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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ZEOH

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00149

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **10/27/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

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

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

B.IIINotIinICmplianceIwithIProgram Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

The facility's request for a continuing waiver involving K67 has been recommended to CMS.

17. SURVEYOR SIGNATURE Date :
Sarah Strenke, HFE NE II 11/08/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 11/18/2016 (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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245223

November 8, 2016

Ms. Catherine Scoville, Administrator
Red Wing Health Center
1412 West Fourth Street
Red Wing, MN 55066

Dear Ms. Scoville:

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 October 17, 2016 the above facility is certified for:

146 Skilled Nursing Facility/Nursing Facility Beds

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

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

We have recommended CMS approve the waiver that you requested for the following Life Safety Code Requirements: K67.

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
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
November 8, 2016

Ms. Catherine Scoville, Administrator
Red Wing Health Center
1412 West Fourth Street
Red Wing, MN 55066

RE: Project Number S5223025 and Complaint Numbers H5223092, H5223086, & H5223084

Dear Ms. Scoville:

On October 13, 2016, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective October 18, 2016. (42 CFR 488.422)

In addition, on October 13, 2016, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedy be imposed:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective November 5, 2016. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for a standard survey completed on August 5, 2016, that included an investigation of complaint numbers H5223092, H5223086, & H5223084, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on September 28, 2016. The most serious deficiencies at the time of the revisit were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On October 27, 2016, 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 September 28, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 17, 2016. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on September 28, 2016, as of September 17, 2016. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective September 17, 2016.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of October 13, 2016. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective

November 5, 2016, 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 November 5, 2016, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective November 5, 2016, is to be rescinded.

In our letter of October 13, 2016, 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 November 5, 2016, due to denial of payment for new admissions. Since your facility attained substantial compliance on September 17, 2016, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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.

Your request for a continuing waiver involving the deficiency cited under K67 at the time of the August 5, 2016 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

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Enclosure

cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
245223		10/27/2016

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0329 Reg. # 483.25(l) LSC	Correction Completed 10/17/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) GPN/kfd	DATE 11/8/2016	SIGNATURE OF SURVEYOR 37476	DATE 10/27/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
8/5/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ZEOH

Facility ID: 00149

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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.IATEIOFISURVEY **9/28/2016** (L34)

8. ACCREIITATIONISTATUS: __ (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	
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04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

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

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

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

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

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

B.IIINotIinICmplianceIwithIProgram Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

The facility's request for a continuing waiver involving K67 has been recommended to CMS.

17. SURVEYOR SIGNATURE Date :
Kyla Einertson, HFE NE II 1017/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 11/8/2016 (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 :
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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

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

October 13, 2016

Ms. Catherine Scoville, Administrator
Red Wing Health Center
1412 West Fourth Street
Red Wing, MN 55066

RE: Project Number S5223025 and Complaint Numbers H5223092, H5223086, & H5223084

Dear Ms. Scoville:

On August 23, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 5, 2016 that included an investigation of complaint number H5223092, H5223086, & H5223084. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On September 28, 2016, the Minnesota Department of Health and on October 4, 2016, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 5, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 12, 2016. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on August 5, 2016.

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

F0329 -- S/S: E Drug Regimen Is Free From Unnecessary Drugs 483.25(l)

The most serious deficiencies in your facility were found to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

- State Monitoring effective October 18, 2016. (42 CFR 488.422)

In addition, Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective November 5, 2016. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective November 5, 2016. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 5, 2016. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Red Wing Health Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective November 5, 2016. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

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 .

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
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Email: gary.nederhoff@state.mn.us
Telephone: (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.

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:

• Civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 allegation of compliance and/or 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

second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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 February 5, 2017 (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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit

Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Enclosure

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 09/28/2016

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 An onsite post certification revisit (PCR) was completed on September 26, 27 & 28, 2016. The certification tags that were corrected can be found on the CMS2567B. Also there is one tag that were not found corrected at the time of onsite PCR which are located on the CMS2567. 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. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. Complaint H5223084 was was found to be in compliance during this PCR. Complaint H5223086 was found to be in compliance during this PCR. Complaint H5223092 was found to be in compliance during this PCR.	{F 000}		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any	F 329		10/17/16

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

Electronically Signed | 10/14/2016

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 09/28/2016

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 329	Continued From page 1 combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on document review and interview the facility failed to complete a comprehensive sleep assessment, monitor, and periodically assess effectiveness for a medication used for sleep for 2 of 3 residents (R73 and R90). In addition failed to ensure non-pharmacological interventions were attempted and documented prior to administration of as needed (PRN) medications for 2 of 3 residents (R35 and R120) reviewed for unnecessary medications. Findings included: R73 FAILED TO COMPLETE A COMPREHENSIVE SLEEP ASSESSMENT: R73 had diagnosis of insomnia according to the facility electronic diagnoses list. R73's annual Minimum Data Set (MDS) dated 8/8/16 indicated R73 was cognitively intact and had clear speech; was able to make self-understood sometimes and able to	F 329	Immediate Corrective Action: Comprehensive sleep assessments were completed for residents R 73 and R 90. Daily monitoring for sleep has been implemented for Residents R 73 and R 90. PRN valium for resident R35 has been discontinued. A pain assessment was completed and non-pharmacological interventions were implemented for the use of PRN pain medications. A pain assessment was completed for R120 and non-pharmacological interventions were implemented. Action as it applies to others: Other residents who receive medications for sleep will be reviewed to ensure sleep assessments are current and that daily monitoring for the effectiveness of the	

