing (DON) said range of motion (ROM) services is a nursing issue. PT-L said if restorative is not getting done, it is definitely a staffing issue. If I do not have a restorative aide, I have no one to communicate with regarding the restorative program. It is hard to assess a patient or see a decline in someone.

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F 688	Continued From page 43 Interview on 2/5/18 at 6:03 p.m. with DON who explained the role of the therapy department if ROM is needed for residents. One hundred percent of residents are screened by physical therapy (PT) occupational therapy (OT) and sometimes speech therapy. Depending on the resident evaluation and recommendation. Therapy will review the Minimum Data Set (MDS) (an assessment) and determine what therapy interventions need to be developed for the resident and these are to be included in the care planning. The recommendations for ROM and nursing restorative therapy services are placed in our computer program under the residents "tasks", "kardex." The kardex is what drives the charting to be completed by aides and any aide can see what needs to be completed. DON verified nursing therapy services need to be completed and would expect designated staff to review the "kardex" for the cares to be completed. Policy review titled "Range of Motion Exercises" dated 1/14 reads documentation for exercises should be recorded in the residents medical record.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 689		3/18/18

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by:
Based on observation, interview and record review the facility failed to comprehensively assess and implement interventions to provide adequate supervision for 1 of 1 resident (R36) assessed for wander guard use and reviewed for accidents.

Findings include:

R36's quarterly Minimum Data Set (MDS) an assessment dated 11/29/17, indicated R36 had unclear speech (slurred or mumbled words), usually makes self-understood, and usually has the ability to understand others, with a moderate cognitive impairment and mild depression. Psychosis, behavior symptoms, rejection of care, and wandering were not exhibited. R36 needs 1 person extensive assist with locomotion on and off the unit. Walking in room and in the corridor did not occur. Diagnoses include: Aphasia (loss of ability to understand or express speech, caused by brain damage), depression, and anoxic brain damage (is injury to the brain due to a lack of oxygen). Wander/elopement alarm not used.

R36's elopement assessment, dated 1/31/18, indicated in Section 1. Criteria: Independent in the community prior to injury and hospitalization. Section 2. Types of wandering: Recreational wandering - wandering based on previous lifestyle. Section 3. Resident Behavior: Talk of leaving (R36) states, "Exit," and points to sign, follows visitors and staff to the door, has psychological concerns and recent loss related to traumatic brain injury (TBI) and loss of independence, and pushes on doors until they open. Section 4. Summary: (R36) is at risk for

F689 Free of Accidents/Hazards/Supervision/Devices

Immediate corrective action:

1. Resident R36 had a wanderguard placed at the time of survey.

Action as it applies to others:

2. All residents with an elopement risk and wanderguard care planned were checked to ensure they had one in place at the time of survey.

3. The Policy and Procedure for Wanderguard use remains current. The DON/designee will educate nursing staff on ensuring wanderguards are in place and signed off as verified in the medical record. Education will occur no later than March 5, 2018. Those not in attendance at education sessions due to vacation, illness or casual work status will be educated prior to their first shift worked.

Date of completion: 3/18/18

Recurrence will be prevented by:

4. The DON/designee will audit all residents with wanderguards each week to ensure device is in place and checks of such are recorded in the medical record. Audits will be weekly for 4 weeks and then monthly for 3 months. Results of audits will be discussed by the DON/designee at the monthly QAPI meeting for further

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F 689	Continued From page 45 elopement. R36 exit seeks and today stated he wanted a cigarette, has impaired cognition, poor impulse control and lack of safety awareness, not aware he should have a coat on to go outside. Brief interview mental status (BIMS) score of 8 indicated moderately impaired on 11/29/17. Section 5. If resident is identified as an elopement risk complete the following environmental assessment: all doors are alarmed/and or have some type of wanderguard system, R36's room is 2 rooms from unit exit, R36's room is 2 doors down from the nursing station, grounds are easily visible from the facility, grounds are well lit, facility is on or near a busy street, there are woods, hills and water on the grounds, and public transportation is available near the facility. Based on the above assessment, care plan intervention needed for this resident is wanderguard and accutech in place. Resident requires staff assist/supervision/supervision off the unit. R36's care plan dated 11/29/17, indicated I (R36) would like my safety needs anticipated for me and met by staff. I live in a secured unit due to my safety needs related to wandering. My continued need for this unit will be evaluated quarterly. I will have a wanderguard (device applied to patient that notifies staff with an alarm going off if a resident tries to leave the building) and accutech (device applied to resident that notifies staff with an alarm going off if a resident tries to leave the unit,) and staff will check that I have the devices on every shift, night shift will check to ensure that they are functioning. R36's physician's orders dated 12/14/17, indicated an order date of 11/28/17, to change wanderguard every 90 days and prn (as needed);	F 689	review and recommendations on continuing or discontinuing the audits based on the findings. The correction will be monitored by: DON/Designee	

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document location. Check placement of wanderguard placement every day and p.m. shift. Check wanderguard function every night shift.

R36's progress note dated 9/26/17, at 12:59 p.m., General Note Text: Resident was moved to 3E. This was due to elopement risk assessment completed today. Resident has entered the elevator and has been found on other units as well as attempting to leave the facility. Resident was agreeable to the move. Resident had wanderguard placed on right ankle and accutech placed on left ankle.

During interview on 1/30/18, at 1:13 p.m., nursing assistant (NA)-B verified R36 does not have a wander guard on himself or his broda chair, "He should have one" they stated.

During interview on 1/31/18, at 9:54 a.m., upon query if R36 has ever made it to the main entrance before, licensed practical nurse (LPN) B stated well a couple days ago, I know he made it out the door of the unit. "You wouldn't think he would be able to wheel that broda chair himself, but you would be surprised at how strong he is, he has long arms, and he is able to open that door and get out." After the alarm from the accutech goes off, the door will release and it is able to be opened and he can get out. Further interview at 10:27 a.m., when LPN-B was queried about R36 leaving the unit last night to get to second floor, LPN-B stated, I did not hear it in shift report this morning, "but I should have." LPN-B verified it was not documented in the progress notes. Subsequent interview at 11:12 a.m., LPN-B verified R36 does not have wanderguard on him or his broda chair. If R36 left this unit and got in the elevator to go down to

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the 2nd floor main street entrance, he could make it out the front doors without the wanderguard on. (The wanderguard when near the front doors has an alarm that sounds alerting staff to check the doors for a possible elopement). LPN-B stated, "[R36] is supposed to have a wanderguard on his wheelchair."
During observation on 3 east Unit on 1/31/18, at 11:14 a.m.,

During interview on 1/31/18, at 11:27 a.m., ADON verified wanderguard is not on R36 or his broda chair and stated, "He should have one!" At 11:30 a.m., ADON stated the care plan should be followed to have the wanderguard in place and staff should be checking for placement every shift.

During interview on 1/31/18, at 11:32 a.m., director of nursing (DON) verified R36 does not have a wanderguard on and further verified it is on his care plan. DON fastened a wander guard to his wheelchair at this time and alarm immediately started alarming as R36 remained parked in front of the main entrance doors next to the 2 West unit.

Facility policy, "Wanderguard," dated Aug 2006, revised last on Oct 2016, revealed upon admission and periodic reassessment, residents will be screened for the behavior of wandering to determine if a resident is a t risk for wandering from the facility and at risk for harm secondary to wandering. It is determined upon admission assessment, and/or by the interdisciplinary team, and/or the resident's family, that a resident may wander form the facility and be subject to elemental harm, a wanderguard alarm bracelet will be placed on the resident's wrist. 6. Testing

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F 689	Continued From page 48 of wanderguard signaling device will be completed daily, on the night shift, by a licensed nurse and visualized every shift for placement.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to	F 690		3/18/18

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F 690	Continued From page 49 restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely assistance with incontinence cares for 1 of 4 residents (R55) observe for incontinence cares. Findings include: R55's quarterly Minimum Data Set (MDS) dated 12/27/17, indicated R55 had diagnoses including anoxic brain damage and cognitive communication deficit. The assessment indicated R55 displayed severe cognitive impairments, required 2 person extensive assistance with toileting and always incontinent of bowel and bladder. R55's care plan dated 1/11/18, revealed R55 to be incontinent of bowel and bladder and needs 1 assist to check and change incontinence brief every 2-3 hours and as needed. Undated, facility document, Visual/Bedside Kardex Report, indicated R55 needed 1 assist to check and change incontinent brief every 2-3 hours and as needed. On 1/29/18, at 10:16 a.m., R55 is sitting in his broda chair in the lounge during a music activity. During interview on 1/29/18, at 10:39 a.m., nursing assistant (NA)-B stated everyone here needs to be toileted every 2 hours, when there is just one nursing assistant working the floor, I get late with doing that. "I do the best I can."	F 690	F690 Bowel/Bladder Incontinence, Catheter, UTI Immediate corrective action: 1. Resident #55 received incontinence care as soon as the discrepancy was identified. Education on incontinence care required was provided to nursing staff on the resident□s unit at the time of survey. Action as it applies to others: 2. All residents who require assistance with toileting needs will be reviewed to assure their care plans accurately reflect their needs. 3. The Policy and Procedure on Incontinence Care remains current. The DON/designee will educate all nursing staff on the ensuring resident□s toileting needs are provided per their plan of care. Education will occur no later than March 5, 2018 and those not in attendance due to illness, vacation or casual work status will be educated prior to their first shift worked. Date of completion: 3/18/18 Recurrence will be prevented by: 4. The DON/designee will audit 5 random residents to ensure their toileting needs	

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F 690	Continued From page 50 On 1/30/18, at 5:28 p.m., R55 is sitting up in his broda chair up to the table in the dining room assisted with eating supper by NA-C. During interview on 2/1/18, at 2:08 p.m., NA-D- I usually work on 3 east unit 3 times a week, and usually I am working by myself with no other nursing assistant on the unit because we are always short staffed. Residents with incontinent needs are not getting changed timely. Like today with working by myself, I was unable to get R55 changed, "It's been a good 5 hours, I did pass that information on to the next shift." During interview on 2/1/18 at 3:46 p.m., licensed practical nurse (LPN)-C verified NA-D reported that R55 was not changed for over 5 hours because of short staffing. Further verified when R55 was changed his incontinent brief was, "saturated." LPN-C confirmed there is one nursing assistant on the secured unit this shift and R55 should be assisted with incontinent care every 2-3 hours and as needed per the care plan. Further confirmed working on the secured unit one time every two weeks and stated, "We usually have one nursing assistant up here not 2." Policy on incontinence care was requested and not received.	F 690	are provided per their plan of care. Audits will be weekly for 4 weeks and then monthly for 3 months. Results of audits will be discussed by the DON/designee at the monthly QAPI meeting for further review and recommendations on continuing or discontinuing the audits based on the findings. The correction will be monitored by: DON/Designee	
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must	F 692		3/12/18

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F 692	Continued From page 51 ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure 1 of 2 residents (R36) who experienced harm, a significant weight loss, had consistent assistance with eating and consistent monitoring of food/fluid intake and weights. Findings include: R36's medical record indicated the resident had been admitted to the facility on 8/29/17 with multiple diagnoses including: head injury, anoxic brain damage (is injury to the brain due to a lack of oxygen), aphasia (loss of ability to understand or express speech, caused by brain damage), agitation and depression. The quarterly Minimum Data Set (MDS) assessment dated 11/29/17, indicated R36 was 30 years old, suffered from aphasia (loss of ability to understand or express speech, caused by brain damage), and depression. The MDS also indicated R36 was totally dependent on assist of 1 with eating,	F 692	F692 Nutrition/Hydration Status Maintenance Immediate corrective action: 1. Staff were verbally educated at the time of the survey on Resident R36□s missed weights and need for assistance at mealtime. Resident R36 family has opted to place resident on Hospice Services as of 2/23/18 due to his overall health decline. Action as it applies to others: 2. All resident weights have been reviewed to ensure they are obtained per RD recommendations/MD order. 3. The Policy and Procedure on Measuring and Weighing the resident and the Unplanned Weight Loss policy remain	

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F 692	Continued From page 52 weighed 173 pounds, had experienced no weight loss in the last 6 months, and required a feeding tube. The resident's care plan, printed 1/31/18, indicated focus areas related to his Nutritional status with ideal body weight (IBW) of 143-188 pounds, pulling his feeding tube out when frustrated, an inability to feed himself without assistance, and a need to be adequately hydrated including 2350 cc of fluid daily. The goals included: "I would like to maintain a stable weight within my IBW (ideal body weight)...I would like to continue to improve my eating abilities...I would like to stay well-hydrated and not suffer thirst or dehydration." Staff interventions included: "...monitor me for changes in intake per MDS schedule or as requested,. Monitor me for weight changes, and further evaluate causes as needed...Staff feed me fluids from a spoon per SLP (speech language pathologist) orders. Staff of 1 provides escort to dining room, meal set up/assistance to apply condiments, pour liquids, season food, and identify foods on plate/available as alternatives. Staff of 1 totally feed me, providing small bites, alternating with sips of liquids. Staff allow adequate time for me to swallow and clear my mouth. Staff observe for choking or signs of aspiration and futher evaluate. Evaluate fluid needs, per MDS schedule or as requested. Staff provide fluids of my choice throughout the day. I am able to have thin liquids between meals but at meals my liquids need to be honey thick per SLP." R36's physician orders dated 9/3/17 indicated the resident's enteral (tube feeding) feeding order included: One time a day Isosource 1.5 130 ml (milliliter)/hour x 12 hours via j-tube (a tube	F 692	current. The DON/designee will educate nursing staff to ensure weights are obtained per order and recorded in the medical record, as well as review of the weight policy. Education will also be provided regarding ensuring residents are assisted/cued to eat per their plan of care. Education will occur no later than March 5, 2018. Those staff not in attendance due to illness, vacation or casual work status will be educated prior to their first shift worked. Date of completion: 3/12/18 Recurrence will be prevented by: 4. The DON/designee will audit 5 residents per week to ensure weights are obtained and recorded and residents who require assistance with eating are assisted per their plan of care. Audits will be weekly for 4 weeks and then monthly for 3 months. Results of audits will be discussed by the DON/designee at the monthly QAPI meeting for further review and recommendations on continuing or discontinuing the audits based on the findings. The correction will be monitored by: DON/Designee	

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placed through the skin of the abdomen into the midsection of the small intestine). Flush with 60 cc (cubic centimeters) water before and after TF (tube feeding) administration...One time a day stop tube feeding total ml 1500."

Progress notes dated 12/15/17, at 5:32 p.m. indicated only speech therapy staff were to assist R36 with oral eating, and that otherwise staff should continue with the prescribed tube feeding.