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 09/28/2016

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 329	Continued From page 2 understand others. The MDS indicated R73 had trouble falling asleep, staying a sleep or sleeping too much. R73's electronic physician's orders included amitriptyline 50 milligrams for insomnia. R73's record did not include a comprehensive sleep assessment or evaluation of sleep integrity and none was provided by facility when requested. During an interview on 9/28/2016, at 2:33 p.m. registered nurse (RN)-B stated she completed the sleep assessment for R73 today (9/28/16) as the director of nursing (DON) had brought it to her attention it had not been completed before the survey team arrived for post certification survey. RN-B stated the sleep assessment for R73 had not been completed prior to today as she did not have time to complete it. RN-B stated to complete the sleep assessment she interviewed staff, R73 and his family member (FM)-A regarding sleep. RN-B stated for all the sleep studies I do, I take the residents word if it is adequate sleep and the staff is concurring that is correct assessment. RN-B stated she was unaware sleep monitoring per shift had been implemented on the medication administration record (MAR) and had not use this data as a part of R73's sleep assessment. R90 FAILED TO COMPLETE A COMPREHENSIVE SLEEP ASSESSMENT: R90's quarterly Minimum Data Set (MDS) dated 6/27/16 indicated R90 had severe cognitive impairment and clear speech; was usually able to make self-understood and able to understand others. The MDS indicated R90 had no trouble falling asleep, staying a sleep or sleeping too much. R90's electronic physician's orders included	F 329	medication is implemented. Other residents who receive PRN pain medication will be reassessed and non-pharmacological interventions will be implemented based on the assessment findings. The policy and procedure pertaining to the use of Hypnotic medications was reviewed and remains current. Licensed nursing staff will be re - educated on the policy and procedure. Date of completion: 10/17/16 Recurrence will be prevented by: Random chart and medication administration review audits will be conducted to ensure non-pharmacological interventions are attempted and documented prior to the administration of PRN pain medications and to ensure residents who use medications for sleep have daily monitoring of the effectiveness as well as current sleep assessments completed. Audits will be completed for a period of 90 days and audit results will be reviewed by the QA committee to determine the need for ongoing monitoring. 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
	245223	A. BUILDING _____ B. WING _____	R 09/28/2016

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 329	Continued From page 3 trazodone 150 milligrams for insomnia. R90's record did not include a comprehensive sleep assessment or evaluation of sleep integrity and none was provided by facility when requested by survey team. During an interview on 9/28/2016, at 1:30 p.m. the director of nursing (DON) stated the nurse had completed the assessment on paper and had just not completed the information in the computer. The DON provided this surveyor a copy of the sleep assessment dated 9/28/16 as the completion dated in electronic medical record. Again this was done after survey team arrived to complete the post certification survey. During an interview on 9/28/2016, at 2:22 p.m. registered nurse (RN)-B stated she did not have any paper forms that she had used to complete R90's sleep assessment. RN-B stated she had completed the sleep assessment today for R90. RN-B stated the reason it was not completed prior to today as she did not have time. RN-B stated the DON brought it to her attention the sleep assessment had not been completed after the surveyors were present in the building. RN-B stated to complete the sleep assessment she interviewed staff and R90 regarding sleep. RN-B stated for all the sleep studies I do, I take the residents word if it is adequate sleep and the staff is concurring that is assessment. RN-B stated she was unaware sleep monitoring per shift had been implemented on the medication administration record (MAR) and had not use this data as a part of R90's sleep assessment. A policy for sleep assessments was requested and not provided. R35 LACK OF NON-PHARMACOLOGICAL INTERVENTIONS ATTEMPTED BEFORE	F 329		

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 09/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 4 GIVING AS NEEDED MEDICATIONS: R35's diagnosis found on the Diagnosis Report identifies paraplegia, pressure ulcer, other muscle spasm and other psychoactive substance abuse. R35's pain assessment completed on 7/18/16, identifies R35 to be in almost constant pain making it difficult to sleep and limiting activities. Pain assessment identifies no non-verbal signs or symptoms of pain identified. Valium and Oxycodone for pain and muscle spasms were used. R35 had orders for Valium 10 milligrams every 4 hours as needed for muscle spasms and Oxycodone 10 milligrams as needed, may have up to two tabs in 24 hours, not to exceed seven tabs in one week. Medication Administration Record (MAR) indicates R35 received Valium PRN on 58 different occasions from 9/12/16 to 9/28/16 and PRN Oxycodone on 16 occasions from 9/12/16 to 9/27/16. Progress notes from 9/12/16 to 9/28/16 indicates non-pharmacological interventions were not attempted or documented for any of the PRN medication administrations for either the valium or oxycodone. Interview on 9/28/16, at 12:30 p.m. with licensed nurse (LPN)-A stated non-pharmacological interventions should be attempted and documented prior to administration of PRN medications. LPN-A stated the non-pharmacological interventions should be documented in a progress note. LPN-A stated if the progress notes do not indicate non-pharmacological interventions then none were attempted. Interview on 9/28/16, at 1:02 p.m. with director of nursing (DON) stated non-pharmacological	F 329		

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 09/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 329	Continued From page 5	F 329		

interventions should be attempted and documented with all PRN medication administration. DON stated the reason non-pharmacological interventions weren't attempted for R35 was due to his verbally aggressive behaviors towards staff when attempts for non-pharmacological interventions were offered and the staff not wanting to be on the receiving end of those behaviors. However, this was not care planned.