Progress notes dated 12/18/17, at 9:14 a.m. included: "This writer was notified by staff around 0630 this morning that resident had pulled out his g-tube. This writer went into resident's room and asked resident why he did it and when. Resident stated that he wanted to eat and that he took it out around 5 a.m. This writer talked with 2 East nurse...and she came up to put a new tube in resident, which was successful. Resident continued to pull out two more tubes. At this point, resident is stating that his stomach hurts. This writer talked with both unit managers when they arrived today and explained the situation and it was decided that instead of continuing to put in tubes and have resident pulling them out and hurting himself; we would wait to hear back from Dr (doctor) who has been notified via text and phone call." At 10:32 a.m., the licensed practical nurse documented, "...spoke with Dr...about resident pulling out his g-tube. Dr...has ordered a swallow eval..which has been done. Resident is now on puree diet with nectar thickened liquids. This writer was also instructed to put a new g-tube in resident and educate resident on the negative effects of pulling out tube. This writer has spoken with resident and told him what the doctor said and resident stated that he didn't care what the doctor said and that if this writer puts

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another tube in, he will just take it out." At 10:50 a.m., the LPN documented she had attempted to insert another g-tube but the resident had swung at her, refusing. At 12:24 p.m., the LPN documented: "This writer has inserted the fourth g-tube today and resident has pulled it out again. This writer has contacted Dr...and is waiting for response as to what he would like me to do next." At 3:27 p.m., a dietary note indicated, "In addition to the upgrade speech therapy would like thin water between by spoon. All liquids by spoon..."

Progress notes dated 12/19/17 included: 3:06 p.m. "Resident is compliant with writer replacing G-tube. Attempted three times without success. Updated PCP (primary care physician) and was advised to send to GI (gastro intestinal) clinic before they close ED (emergency department. Will continue to monitor." At 4:10 p.m. "IDT (interdisciplinary team) met to discuss resident. In attendance were social service, dietician, recreational therapy, and OT (occupational therapist). It has been reported resident has behaviors lately where he was pulling out his feeding tube. Because he won't keep the tube in it was decided to monitor his intake to see if it would be enough. Social service talked to ACP (associated clinic of psychology therapist) to see if she would be able to see him on her rounds today. She was able to but resident refused to communicate with her." However at 4:24 p.m. an LPN documented, "Resident [to] ED for G-tube placement. Will continue to monitor." An entry at 7:58 p.m. included "Returned from ED at 1945 (7:45 p.m.). GT (G-tube) placed. No behavior noted."

A progress note dated 12/20/17 at 5:37 p.m., included "Tube feeding has been Dc'd

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(discontinued). Receives pureed diet with honey thick liquids."

A progress note dated 12/22/17 at 8:05 p.m. indicated "resident is on feeding tube and soft diet..."

A progress note from 12/23/17 at 8:41 p.m. included: "...Became agitated. Yelling out attempting to grab me or hit me when I attempted to hook feeding up."

On 12/27/17 at 7:03 p.m., "Refused feeding (tube feeding). Consumed 100% of supper"

On 1/3/18 at 7:05 p.m., "Refused feeding (tube feeding). Ate 100% of supper.

The dietician's progress note dated 1/5/18, at 9:45 a.m. included, "wt (weight) trending up since initiation of the oral diet. Per MAR (medication adminsitration record), tube feeding has been primarily on hold. Recommend putting in on hold for now to see if person served can meet needs via PO (oral) intake only. Recommend increasing water flushes since he is no longer getting the fluid from the TF and is on honey thick liquids. Recommend fluid intake monitoring q (every) shift to get a more accurate picture of his PO intake of fluids. Recommendations passed on to MD (medical doctor) inbox for review."

A progress note dated 1/9/18, at 8:47 p.m., indicated R36 had again pulled out his feeding tube, and attempts to reinsert had failed. "...took all his meds orally. Dr...was notified. Refused supper tonight."

A progress note dated 1/11/18 at 1:54 p.m.

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included, "person served (R36) pulled his tube out a couple of days ago. MD advised to leave it out. RDN (dietician) will update care plan."

A progress note dated 1/22/18 at 1:16 p.m. included "Weight monitoring 2 x/wk one time a day every Mon, Thu (Thursday). Person served (R36) refused to get out of bed this shift."

A progress note by the dietician, dated 1/24/18 at 1:55 p.m. included, "RDN and CDM (certified dietary manager) have requested updated wt on multiple occasions r/t (related to) recent wt being down significantly from previous wts. Will continue to await reweigh an further evaluate need for intervention upon its completion."

Review of data identifying how much food/fluid R36 consumed was reviewed. The data from 1/13/18 to 2/4/18, revealed R36 had refused liquids at 20 meals, and had an overall average oral intake of fluids of 287 cc per day. Data from 1/23/18 to 2/4/18, indicated R36 had eaten 0-25% for 8 meals, 25-50% for 4 meals, and 75-100% for 2 meals. The documentation also indicated R36 had refused-14 meals during this timeframe and was unavailable for 1 meal.

During observation on 1/29/18 at 12:20 p.m., R36 was observed in bed, fully dressed. At 12:31 p.m., R36's lunch tray remained covered in the lunch tray cart. At 12:34 p.m., nursing assistant (NA)-B was observed to bring R36 out of his room in a Broda chair (special wheelchair) to the common area, and R36 wheeled himself-down the hall towards the exit doors of the unit. At 12:36 p.m., R36's lunch tray still remained covered in the cart. At 12:39 p.m., R36 remained in his chair sitting in the hallway looking at the exit

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doors. At 12:45 p.m., R36 was observed still sitting in his chair by the exit door, and the door alarms were sounding. At that time, a therapy staff was observed to wheel R36 out the door to go to therapy. No one was observed to have offered or assisted R36 with his lunch tray.

During interview on 1/30/18, at 12:15 p.m. NA- B stated it was hard to get everybody fed because she is the only nursing assistant on the floor. NA-B stated "there are 3 people that are completely dependent with feeding", and added, [R36] "has been refusing his lunch lately, I am not sure what is up with that."

During interview on 1/31/18, at 9:30 a.m., NA-B stated NA-E had been reassigned that morning, so NA-B was again the only nursing assistant on the unit. NA-B stated, "I have [LPN-B] to help me, I will try to get [R36's] weight when she can help me.

During interview on 1/31/18, at 10:27 a.m., LPN-B verified R36 is supposed to be weighed twice a week per order, "on Mondays and Thursdays." LPN-B also stated, "Unfortunately is not consistent, it depends on staffing, we have one aide up here, and when they are short they always take from this floor, even though this is not the floor to be doing that from...so that is why weights do not get done like they should."

During observation on 2/1/18, at 7:43 a.m., the cart with trays was delivered next to the dining room. At 8:27 a.m., R36's breakfast tray remained covered in the cart. At 8:43 a.m., NA-D put R36's breakfast tray on the counter in the dining room. R36 was not observed to be offered his breakfast tray. At 10:49 a.m., R36 was lying

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in his bed awake. NA-D and LPN-B both verified R36 had not been offered breakfast.

During interview on 2/1/18, at 12:39 p.m., NA-D verified R36 receives a pureed diet and requires assistance with eating. When observed, NA-D assisted R36 to eat his spaghetti, carrot cake, ½ orange juice, cranberry juice, yogurt, half of the applesauce he'd been served, and a chocolate milk. Following the meal, when asked how he felt after eating, R36 nodded his head up and down.

During interview on 2/1/18, at 12:42 p.m., LPN-B stated it had been a trend that R36 was fed last. LPN-B stated, "if we had more staff on the floor, we would have more time to feed people. We used to have a seating chart to indicate where people sat, but that has been gone for about a year or so. When we get another staff who is not familiar with this floor up here, there is nothing to show them who sits where and to tell them who eats meals in their rooms."

During interview on 2/1/18, at 1:17 p.m., unit manager (UM)-J stated R36 had experienced a weight loss, and also stated staff were not always monitoring his weight 2 times a week because there was not a scale on his living unit. UM-J stated, "[R36] has to go to the other unit, 3 west, and he never seems to make it there because he sees the elevator and wants to get on it." UM-J confirmed R36's weights should be monitored and recorded consistently so the dietician could accurately assess his nutritional needs, especially since the removal of his feeding tube and initiation of an oral diet.

R36's weights were reviewed from a Weights and Vitals Summary document, and the Treatment

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Sheets. The weights were not consistently taken twice a week, and were not taken in a consistent manner. Weights included:
9/5/17 167# (weight in wheelchair)
9/14/17 168# (weight in wheelchair)
9/22/17 167.8# (weight in wheelchair)
9/25/17 169.6# (weight in wheelchair)
10/4/17 172.8# (no indication of how weighed)
11/9/17 171.8# (weight in wheelchair)
11/22/17 173.4# (no indication of how weighed)
12/7/17 175.3# (weight in wheelchair)
1/4/18 182.4# (weight in wheelchair)
1/8/18 179.9# (weight while standing)
1/29/18 175.5# (weight while standing)
2/1/18 160.6# (weight by Hoyer)
2/5/18 165.2# (weight in wheelchair)

During a phone interview on 2/1/18 at 4:17 p.m., dietician (D)-M stated R36 had been started on weights twice a week because they were not getting documented timely. She stated, "He [R36] needs to be weighed more than what they have been doing." D-M further stated she thought a Hoyer weight would be the most accurate, and verified staff had not been consistently using the same scale to weigh the resident, so any actual weight loss may be difficult to determine. D-M stated, "Going forward R36 needs to have his weights done as ordered, at the same time of the day with the same scale." When D-M was informed of the Hoyer weight recorded 1/30/18 at 160.6 pounds, she stated she would reassess, add supplements, call and notify the doctor and go from there due to the resident's weight loss since his feeding tube had been removed 1/9/18.

The facility's policy Weighing and Measuring the Resident revised March 2014, indicated to obtain weight properly and record accordingly. "To

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F 692	Continued From page 60 determine the resident's weight, to provide a baseline and an ongoing record of the resident's body weight as an indicator of the nutritional status and medical condition of the resident...5. When you weigh the resident, you should: measure the resident's weight at the same time of the day, use the same scale for measuring the resident's weight each time it is measured, and with the resident wearing the same amount of clothing each time. 6. be sure the weight scale is balanced to zero. Report any significant weight loss/gain to the nursing supervisor. Notify the nurse supervisor if the resident refuses the procedure. Physician to be notified if weight gain/loss meets criteria above." The facility policy Nutrition Unplanned Weight Loss Clinical Protocol revised Mar 2014, indicated nursing staff should monitor and document the weight and dietary intake of residents "in a format which permits readily available comparison's over time... 3. a. 1 month-5% weight loss is significant; greater than 5% is severe." In addition, the protocol included: "Monitoring: The physician and staff will closely monitor residents who have been identified as having impaired nutrition or risk factors for developing impaired nutrition. Such monitoring may include: evaluating the care plan to determine if the interventions are being implemented and whether they are effective in attaining the established nutritional and weight goals."	F 692		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with	F 725		3/18/18

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F 725	Continued From page 61 the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) 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: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure sufficient staffing was provided to meet all residents assessed needs and services which included self-determination for 1 of resident (R36); Activities of daily living for 4 of 4 residents (R22, R30, R36 & R281); Range of motion services for 2 of 2 residents (R66, & R21); Nutritional needs for 1 of 2 residents (R36); This practice had the potential to affect all 86 residents who resided in the facility.	F 725	F725 Sufficient Nursing Staff Immediate corrective action: 1. Staffing level are reviewed and adjusted as needed. (See F677 and F692 for further corrective actions) Action as it applies to others: 2. Staffing levels are reviewed and adjustments made per unit based on	

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F 725	Continued From page 62 Findings include: See 677- Activities of daily living cares for dependent resident: the facility failed to provide assistance with shaving for 1 of 1 residents (R22), provide oral care to 1 of 1 residents (R30), ensure good nutrition was provided for 1 of 1 residents (R36), and dining assistance for 1 of 1 residents (R281) reviewed for activities of daily living (ADL's) and who were dependent upon staff for care. See 692- Nutrition: the facility failed to ensure a resident was assisted with nutrition to maintain good nutritional status for 1 of 2 resident (R36) reviewed for nutrition. STAFF CONCERNS: During interview on 1/29/18, at 11:23 a.m., licensed practical nurse (LPN)-D stated, "The staffing here [working 3 east unit] is horrible." That is why it is my last day here today. Nursing assistant (NA)-B works in this unit a lot by herself and then most of the time with a trained medication aide (TMA), and not even a nurse. This is definitely a floor you need to have a nurse on. Staff here either don't show up or they just call in. You can only get so much done when you are short staffed all the time. "Oh yeah, there are lots of things that don't get done when we are working short, (shaving, nail care, and even oral care), I hate to say it, it's sad." During interview 1/29/18, at 2:49 p.m., NA-C who was working on 3 east unit stated. "I am the only aide on for tonight because we had a no call/no show and our nurse for the night is [TMA-B]. We are running around ragged here. I don't think the	F 725	census and acuity. A new scheduler has been hired as of 2/1/18 and the facility has an active recruitment plan which includes sign on bonus, referral bonuses, and bonus pay for staff working extra shifts. Date of completion: 3/18/18 Recurrence will be prevented by: 3. Staffing levels will be reviewed and adjustments made as necessary. The Administrator/Designee will meet with the scheduler to review staffing each morning in/prior to Quality Conference. The Administrator will have weekly calls with the recruiter and update recruitment and retention plans as necessary. This will be an ongoing process as long as needed. Staffing will be discussed at resident council meetings as well as all staff meetings to keep residents and staff informed of recruitment and hiring updates. The correction will be monitored by: Administrator/Designee	

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facility takes into consideration the resident's behaviors we have here on this unit. Like right now if I had a resident break out of the unit, I wouldn't be able to do anything. I would say 5 out of 7 days I work, as the only aide up here on this unit. It's not safe for the residents, and it's not safe for us. Some things that do not get done when we are short staffed include: showers get missed once or twice a week and charting does not get done. I also think we have more falls from being short staffed, like earlier we just had [R30] fall. Half the residents up here need help with toileting and there is no way to get to them all every 2 hours like you are supposed to with one aide on the floor. I have worked here for 12 years and this [staffing] is the worst it has ever been."

During interview on 1/31/18 at 10:27 a.m., LPN-B stated the weight in R36's chart for 1/30/18, is 218 pounds and is incorrect, that is a different resident's weight and must have got put in there by mistake. LPN-B verified R36 is supposed to be weighed twice a week per order on Mondays and Thursdays. "That unfortunately is not consistent, that depends on staffing, we have one aide up here, and when they are short they always take from this floor, this is not the floor to be doing that from, it is not safe, so that is why R36's weights do not get done like they should." When LPN-B was queried about R36 leaving the unit last night to get to second floor unsupervised, LPN-B stated, I did not hear it in shift report this morning, "but I should have." LPN-B verified it was not documented in the progress notes. "I am so scared someone here is really going to get hurt." There has been several times when NA-B has worked by herself, and at times was scheduled by herself. "It ultimately hurts the residents, and we (staff) are emotionally stressed

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over it!" On 1/4/18, I was working with one aide on the floor, (NA-D) got attacked by (R30), I was in the office trying to get my charting done. I made a progress note on it. "It was not safe!" We also had 4 people to feed that day, it was done untimely. "It is unsafe for us and the residents!" We have 3 people that require 2 assist and a Hoyer lift and several others that require 2 people assist. I would say 8 people total for 2 person assist, with one aide on the floor, "We are late a lot." One time when I was the nurse on 3 West, we had TMA's for 3 East and 2 East, and I had to do all of the insulins and the charting for 3 different units. "It just can't all be done!" I have tried to bring up our staffing issues with the union stewards and administration, and "Nothing gets done, I absolutely do not feel it is safe!" For evening shift it is pretty standard to have 1 TMA and one aide, (NA-C) works the floor herself a lot for the evening shift. "I am sure we do have residents who wet and soil themselves, we do not have enough staff to toilet everyone every 2 hours like we are supposed to and these residents on this unit all have brain injuries, half of them can't tell you anyways if they have to go to the bathroom or not.