R120 LACK OF NON-PHARMACOLOGICAL INTERVENTIONS ATTEMPTED BEFORE GIVING AS NEEDED MEDICATIONS:
R120's diagnosis found on the Diagnosis Report identifies malignant neoplasm of base of tongue.
R120's pain assessment which was completed on 8/29/16 indicates almost constant pain making it difficult to sleep. Pain assessment identifies no nonverbal signs or symptoms of pain being displayed. Interventions include administration of PRN Hydromorphone.
R120's orders indicates Hydromorphone solution 4 ml every four hours as needed for pain.
MAR indicates R120 received Hydromorphone PRN on 28 occasions from 9/12/16 to 9/25/16.
Progress notes indicate of the 28 occasions R120 received PRN Hydromorphone no non-pharmacological interventions were attempted or documented prior to administration of narcotic.
Interview on 9/28/16, at 12:50 p.m. with LPN-B stated R120 has a history of drug abuse and was seen in the pain clinic. LPN-B stated she was instructed to give R120 all the PRNs that are needed. LPN-B stated the staff give R120 what he asks for.
Interview on 9/28/16, at 1:02 p.m. with director of nursing (DON) stated non-pharmacological

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 09/28/2016

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

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F 329	Continued From page 6 interventions should be attempted and documented with all PRN medication administration. Facility provided copies of what education was provided to staff for compliance with F329. the education had not include any education related to non-pharmacological interventions prior to administration of all PRN medications given. Requested the policy for administration of PRN medications form facility. Facility did not provide a policy.	F 329		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245223 Y1	A. Building B. Wing Y2	9/28/2016 Y3

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

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

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	F0176	Correction	ID Prefix	F0221	Correction	ID Prefix	F0225	Correction
Reg. #	483.10(n)	Completed	Reg. #	483.13(a)	Completed	Reg. #	483.13(c)(1)(ii)-(iii), (c)(2) - (4)	Completed
LSC		09/12/2016	LSC		09/12/2016	LSC		09/12/2016
ID Prefix	F0226	Correction	ID Prefix	F0241	Correction	ID Prefix	F0248	Correction
Reg. #	483.13(c)	Completed	Reg. #	483.15(a)	Completed	Reg. #	483.15(f)(1)	Completed
LSC		09/12/2016	LSC		09/12/2016	LSC		09/12/2016
ID Prefix	F0250	Correction	ID Prefix	F0253	Correction	ID Prefix	F0280	Correction
Reg. #	483.15(g)(1)	Completed	Reg. #	483.15(h)(2)	Completed	Reg. #	483.20(d)(3), 483.10(k)(2)	Completed
LSC		09/12/2016	LSC		09/12/2016	LSC		09/12/2016
ID Prefix	F0282	Correction	ID Prefix	F0309	Correction	ID Prefix	F0312	Correction
Reg. #	483.20(k)(3)(ii)	Completed	Reg. #	483.25	Completed	Reg. #	483.25(a)(3)	Completed
LSC		09/12/2016	LSC		09/12/2016	LSC		09/12/2016
ID Prefix	F0314	Correction	ID Prefix	F0315	Correction	ID Prefix	F0318	Correction
Reg. #	483.25(c)	Completed	Reg. #	483.25(d)	Completed	Reg. #	483.25(e)(2)	Completed
LSC		09/12/2016	LSC		09/12/2016	LSC		09/12/2016

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GPN/kfd	10/14/2016	31221	9/28/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245223 Y1	A. Building B. Wing Y2	9/28/2016 Y3

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

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0322	Correction	ID Prefix F0328	Correction	ID Prefix F0354	Correction
Reg. # 483.25(g)(2)	Completed	Reg. # 483.25(k)	Completed	Reg. # 483.30(b)	Completed
LSC	09/12/2016	LSC	09/12/2016	LSC	09/12/2016
ID Prefix F0425	Correction	ID Prefix F0441	Correction	ID Prefix F0465	Correction
Reg. # 483.60(a),(b)	Completed	Reg. # 483.65	Completed	Reg. # 483.70(h)	Completed
LSC	09/12/2016	LSC	09/12/2016	LSC	09/12/2016

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
8/5/2016	☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245223 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	10/4/2016 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0025	09/12/2016	LSC K0046	09/12/2016	LSC K0047	09/12/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0062	09/12/2016	LSC K0067	09/12/2016	LSC K0069	09/12/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	TL/kfd	10/14/2016	37008	10/4/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
8/3/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ZEOH

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 **08/05/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

The facility's request for a continuing waiver involving K67 has been recommended to CMS.

17. SURVEYOR SIGNATURE Date :
Lisa Carey, HFE NE II 09/20/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 09/27/2016 (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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
August 23, 2016

Ms. Catherine Scoville, Administrator
Red Wing Health Center
1412 West Fourth Street
Red Wing, MN 55066

RE: Project Number S5223025, H5223092, H5223087, H5223086, & H5223084

Dear Ms. Scoville:

On August 5, 2016, 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. In addition, at the time of the August 5, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5223092, H5223086, & H5223084.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the August 5, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5223087 that was found to be unsubstantiated.