During interview on 1/31/18, at 12:49 p.m., NA-B verified when R36 was down on 2nd floor earlier he wanted to go outside. Further verified she was the only nursing assistant working the 3 east unit, and could not leave the rest of the residents to go get a jacket and hat to take R36 outside. NA-B stated, "This is why we need two aides on this floor." Further stated we do not have time to do 1:1 with these residents when they need to be redirected for their behaviors, it's impossible. "I am doing the best that I can."

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During interview on 2/1/18, at 7:25 a.m., LPN-B stated it is me and NA-D for staff today on this secured unit, "that is it." LPN-B stated we have to weigh our people on the 3 West unit scale because we do not have a scale over here. "We never have as far as I know" regarding a scale on 3 east unit. It is hard to get a weight on R36 because we have to go through the secured doors, then when R36 sees the elevator which is located just outside the door to the unit R36 is adamant on going down stairs to the second floor which exits the building. We never end up getting him on the 3 West unit to get weighed because of his behavior of wanting to go outside.

During interview on 2/1/18, at 8:17 a.m., NA-D stated she is the only aide on the secured unit for the day and she said she still had 4 residents to get out of bed. Half the residents do not get the help they need because we are not staffed for it. For example: resident R22 needs help with washing up, shaving and changing his clothes, but no one ever does because we are always working short, also R30 needs help washing up and getting teeth brushed. I refuse to go in there by myself because when we worked short on 1/4/18, I was in helping him and he grabbed me by my hair and shook me like a rag doll. I was screaming for help, but the only other staff was LPN-B and she was in the office charting and she couldn't hear me. The resident finally let go of my hair. NA-D then said she was here for the resident's, but the facility sure isn't, they do not care about their employees or their residents. "It's dangerous working here for everyone." Everyone here is running around because state is here, and I say, they can see what really happens. We still work short, imagine how short we work when you are not here (in reference to

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having state surveyors in facility). Subsequent interview on 2/1/18, at 2:08 p.m., NA-D stated she works the unit on 3 East three times a week and stated she is usually the only aide on with a medication nurse/TMA. Things that do not get done because of the short staffing are: turning and repositioning residents, toileting residents timely, residents not getting out of bed timely, shaving, brushing teeth and restorative therapy. We do not currently have a restorative aide. When we did have a restorative aide they were frequently pulled to help on another unit due to being short staffed. Some of the aides take short cuts like when they are changing someone's incontinent brief they don't wash them up, they just slap another one on them. We used to have a kardex (is a quick summary of individual patient needs that is updated at every shift change), that would tell us our assignments now I have no idea. We get shift report from the aide and they write it on a report sheet, that is how I know what to do for the day, or the nurse will tell me.

During interview on 2/1/18, at 3:46 p.m., LPN-C stated he works the secured unit (3 East unit) one time every two weeks and stated, "we have one aide usually, not two of them up here." LPN-C verified he only has one aide on the floor for this shift.

During interview on 2/3/18, at 10:43 a.m., LPN-B verified R22 needs help to be shaved daily and it should be offered daily. Further stated, "He definitely needs to be shaved!" It makes sense when there is only one nursing assistant on, they probably don't have time to shave him. Further stated, I am not sure where I go to figure out who on this floor needs range of motion or not, assistant director of nursing (ADON) should

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know." Subsequent interview at 10:47 a.m., LPN-B stated, "I know the aides have struggles with finding the kardex (is a quick summary of individual patient needs that is updated at every shift change), and I am not sure how to get into a resident's electronic care plan."

During interview on 2/5/18, at 3:09 p.m., TMA-B verified it is just her and NA-C on the 3 east unit for the evening shift.

During interview on 2/5/18, at 4:32 p.m., physical therapist (PT)-L, stated, we depend heavily upon the restorative aide to communicate with us if the residents restorative program is working or not and this is the basis we would use to reassess a resident for mobility. I heard they just hired a restorative aide, but I am not sure if she has started yet. The restorative aide they had was good, but she kept getting pulled to the floor because of short staffing so it was not getting done. For example with R21, she complained to me about her restorative program not being done, so I asked the director of nursing (DON) and she told me to tell her that doing range of motion is a nursing issue. This was about a month ago. If restorative program is not getting done, it is definitely a staffing issue. If I don't have a restorative aide, I have no one to communicate with in regards to if therapy is affective or not, which makes it hard to accurately assess a resident for improvement or decline.

During interview on 2/5/18 at 4:47 p.m., occupational therapist (OT)-F verified R66 should still have her left hand orthotic in place as well as her passive range of motion (PROM) program to her left upper extremity daily. OT-F stated this was implemented on 1/12/17, and it needs to be

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F 725	Continued From page 68 done to maintain mobility and range of motion in her upper extremities. Further stated, "R66 is a vulnerable adult, if the splint is not being used on her left hand it should be documented and I should be notified." OT-F commented, "I can tell you the turnover rate at this building has been astounding!" The facility has not had a restorative aide for about a year, "I feel bad when this isn't getting done." At 5:00 p.m., OT reassessed R66's upper extremity and reports there has been no decline even though the therapy program had not been done as required. During interview on 2/6/18, at 1:54 p.m., director of nursing (DON) stated, we staff the building based on acuity and census. So, for example, with the census of 80-84 we would absolutely need 9 aides and 5 nurses/TMA on every day and evening shift. Need 6 aides and 3 nurses for night shifts. That is how the schedule is sent out. When there is a call-in we follow the policy. Once an absence is identified, staff call the scheduler, and they have the option to text each other. On 3 west there is a list of all employees with their phone numbers. We had a 2 week gap between our old scheduler and our new scheduler. Our new one just started on 2/1/18. " I have had grumbling verbally about the staffing, I follow the policy." A policy related to sufficient staff was requested, however none was provided.	F 725		
F 741 SS=G	Sufficient/Competent Staff-Behav Health Needs CFR(s): 483.40(a)(1)(2) §483.40(a) The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to	F 741		3/12/18

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F 741	Continued From page 69 provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with §483.70(e). These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for: §483.40(a)(1) Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to §483.70(e), and [as linked to history of trauma and/or post-traumatic stress disorder, will be implemented beginning November 28, 2019 (Phase 3)]. §483.40(a)(2) Implementing non-pharmacological interventions. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure staff were trained/skilled to respond to unwanted behaviors exhibited by 1 of 1 resident (R36), so as to help the resident maintain his highest psychosocial well-being. The staff failure to implement therapeutic interventions for R36 caused actual harm, agitation and distress, exhibited by the resident's screaming, crying, and resistance to movement. Findings include:	F 741	F741 Sufficient/Competent Staff-Behav Health Needs Immediate corrective action: 1. Resident R36 is being assisted outside as he desires. Action as it applies to others: 2. All Resident care plans will be reviewed to identify any residents who	

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F 741	Continued From page 70 R36's medical record indicated the resident had been admitted to the facility on 8/29/17 with multiple diagnoses including: head injury, anoxic brain damage (is injury to the brain due to a lack of oxygen), aphasia (loss of ability to understand or express speech, caused by brain damage), agitation and depression. The quarterly Minimum Data Set (MDS) assessment dated 11/29/17, indicated R36 was 30 years old, suffered from aphasia (loss of ability to understand or express speech, caused by brain damage), and depression. The MDS also indicated R36 had unclear speech (slurred or mumbled words), but was usually able to make himself-understood, usually had the ability to understand others, and had moderate cognitive impairment. In addition, the MDS indicated R36 required 1 person extensive assist with locomotion on and off the unit, and received antipsychotics and antidepressants daily. R36's medical record indicated he received services from the Associated Clinic of Psychology (ACP), a clinic to help manage mental health care for clients in all stages of life. An ACP visit summary dated 10/24/17, included recommendations related to aggressive behaviors R36 exhibited including: "may benefit from staff moving slowly, speaking in a calming voice, and reproaching as needed when increased agitation is noted, rather than trying to complete care when resident is agitated." Recommendations to treat mood symptoms included: "client will continue to benefit from staff support, kindness, patience, and reminders that client is well liked, appreciated and respected." R36's ACP summary dated 11/21/17, included	F 741	enjoy going outside to ensure these residents are offered this opportunity. 3. The Policy and Procedure for Quality of Life, Self-Determination remains current. 4. The Regional Clinical Director/Designee will educate the DON and ADON who will then educate the all staff on resident rights and preferences, dealing with TBI Behaviors, including assisting residents to go outside when they require supervision for safety. Education will occur no later than March 5, 2017 and those not in attendance at staff education due to illness, vacation or casual status will be educated prior their first shift worked. Date of Completion: 3/12/18 Recurrence will be prevented by: 5. The DON/designee will interview10 residents each week to ensure resident rights and preferences are being honored per their plan of care. Audits will include interview and observation. Audits will continue for 4 weeks and then monthly for 3 months. Results of audits will be discussed by the DON/designee at the monthly QAPI meeting for further review and recommendations on continuing or discontinuing the audits based on the findings. The correction will be monitored by:	

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recommendations for staff to: "consider using a communication board with [R36]. Due to his aphasia it is challenging for him to fully articulate his needs, and having a communication board may decrease his frustration. Staff are encouraged to get [R36] out of his room on a regular basis. Keeping him engaged in activities at the facility is helpful for his continued mood enhancement."

R36's care plan dated 12/6/17, indicated communication was a problem area and indicated staff interventions: staff to "be patient with me and actively listen when I speak, even though it may take more time for me to express myself. I communicate best by words/gestures/facial affect. I have difficulty understanding others when they are not making direct eye contact with me, and allowing me ample time to respond." In addition, the care plan included: "Staff validate communication when needed to ensure messages are clearly understood. I may become frustrated with staff and others if I feel I am not being understood. Please redirect me as able, and spend the time needed to communicate-including picture/letter/number board."

During an observation on R36's living unit, 3 East, at 11:14 a.m. on 1/31/18, R36 was observed to have wheeled himself in his Broda chair towards the unit's exit doors. The exit door alarm went off, to notify staff R36 was possibly leaving the unit. Nursing assistant (NA)-B proceeded to assist R36 off the unit and guided R36 down the hallway from 3 East, towards the 3 West unit. When R36 saw the elevator doors, he started propelling his wheelchair toward the elevator grabbing onto the handrail by the elevator. R36 began yelling and

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moaning while he tried to get in the elevator. NA-B attempted to redirect R36 to the 3 West unit so she could weigh him, but R36 had his feet on the floor, pushing against the floor to back himself into the elevator. R36 continued to yell and moan. Once inside the elevator, NA-B looked R36 in the eyes and in a calm voice stated, "Ok we will go downstairs." R36 was observed to stop moaning and yelling, and became calm and quiet for the ride to the second floor main street entrance. At 11:19 a.m., R36 propelled his wheelchair out of the elevator, heading straight for the front door. NA-B assisted R36 to the right of the door to offer an opportunity to look out the window at the birds. However, R36 became agitated and used his feet to push himself backwards toward the front door. When he reached the door, R36 attempted to open it. NA-B continued to speak quietly in a calm voice to R36, and. R36 became quiet and listened. NA-B explained to R36 that it was cold outside so he would need a jacket and a hat. NA-B then offered R36 a drink of water before R36 started yelling and moaning again, and reaching for the door handle. The assistant director of nursing (ADON) then arrived and began trying to talk to R36 to convince him to go back upstairs to the 3 East unit. At 11:25 a.m., the ADON handed a stack of papers she was holding to NA-B and stated, "Put these in my office and I will stay with [R36]." NA-B then left the area. R36 continued to reach for the front door handle at which time the ADON was observed to move R36 away from the door. R36 became more agitated and started arching his back in his chair and pushing his feet off the floor to keep his chair near the door. Unit manager (UM)-I and the director of nursing (DON) then arrived to assist with R36. At 11:48 a.m., R36 was assisted by UM-I, the ADON and the DON from

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	245223	A. BUILDING _____ B. WING _____	02/06/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 741	Continued From page 73	F 741		

the front door to the elevator. When the elevator got back to the 3rd floor, they assisted R36 out of the elevator and proceeded to attempt to direct him back to his unit. R36 was observed screaming, moaning and crying with tears visibly running down his face. R36 had his feet on the ground trying to kick backwards to stop from being pushed forward toward the 3 East unit as the DON continued to try and push R36 forward. The ADON was next to R36 on his left side and UM-I was holding his hands, facing R36, and walking backwards. All three were heard saying, "Come on [R36], and let's go [R36]!" R36 continued to protest and pushed with his feet on the ground to prevent his chair from moving forward. R36 arched his back, and bent his head back while screaming and crying. The DON continued to push the Broda chair forward, and UM-I was observed to grab R36's pants by the knees to lift the resident's feet off the ground in order to move the wheelchair forward while R36 attempted to resist. LPN-F came forward with a dish of chocolate pudding and attempted to give R36 a bite of the chocolate pudding. R36 moves his head away from the spoon of pudding while he continued to scream and cry. The DON, ADON and UM-I, continued to push R36's Broda chair back to the 3 East unit. During the entire observation, no one had offered R36 the communication board, no one validated his responses, and no one offered him a coat and hat to just take him outside for a bit. The DON, ADON, and UM-I failed to implement approaches identified for R36 by the ACP indicated in R36's care plan.

During interview on 1/31/18 at 12:49 p.m., NA-B verified when R36 was down on 2nd floor earlier he wanted to go outside. NA-B also verified she

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F 741	Continued From page 74	F 741		

was the only nursing assistant working on the 3 East unit. NA-B said she could not have left the rest of the residents to go get R36's jacket and hat to take him outside. NA-B stated, "This is why we need two aides on this floor." NA-B also said, "We do not have time to do 1:1 with these residents when they need to be redirected for their behaviors, it's impossible. I am doing the best that I can."

During interview on 2/1/18, at 12:42 p.m., LPN-B stated yesterday would have been a great day to take R36 outside, the weather was nice, if we would have had the staff to do it, we could have done that. In addition, LPN-B stated, "We should be accommodating [R36's] preferences, if he wants to go outside and the weather is nice, he should be able to go outside."

During interview with the ADON on 2/5/18 at 12:54 p.m., the ADON stated any resident with exit seeking behaviors could go outside with a staff. The ADON stated the 2 East doors led to an outside area that was safe, with a fenced in area, and said "there is also a safe fenced in area on 1 East unit to go outside."