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
Health Regulation Division
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Telephone: (507) 206-2731
Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 12, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 12, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

Your ePoC must:

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire

Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility 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 remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by November 5, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the

identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 5, 2017 (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 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,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
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 _____	08/05/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. 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. Upon receipt of an acceptable electronic 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 recertification survey was conducted and complaint investigation(s) were also completed at the time of the standard survey." An investigation of complaints H5223084 were completed. The complaint was substantiated and deficiencies were cited at F282 & F312. An investigation of complaint H5223086 were completed. This complaint was substantiated and deficiencies were cited at F314, F322, F328. An investigation of complaint H5223092 were completed. This complaint was substantiated and deficiencies were cited at F309. An investigation of complaint H5223087 was completed during the survey and found not to be substantiated.	F 000		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if	F 176		9/12/16

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

Electronically Signed | 08/31/2016

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

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F 176	Continued From page 1 the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure residents were assessed to safely administer their medicaiton for 1 of 5 residents (R120) was had been observed to self administer medications. Findings include: R120's admission record indicated the resident was admitted to the facility on 4/5/2016. R120's diagnosis report, dated 6/10/2016, indicated that the resident had a diagnosis of pneumonia. R120's care plan, dated 5/13/2016, indicated that the resident had lung infections. It identified a goal of normal gas exchange. R120's medication administration record (MAR) reviewed from 7/10/2016 through 8/3/2016 indicated that the resident had been prescribed Ipratropium-Albuterol Solution (a medication used to help breathing better that is administered through a machine which produces a mist and is breathed) four times a day for chronic obstructive pulmonary disease (COPD). This was to be administered via trachea. In addition, R120 was prescribed sodium chloride Nebulized solution which was to be administered four times a day via his trachea for the diagnosis of COPD. During an observation on 8/4/2016 at 7:26 a.m., licensed practical nurse (LPN)-E prepared R120's medications. After she had administered his medications through his gastronomy tube, she opened the contents of the sodium chloride solution, put it in the canister and affixed this to	F 176	F 176 Immediate Corrective Action: An assessment to self-administer medications was completed for resident R120 on 09/12/2016. An MD order was obtained to allow the resident to self-administer nebulized medications. LPN-E received reeducation on the policy and procedure for Self-Administration of Medications Corrective Action as it Applies to Others: Other residents, who wish to self-administer medications, will be re-assessed by the IDT on their ability to safely do so according to facility policy. Physician's orders to self-administer medications will be sought for those residents deemed safe to do so. The policy and procedure for Self-Administration of Medications was reviewed and remains current. Staff will be reeducated on the policy by 09/12/2016. Recurrence will be prevented by: Weekly random audits will be conducted on each nursing unit for a period of at least 90 days to ensure residents and staff remain complaint with self-administration of medication orders and facility policy. Audits will be reviewed by the Director of	

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F 176	Continued From page 2 the mask and set up for him to use. She then set it on top of his nebulizer machine and explained that he would use it when he wanted to. She also put the intact Ipratropium-Albuterol (used to relax muscles in airway to increase air flow) vial on the table and explained that he would use it later on. LPN-E said sometimes R120 would wait until noon to take his nebulized medication. After LPN-E left there resident's room she stated that R120 had not been assessed by a registered nurse to determine if he could safely administer medications without a nurse present. She stated that there was not a physician's order which stated R120 could safely administer his own medications. She stated the normal procedure would be for the charge nurse to assess a resident to determine if they were safe to administer their own medications; the charge nurse would then consult with the physician who would write an order which indicated the resident could safely administer his own medications. When interviewed on 8/4/2016 at 2:42 p.m., registered nurse (RN)-A stated that R120 should have been assessed prior to having medications in his room. She stated that it required a physician's order in order to have the resident safely administer his own medications. Review of the document titled, Storage and Expiration of Medications ...(1/1/13) it stated that the facility should not provide beside medications or biologicals without a physician order and it was approved by the interdisciplinary care team and facility administration. Review of the document titled, General Dose Preparation and Medication Administration (1/1/13) it stated that facility staff should not leave medications or chemicals unattended.	F 176	Nursing and submitted to the monthly Quality Assurance committee for input and recommendations on the need for continued monitoring. Date of Completion: 09/12/2016 The Correction will be monitored by: Administrator or Designee.	
F 221	483.13(a) RIGHT TO BE FREE FROM	F 221		9/12/16

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F 221 SS=D	Continued From page 3 PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure physical restraints were used according to physician's orders, evaluate ongoing need and document the use of restraints, and assess and evaluate for the least restrictive device as behavior changed for 2 of 2 residents (R90, R79) reviewed for physical restraints. Findings included: R90: LACK OF RESTRAINT USE ACCORDING TO PHYSICIAN ORDERS, LACK OF ONGOING ATTEMPTS TO REDUCE RESTRAINT TO LEAST RESTRICTIVE AS HEALTH STATUS CHANGED, AND LACK OF ONGOING MONITORING FOR SAFETY WHEN RESTRAINT(S) WERE IN USE: R90 had been observed on 8/4/16, at 8:39 a.m. R90's bed had a blue tent like structure that fully enclosed R90's bed. The tent had zippers that locked for keeping R90 inside the enclosure. R90 noted to be sitting in a Broda chair with a thigh belt in place. R90 suddenly lunged forward in the Broda chair with arms wide open in front of him; the thigh restraints prevented him from tumbling out of the chair onto the floor. This sudden movement did not appear to be intentional or reactionary from surrounding environmental stimuli. R90 admitted to the facility on 4/15/15 according	F 221	F 221 Immediate Corrective Action: R 90 was reassessed and the care plan for the use of physical restraints was updated to include interventions to decrease the use of the restraints. The IDT team met to discuss the use of the restraints for R 90 and a restraint reduction plan will be implemented to ensure the least restrictive device is in use. The Physician for R 90 was updated and new orders were obtained for the use of the physical restraints based on the IDT recommendations. A Restraint Assessment for R 79 was completed and the use of the hand mitt was discontinued. Corrective Action as it Applies to Others: Other residents who use net beds, thigh straps, or hand mitts will be reassessed to ensure the least restrictive device is in use and MD orders will be sought based on assessment findings. Restraint reduction plans will be implemented for any resident found to have a restraint in place that is no longer warranted or not the least restrictive device.	