During interview on 2/6/18 at 2:18 p.m., the DON verified she was responsible to monitor staff training competencies for UM-I and the ADON. The DON said, "All staff are required to have these competencies completed before they can work the floor." During a subsequent interview at 2:31 p.m. on 2/6/18, the DON verified no one had offered to take R36 outside, and confirmed that R36 has a right to make choices stating, "I could not understand what [R36 wanted]," in regards to the incident that occurred on 1/31/18. The DON continued to say that staff were not familiar with

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F 741	Continued From page 75 his cares and were trying to assess him. The facility's policy Quality of Life-Self Determination revised Jan 2014, included: "Our policy respects and promotes the right of each resident to exercise his or her autonomy regarding what the resident considers to be important facets of his or her life... 2. In order to facilitate resident choices, staff shall: a. inform (and regularly remind) the resident and family members of the resident's right to self-determination and participation in preferred activities; b. Gather information about the resident's personal preferences on initial assessment and periodically thereafter, and document these preferences in the medical record; c. include information gathered about the residents preferences in the care planning process; and d. document and communicate any medical conditions or limitations that may inhibit or interfere with participation in preferred activities."	F 741		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any	F 756		3/18/18

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F 756	Continued From page 76 drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failure to act upon pharmacist recommendations regarding medications for 1 of 5 residents (R46) who received as needed (PRN) medications during review for unnecessary drugs. Findings include: R46's monthly pharmacist review progress notes dated 11/8/17 and 12/13/17 included the recommendation to discontinue lorazepam (Ativan an antianxiety) started 6/16/17, and trazodone (pain medication) started 6/26/17, due	F 756	F756 Drug Regimen Review, Report Irregular, Act On Immediate corrective action: 1. Resident 46□s pharmacy recommendation has been addressed by the physician. Action as it applies to others: 2. All pharmacy recommendations currently out longer than 30 days will be	

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F 756	Continued From page 77 to used for greater than 14 days as a PRN medication, without prescriber indication for ongoing use, no stop date and no diagnosis for use. R46's medication administration record was reviewed for 10/2018 to 1/2018 with the following findings: 10/2017 Ativan used 10 times and trazodone used 26 times prn 11/2017 ativan used 12 times and trazodone 23 times prn. 12/2017 ativan used 9 times and trazodone used 24 times prn. 1/2018 ativan used 9 times and trazodone used 21 times prn. Pharmacist progress notes dated 1/3/18 reads "pending, 12/13/17" (facility had change in pharmacist) On asking the facility for the physicians response to the pharmacist recommendations written on 11/8/17 and 12/13/17, none was provided and on review of R46's records none was located either. Interview on 2/5/18, at 1:00 p.m. with Medical Doctor (MD) would have expected a resident receiving a PRN medication on a routine basis the staff would have notified the doctor to respond to the pharmacist recommendations. Interview on 2/5/18, at 2:35 p.m. with director of nursing said PRN medication were only to be used for 30 days but would have to look up policy.	F 756	resent. 3. A new pharmacist has started effective 12/1/17. All recommendation will be given to the DON/designee so they are able to track responses from physician and resend recommendation if necessary. Date of completion: 3/18/18 Recurrence will be prevented by: 4. The Policy and Procedure for Pharmacy recommendations remains current. The DON/Designee will audit all pharmacy recommendations each month to ensure recommendation is sent to the physician and that a response is received back from the physician and any new orders are recorded in the medical record. Audits will be monthly corresponding to pharmacy consultant visits and will continue for 3 months. Results will be shared with the facility QAPI committee for input. The correction will be monitored by: DON/Designee	

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F 756	Continued From page 78 Policy requested and none given.	F 756		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to be free from medication error rate of 5 percent or greater identified observations of 29 medications with 5 errors resulting in an error rate of 17.24 percent. This had the potential to affect all resident who received medications. Findings include: R1's medication set up was being completed by registered nurse (RN)-A on 2/3/18 at 1:27 p.m. RN-A was observed to set up the 12:00 p.m. medications of Tylenol 1000 milligrams (mg) and Tramadol 50 mg . It was also learned from RN-A that the 8:00 a.m. medications found on the MAR of Tylenol 1000 mg, Aspirin 81 mg, Metoprolol 25 mg, and Tramadol 100 mg. were not given during the standard time allowed of one hour before or after scheduled time of 8:00 a.m. was outside this accepted window of 7:99 a.m. to 9:00 a.m. window. They had been given at 10:37 a.m. which was 1.5 hours after the accepted window. During a interview with RN-A during this time she agreed the 8:00 a.m. medicaitons were not given timely.according to the automatic time on the electronic medication administration record	F 759	F759 Free of Medication Error Rts 5 Prcnt of More Immediate corrective action: 1. The nurse identified was educated at the time of survey on the hour before and hour after the scheduled time to administer medications. Action as it applies to others: 3. The Policy and Procedure on Medication Administration remains current. The DON/designee will educate all nurses and medication aides on the medication window of time that a medication can be given. Education will be no later than March 5, 2018 and those not in attendance at education sessions due to illness, vacation or casual work status will be educated prior to their first shift worked. Date of completion: 3/18/18 Recurrence will be prevented by:	3/18/18

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F 759	Continued From page 79 (MAR). At 1:48 p.m. RN-A was interviewed regarding the 8:00 a.m. medications given at 10:37 a.m. and said that was correct in that they were not given on time. During an interview on 2/5/18 at 9:16 a.m. with the director of nursing (DON) regarding the medication errors made on 2/3/18 for the 8:00 a.m. and 12:00 p.m. medicaiton pass the DON said she had instituted a corrective action and had educated the nurse involved with the medication errors.	F 759	4. The DON/designee will observe 15 medication passes per week with various nurses and various times to ensure medications are given within the appropriate timeframe of one hour before or one hour after the scheduled medication time. Audits will continue for 4 weeks and then monthly for 3 months. Results of audits will be discussed by the DON/designee at the monthly QAPI meeting for further review and recommendations on continuing or discontinuing the audits based on the findings. The correction will be monitored by: DON/Designee	
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident-	F 791		3/18/18

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F 791	Continued From page 80 (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to schedule a routine and follow up dental appointment necessary to meet resident's need for 1 of 1 resident (R30) reviewed for dental services. Findings include: R30's annual Minimum Data Set (MDS) assessment dated 12/5/17, identified an admit date of 3/3/16, severe cognitive impairment and R30 required 1 staff with limited assist with personal hygiene. It was also identified that R30	F 791	F791 Routine/Emergency Dental Services in NFs Immediate corrective action: 1.Resident R30 is scheduled for a dental appointment March 26, 2018 at 10:00. Action as it applies to others: 2. All resident oral screening forms will be reviewed to see if dental services are needed and appointments made as	

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F 791	Continued From page 81 had obvious or likely cavity or broken natural teeth under the dental area. R30's care plan dated 3/5/16, indicated a diagnoses of traumatic brain injury, bipolar disorder and restlessness and agitation and required extensive staff assistance with personal hygiene. The care plan lacked any interventions related to dental services. R30's, Oral Health Screening Form, dated, 1/23/18, indicated missing most upper front teeth, swollen bleeding gums, and caries. It identified that R30 needs staff supervision with brushing teeth twice a day. Dental care referral recommendations indicate routine dental referral. Needs to see a dentist. During observation on 1/29/18, at 3:08 p.m. R30 remained seated in a wheelchair located in his room and was noted with several missing teeth. During interview on 2/1/18, at 1:48 p.m., unit manager (UM)-J verified R30 has not seen the dentist and further verified nothing is documented in R30's records that a dental appointment has been made from the dental referral from Apple Tree Dental on 1/23/18. UM-J stated, "I did not see that dental assessment." Facility Policy, "Routine Dental Care Services," dated 2014, revised July 2017. Revealed this facility takes responsibility for provision of dental care needs of each resident. This facility will assist residents in obtaining routine and 24-hour emergency dental care for each resident based on routine and emergency oral assessments and the residents and/or representative stated needs. Procedure: 3. The Nursing and or Social Service	F 791	necessary. 3. The DON/designee will educate the IDT on the Routine Dental Care Services policy no later than March 5, 2017. Date of completion: 3/18/18 Recurrence will be prevented by: 4. The DON/designee will audit 5 random residents each week to ensure any dental needs are addressed and appointments made as needed. Audits will continue for 4 weeks and then monthly for 3 months. Results of audits will be discussed by the DON/designee at the monthly QAPI meeting for further review and recommendations on continuing or discontinuing the audits based on the findings. The correction will be monitored by; DON/Designee	

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F 791	Continued From page 82 staff is responsible for assisting the resident in making appointments and for arranging transportation to and from dental services locations if requested by the resident and or representative.	F 791		

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K 000	INITIAL COMMENTS Aspen with Deficiencies (NHF) 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, (Name of facility) was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), 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 St Paul, MN 55101-5145, or	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/03/2018

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

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K 000	Continued From page 1	K 000		

By email to:
Marian.Whitney@state.mn.us and
Angela.Kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

Red Wing Health Center is a 3-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1965 and was determined to be of Type II(222) construction. In 1972, addition was constructed to the West Wing that was determined to be of Type II(222) construction. In 1999 a small addition was added to the west wing. Because the original building and the 2 addition are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building.

The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification.

The facility has a capacity of 130 beds and had a

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	245223	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/01/2018**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 census of 87 at the time of the survey.	K 000		
K 200 SS=F	Means of Egress Requirements - Other CFR(s): NFPA 101 Means of Egress Requirements - Other List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 18.2, 19.2 This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility failed to comply with LSC 19.2 Failure could result in fire doors not operating. This deficient practice could affect the safety of all (87) the residents, staff and visitors within the Facility. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 2/1/2018, observation and documentation reviewed revealed the following: The Facility does not have a current fire door inspection. This deficient practice was confirmed by the Facility Maintenance Director at the time of	K 200	K200- All fire doors have been inspected and tested for compliance. The facility alleges compliance 3/19/2018. The Director of Maintenance shall be responsible for semiannual inspection, correction if applicable and documentation.	3/19/18

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K 200	Continued From page 3 discovery.	K 200		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility failed comply with LSC 19.3.2.5.2, 19.3.2.5.3, Not having the system inspected could cause a failure in the system	K 324	K324-The kitchen hood has been inspected and documentation is on file. The facility alleges compliance 3/19/2018. The facility will maintain kitchen hood inspections semiannually. The Director of Maintenance shall be responsible for	3/19/18

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K 324	Continued From page 4 This deficient practice could affect the safety of all (87) the residents, staff and visitors within the Facility. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 2/1/18, documentation reviewed revealed the following: The Facility does not have a current 6 month inspection report on kitchen hood system. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 324	semiannual inspection, correction if applicable and documentation.	
K 354 SS=F	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This REQUIREMENT is not met as evidenced by: The facility failed to comply with LSC 19.3.5.1, 9.7.5 This deficient practice could affect the safety of all	K 354	K354-The facility has a current out of service policy for the fire sprinkler system. The facility alleges compliance 3/19/2018.	3/19/18

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K 354	Continued From page 5 (87) the residents, staff and visitors within the Facility. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 2/1/2018, observation and documentation reviewed revealed the following: The Facility does not have a current out of service policy for the fire sprinkler system. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 354	The Director of Maintenance shall be responsible for the availability of the policy upon future inspections.	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates	K 363		3/19/18

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K 363	Continued From page 6 of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation review and staff interview, the facility failed to check doors latches. Failure of LSC 19.3.6.3 Failure could cause fire rated doors not to latch closed. This deficient practice could affect the safety of all the residents, staff and visitors within the smoke compartment. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 2/1/2018, observations and staff interview revealed the following: The doors for 3rd floor soil and therapy room did not latch close when tested. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 363	K363-All applicable facility fire rated doors have been inspected and adjusted for positive latch. The facility alleges compliance 3/19/2018. The facility will complete inspections and adjustments to doors monthly. The Director of Maintenance shall be responsible for the documented inspections.	

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K 511	Continued From page 7	K 511		
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This deficient practice could affect the safety of all (87) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 2/1/2018, observations and staff interview revealed the following: The large diameter ductwork for laundry had lint built-up showing. This deficient practice was confirmed by the Facility Maintenance Director at the time of	K 511	K511-The large diameter ductwork for laundry has been cleaned. The facility alleges compliance 3/19/2018. The facility will maintain inspection and cleanliness of the ductwork. The Director of Maintenance shall be responsible for the documented inspections and cleanliness of the ductwork.	3/19/18

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K 511	Continued From page 8 discovery.	K 511		
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Findings Include: On facility tour between 09:00 AM and 01:00 PM on 2/1/2018, based on observation and interview revealed that the following include: The ventilation system on the 1st, 2nd, and 3rd floors in the 1965 addition utilizes the egress corridor as the return air for the resident rooms. This deficient practice could affect the safety of all the residents, staff and visitors within this addition from 1965. This deficient practice was confirmed by the	K 521	K 521 Please see attached waiver. Red Wing Health Center requests a waiver for the K521. The facility is documented to be fully sprinklered and has auto shutoff of the HVAC system. Additionally, evidence that corrective action would pose an unreasonable hardship on the facility. Cost to improve HVAC system would cost approximately $530,000. It is also estimated that such work would disrupt the normal use of patient areas for at least 6 months.	3/19/18

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K 521	Continued From page 9 Facility Maintenance Director at the time of discovery.	K 521		
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: The facility failed to comply with LSC 6.3.4 NFPA 99 This deficient practice could affect the safety of all (84) the residents, staff and visitors within the Facility. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 2/1/2018, observation and documentation	K 914	K914-The facility has a current outlet testing report. The facility alleges compliance 3/19/2018. The facility will have inspections annually and maintain documentation. The Director of Maintenance shall be responsible for the annual inspections and required documentation.	3/19/18

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K 914	Continued From page 10 reviewed revealed the following: The Facility does not have a current outlet testing report. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 914		
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: The facility failed to comply with LSC 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8	K 920	K920-The extension cords has been removed from laundry room and 3rd floor	3/19/18

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K 920	Continued From page 11 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This deficient practice could affect the safety of all (00) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 2/1/2018, observations and staff interview revealed the following: We found extension cords in laundry room and 3rd floor residents room. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 920	residents room. The facility alleges compliance 3/19/2018. The Director of Maintenance shall be responsible for identifying future extension cord use and correction.	
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be	K 923		3/19/18

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K 923	Continued From page 12 stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: The facility failed to comply with LSC 11.3.1 of NFPA 99 This deficient practice could affect the safety of all (84) the residents, staff and visitors within the Facility. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 2/1/2018, observation and documentation reviewed revealed the following: The Facility does not have a current Medical gas training program. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 923	K923-The facility has a current Medical Gas training program. The facility alleges compliance 3/19/2018. Applicable staff have been in-serviced. The Director of Staff Education will be responsible for the training of applicable facility staff.	

Name of Facility
Red Wing Health Care

2000 CODE

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

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

PROVISION NUMBER(S)	JUSTIFICATION
K84	02/26/2018 Red Wing Health Center requests a waiver for the K521. The facility is documented to be fully sprinklered and has auto shutoff of the HVAC system. Additionally, evidence that corrective action would pose an unreasonable hardship on the facility. Cost to improve HVAC system would cost approximately $530,000. It is also estimated that such work would disrupt the normal use of patient areas for at least 6 months. 3-5-18 Vicki Holtzer DON

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title	Office	Date
Thomas Linhoff 12424	Fire Safety Supervisor	MN State Fire Marshal	03-12-2018