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F 221	Continued From page 4 to the facility face sheet with diagnoses that included anoxic brain damage, restlessness and agitation, lack of coordination, muscle weakness, assault with a sharp object, insomnia, and brain injury. R90's quarterly Minimum Data Set dated 6/27/16 indicated severe cognitive impairment with a Brief Interview for Mental score of three and demonstrated fluctuating inattention. The MDS further indicated no verbal or physical behaviors and no wondering or rejection of care behaviors. The assessment identified R90 to require extensive assistant from staff for bed mobility and transfers. The MDS also reported the use of restraints. R90's current electronic physician's orders included: · "Net bed to be used as needed to provide environment for for [sic] de-escalation of unredirectable [sic] behavior AEB [as evidenced by] increased pacing with inability to get resident to stop. Check every 30 minutes. as needed document behaviors." · Patient to position in non-propelling Broda chair with thigh strap for positioning; check every 30 minutes and release every two hours. R90's current electronic care plan identified and defined agitative behaviors on 5/4/15 as restlessness, bouncing/shaking left leg, pacing, running hands through hair, dazed look, and standing up and sitting down. The care plan reflected the intended use of the net bed prescribed by the physician, however directed staff to use the net bed for uses not prescribed by the physician. The care plan intervention dated 5/15/15 reflected the physician order verbatim, however the care plan intervention last updated on 6/29/15 directed and informed staff, "the net bed to remain zipped in the morning until [R90]	F 221	The policy and procedure Physical Restraints was reviewed and revised on 09/12/2016 Staff will be reeducated on the policy by 09/12/2016 Recurrence will be prevented by: Random weekly visual audits and medical record reviews will be conducted to ensure physical restraints are used as indicated by the MD order and that ongoing use is warranted based on the most current restraint assessment. Audits will be completed for a period of 90 days and audit results will be reviewed by the QA committee to determine the need for ongoing monitoring. Date of Completion: 09/12/2016 The Correction will be monitored by: Administrator or Designee.	

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wakes up to assist with decreasing paranoia." The care plan directed staff to check on R90 every 30 minutes while in use. R90's care plan indicated no revision of interventions were put into place for almost a year to decrease the use of the net bed and still did not reflect physician's orders of intended use. The care plan intervention dated 4/28/16 advised, "person served will be trialed for naps only in regular bed only during the day, to use net bed only at night." R90's care plan also addressed the use of the thigh restraints and the Broda chair, however did not have interventions or goals that would include decreasing the restraint use.
R90's care guide not dated directed staff to use Broda chair with thigh straps-check every 30 minutes and release every 2 hours, tip Broda chair back when not eating, and "redirect to "safe place" (his room) if he appears agitated. Zipped net bed PRN [as needed] to de-escalate unredirectable behaviors such as pacing, agitation." The care plan directed staff the net bed was to remain zipped in the morning until he wakes up to assist with decreasing paranoia.
R90's last Physical Device Assessment was completed on 4/11/16 and indicated the use of net bed, Broda chair, and thigh straps were started on 5/29/15. The assessment included, "Net bed when resident becomes anxious, too much stimulus-net bed appears to help calm resident down, resident can move around and is safe to do so." The assessment reported, the thigh straps would be on while in wheelchair, check and release every two hours, and the net bed would be used while in bed; check every 30 minutes. The physical device assessment also indicated, the devices were not used as a therapeutic intervention, devices were restraints, devices used for fall prevention, the resident was

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not able to demonstrate to appropriately utilize the device, and the resident was not able to remove the devices on command, and the care plan addressed measures to minimize any potential for decline or negative outcomes when devices were to be used, frequency of monitoring and repositioning. The assessment further indicated the net bed provided safety while R90 was in bed.
The assessment did not reflect prescribed use of the net bed.
R90's July 2016 and August treatment administration record (TAR) reflected the as needed net bed order. The TAR did not reflect documentation of any behaviors that would warrant the use for the net bed according to physician orders, nor did the TAR reflect the use. In addition, the TAR did not reflect the order and use of the thigh straps.
R90's Treatment Team Weekly report dated 5/27/16 indicated behavioral plans were in place for agitation and physical aggression, did not reflect the use of the restraints, and reported R90 was in stable condition. The 5/27/16 report did not identify agitation or physical aggression was displayed by R90. The next weekly report was completed on 6/24/16; the report indicated behavioral plans for agitation and physical aggression, reported the net bed and thigh straps were still necessary, however did not identify agitation and physical aggression were displayed by R90. The report indicated the facility was attempting to wean pending therapy evaluation and indicated the plan for R90 was to try a regular bed for napping next week.
R90's nursing progress notes since 7/1/16 did not reflect documentation of behaviors, monitoring or evaluation of the net bed, thigh, belt, or Broda chair. The progress notes did not reflect

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documentation of attempts of weaning off restraints to least restrictive.
R90's psychiatric progress note dated 7/11/16 and 7/25/16 did not mention, plan, or evaluation of agitated or aggressive behaviors. Psychiatric evaluation dated 7/15/16 indicated R90 had depressed mood with flat affect, however was more alert. The note on 7/11/16 and evaluation on 7/15/16 indicated R90 had gross motor control deficits. However, progress notes do not reflect monitoring or evaluation.
R90's record contained only one consent for net bed signed on 9/28/15; the consent indicated the net bed would be used as needed to provide environment for de-escalation of unredirectable behavior AEB increased pacing with inability to get resident to stop.
During an interview on 8/1/16, at 2:00 p.m. ombudsman reported concern pertaining to net bed restraint use for R90. Ombudsman stated, the facility had not really done anything to decrease the use, and reported the care plan had not been changed in a long time. Ombudsman reported R90's goal was to discharge back home to another state. Ombudsman expressed concerns the facility was not working towards R90's goals of returning home in a timely manner.
During an interview on 8/4/16, at 2:30 p.m. nursing assistant (NA)-H stated an unawareness for reasons why R90 would use the net bed. NA-H read what was on the care guide for indications of use.
During an interview on 8/4/16, at 2:34 p.m. NA-I explained R90 used the net bed at night and it was "zipped and locked." NA-I indicated R90 sleeps in the bed all night like that. NA-I also said it's for agitation.
During an interview on 8/4/16, at 2:38 p.m. registered nurse (RN)-B reported R90 was

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"getting zipped in during night and locked." RN-B stated the net bed was for safety related to throwing extremities out of bed and sleeping in weird positions. RN-B explained we have been trying to get rid of the net bed during the day for naps we aren't putting him in the net bed. RN-B reported there was no documentation of the progress. RN-B had an unawareness of the indication for use per physician order. RN-B reported there was not documentation of behaviors that would warrant the use of the net bed per physician orders and no documentation of 30 minute being completed while using restraints. RN-B also indicated there was no documentation or evaluations of attempts at weaning from the restraints. RN-B then presented a blank 30 minute check monitoring form and explained that it should have been in place. RN-B also indicated R90 had been working with therapy in order to get back home or a facility near his home.

During an interview on 8/5/16, at 1:45 p.m. director of nursing (DON) was asked, "What is your expectation on the use of restraints and following physician orders for the use of restraints?" DON responded, "We follow physician orders and the expectation would be restraint free would be the goal." DON explained process for monitoring and care planning restraint use. DON indicated staff should follow the policies and procedures for documenting the use of restraints.

Facility policy Physical Restraints last revised April 2016 included, "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 the use of the device and quarterly thereafter. Least restrictive

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device will be the goal." The policy did not include care planning direction or documentation standards for restraint use.

R79: LACK OF REASSESSMENTS TO REDUCE/ELIMINATE RESTRAINT USE AS HEALTH STATUS HAS CHANGED FROM FIRST USE OF RESTRAINT:

R79 was observed on 8/4/16, at 7:19 a.m. to be asleep in bed with a hand mitt on his right hand. On 8/4/16, at 10:27 a.m. R79 was observed to be awake in bed with hand mitt on his right hand. R79 was not observed to be moving his extremities.
8/5/16, at 8:41 a.m. R79 was observed awake in bed with hand mitt present on right hand. R79 was not observed to be moving his extremities.
R79's material data sheet (MDS) identifies R79 is totally dependent on staff for all cares. Diagnosis include stroke with left hemiplegia, tracheostomy and ventilator dependent.
Care plan for R79 dated 5/25/15 identifies R79 as having Focus behaviors, "I am exhibiting the following behaviors, resisting cares by grabbing inappropriately and using my hand to dig into my incontinent stool, pulling out trach, I have diagnosis of intra-cerebral hemorrhage." Interventions identified, "wearing a mitt on my hand to help deter me from digging in my stool, pulling out my trach or scratching my left arm."
R79's treatment administration record (TAR) identifies, "may use Mitts to hands to prevent pulling at G-tube and pulling vent lines and trach use as needed", start date of 3/21/15. TAR does not identify staff documenting the use of the mitt.
R79's care guide (document direct care staff use to describe necessary cares identified from care plan for each resident), does not include any

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information on when the hand mitt should or shouldn't be applied to R79's right hand.
Nursing home provider regulatory visit progress note dated 6/22/16 identifies only that R79 "has a mitt on his right hand to prevent pulling at his lines."
Facility could not provide a comprehensive assessment for the use of the right hand mitt when requested.
Interview with nursing assistant, (NA)-B on 8/5/16, at 9:53 a.m. stated the mitt is only worn during the day and is supposed to be off during the night.
Interview with licensed practical nurse (LPN)-C on 8/5/16 at 10:00 a.m. stated R79 is only to wear the mitt at night and it is supposed to be off during the day. LPN-C stated she was unaware of any order on when R79 was to wear the mitt. LPN-C stated she takes the mitt off when R79's family member visits so they can hold hand. LPN-C removed the mitt and R79's hand was red in color. LPN-C stated when she removes the mitt R79 will thank her. LPN-C stated she did not believe the mitt was necessary because R79 doesn't try and pull things out anymore. LPN-C was unaware of when an assessment for the mitt was last completed.
Interview with registered nurse (RN)-A on 8/5/16, at 10:40 a.m. stated the mitt should be checked every 30 minutes and released every two hours. RN-A stated R79 doesn't wear the mitt when he is with family. RN-A stated she wasn't sure about an assessment and thought an assessment should be completed at least quarterly.
Policy titled Physical Restraints dated April 2016 identifies, "to assure a restraint is used only when assessed as necessary to treat a medical condition and/or appropriate measure to be used to provide resident safety. Facility will complete

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F 221	Continued From page 11 an assessment prior to the use of the device and quarterly thereafter. Least restrictive device will be the goal."	F 221		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the	F 225		9/12/16

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F 225	Continued From page 12 incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to report an allegation of abuse immediately to the designated state agency (Office of Health Facility Complaints-OHFC) for 1 of 3 resident (R106) reviewed for Abuse. Findings include: R106's diagnosis listed on order recap report includes: Cerebral infarction, unspecified and polysubstance abuse. Material data sheets (MDS) identifies R106 brief interview for mental status (BIMS) score is a 13 out of 15. Progress note dated 5/16/16, at 10:57 a.m. which is identified as a late entry identifies, "person served wheelchair was held by NAR [nursing aide registered] as person served continued to attempt to leave the unit (he was already out of the unit). NAR was returning from break and assisted activities personnel to have person served return to unit. NAR was not pulling or pushing wheelchair, holding onto handles, and person served reached for the door jam and slipped forward out of wheelchair landing on left knee on the floor. NAR assisted him back into chair and person served got up from wheelchair and walked to table and chairs by the elevator and sat down in a chair at the table. Previous to this activities staff had already informed him he would not be going to Bingo." During stage one interview on 8/3/16, at 1:30 p.m. R106 stated a staff member, "made him fall out of the chair." R106 stated it "was no	F 225	F 225 Immediate Corrective Action: An internal accident and investigation report was completed, with an internal investigation regarding the incident involving resident R 106. Corrective Action as it Applies to Others: The policy and procedure Abuse Prevention was reviewed and remains current. Staff will be re-educated on the policy by 09/12/2016 Recurrence will be prevented by: All suspected incidents of alleged abuse will be reviewed by the Administrator, Director of Nursing and Social Service Director to ensure incidents were reported in accordance with facility policy and procedure. Reviews will be completed for a period of 90 days and the results will be reviewed by the QA committee to determine the need for ongoing monitoring. Date of Completion: The Correction will be monitored by: Social Service Director or Designee.	

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accident." R106 stated the staff member pulled the chair back when R106's "butt was at the edge of the chair." R106 stated he fell on his butt from the chair to the floor which caused his back to be sore after that.

Interview on 8/4/16, at 12:49 p.m. with R106 stated, nursing assistant was telling me I couldn't go to Bingo. I was sitting halfway in the chair and he pulled the wheelchair and I landed on my bottom. I hurt my back. R106 stated the facility had given him a wheelchair even though he doesn't need it. R106 stated he would use the wheelchair because it was there. R106 stated he had told staff and that someone had come to talk with him. R106 identified the nursing assistant who he felt intentionally harmed him as (NA)-F.

Interview on 8/4/16, at 12:56 p.m. with licensed practical nurse (LPN)-D stated she wasn't working the day of the incident but worked the next day. LPN-D stated R106 had told her that he had fallen because NA-F had grabbed the back of his wheelchair and he fell forward. LPN-D stated R106 was adamant that NA-F was the reason he had fallen. LPN-D stated there should have been a progress note completed at the time of incident as well as an accident and injury form. LPN-D stated when she was told of the incident she documented the information as a progress note and reported the incident to the unit manager.

Interview on 8/5/16, at 8:30 a.m. with registered nurse, (RN)-B stated she was first notified of the incident by LPN-D the day after it occurred. RN-B stated there should be an incident report because RN-B and the director of nursing at that time had investigated it.

Interview on 8/5/16, at 8:35 a.m. with director of nursing (DON), stated if a resident reports feeling as though they are abused that it should be

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F 225	Continued From page 14 immediately reported as a vulnerable adult. The administrator and DON should be notified immediately. DON was unable to provide any documentation that a report had been filed related to this incident. Interview on 8/5/16, at 9:42 a.m. with NA-F confirmed what had been documented in the progress note dated 5/16/16. NA-F stated he had completed the necessary section of the incident report and then handed it off to the nurse who was working. NA-F stated the social worker had followed up with him the next day. Facility was unable to locate any documentation other than the progress note related to the abuse allegations. DON on 8/5/16, at 2:34 p.m. stated she would follow facility policy and a report would be filed by the end of the day. Policy titled Abuse Prevention Plan-MN, dated November 2015, identifies, "The administrator is ultimately in charge of the Abuse Prohibition plan and must be informed of all alleged or substantiated incidents of abuse, neglect or maltreatment immediately." "All incidents of maltreatment or suspected maltreatment will be reported immediately for the initial report."	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 226	F 225	9/12/16

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F 226	Continued From page 15 facility failed to follow their policy of reporting an incident of suspected abuse immediately to the administrator and designated state agency (Office of Health Facility Complaints-OHFC) for 1 of 3 residents (R106) reviewed for abuse/neglect protocol. Findings include: R106's Progress note dated 5/16/16, at 10:57 a.m. which is identified as a late entry identifies, "person served wheelchair was held by NAR [nursing assistant registered] as person served continued to attempt to leave the unit (he was already out of the unit). NAR was returning from break and assisted activities personnel to have person served return to unit. NAR was not pulling or pushing wheelchair, holding onto handles, and person served reached for the door jam and slipped forward out of wheelchair landing on left knee on the floor. NAR assisted him back into chair and person served got up from wheelchair and walked to table and chairs by the elevator and sat down in a chair at the table. Previous to this activities staff had already informed him he would not be going to Bingo". During stage one interview on 8/3/16, at 1:30 p.m. R106 stated a staff member, "made him fall out of the chair." R106 stated it "was no accident." R106 stated the staff member pulled the chair back when R106's "butt was at the edge of the chair." R106 stated he fell on his butt from the chair to the floor which caused his back to be sore after that. Interview on 8/4/16, at 12:56 p.m. with LPN-D stated she wasn't working the day of the incident but worked the next day. LPN-D stated R106 had told her that he had fallen because NA-F had grabbed the back of his wheelchair and he fell	F 226	Immediate Corrective Action: An internal accident and investigation report was completed, with an internal investigation regarding the incident involving resident R 106. Corrective Action as it Applies to Others: The policy and procedure Abuse Prevention was reviewed and remains current. Staff will be re-educated on the policy by 09/12/2016 Recurrence will be prevented by: All suspected incidents of alleged abuse will be reviewed by the Administrator, Director of Nursing and Social Service Director to ensure incidents were reported in accordance with facility policy and procedure. Reviews will be completed for a period of 90 days and the results will be reviewed by the QA committee to determine the need for ongoing monitoring. Date of Completion: The Correction will be monitored by: Social Service Director or Designee.	

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F 226	Continued From page 16 forward. LPN-D stated R106 was adamant that NA-F was the reason he had fallen. LPN-D stated there should have been a progress note completed at the time of incident as well as an accident and injury form. LPN-D stated when she was told of the incident she documented the information as a progress note and reported the incident to the unit manager. Interview on 8/5/16, at 8:30 a.m. with registered nurse, (RN)-B stated she was first notified of the incident by LPN-D the day after it occurred. RN-B stated there should be an incident report because RN-B and the director of nursing at that time had investigated it. Interview on 8/5/16, at 8:35 a.m. with director of nursing (DON), stated if a resident reports feeling as though they are abused that it should be immediately reported as a vulnerable adult. The administrator and DON should be notified immediately. DON was unable to provide any documentation that a report had been filed related to this incident. Policy titled Abuse Prevention Plan-MN, dated November 2015, identifies, "The administrator is ultimately in charge of the Abuse Prohibition plan and must be informed of all alleged or substantiated incidents of abuse, neglect or maltreatment immediately." "All incidents of maltreatment or suspected maltreatment will be reported immediately for the initial report."	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	F 241		9/12/16

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F 241	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to promote dignity to each resident by removing assistive medical devices that do not support or enhance dignity, and are left on the resident for staff convenience, while out in the public view for 1 of 4 residents (R3) reviewed for positioning. Findings included: R3 had been observed on 8/3/16, at 3:29 p.m. R3 was sitting in her Broda wheelchair; Hoyer lift sling draped over shoulders and was visible along her thighs. During a subsequent observation on 8/4/16, at 8:33 a.m. R3 was sitting in the dining room in her Broda chair; Hoyer lift sling was draped over her shoulders and was visible along her thighs. R3's quarterly Minimum Data Set (MDS) dated 6/20/16 indicated severe cognitive impairment with a Brief Interview for Mental Status score of three, had diagnoses that included dementia, psychotic disorder, and schizophrenia. The MDS indicated R3 was totally dependent on two staff members for transfers, hygiene, and dressing. R3's current electronic care plan did not provide direction to staff regarding the placement of the Hoyer sling once in the wheelchair. During an interview on 8/4/16, at 9:40 a.m. nursing assistant (NA)-E reported working for a staffing agency; NA-E indicated the reason why the Hoyer sling was left under R3 was because, "I assume it's ok, because I've seen it here before." NA-E indicated if the sling was supposed to stay underneath the resident it would be in the care plan. During an interview on 8/4/16, at 9:45 a.m. NA-C	F 241	F241 Immediate corrective action: Resident R3 was reassessed as appropriate to leave the hoyer sling placed while seated in the wheelchair. Action as it applies to others: Other residents who are dependent on a hoyer lift for transfers will be assessed to determine the need to leave the hoyer sling in place if appropriate based on assessment findings. Residents without an appropriate need will have hoyer slings removed while not being actively used. The Care Plan and NAR Care Cards for hoyer lift dependent residents will be updated based on the assessment findings. The policy and procedure “Quality of Life: Dignity” was reviewed and remains current. Nursing staff will be reeducated on the policy by September 12th, 2016 Date of completion: September 12th, 2016 Recurrence will be prevented by: Random weekly visual audits will be conducted on each unit to ensure compliance with the use of hoyer slings as care planned. Reviews will be completed for a period of 90 days and the results will be reviewed by the QA committee to determine the need for ongoing monitoring. The correction will be monitored by: Director of Nursing and/or designee.	

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F 241	Continued From page 18 was asked, "When do you remove the Hoyer slings from underneath the residents?" In response, NA-C reported,"I think the normal procedure is they usually leave it in. They [Hoyer slings] are removed when people lay down." During an interview on 8/4/16, at 9:47 NA-G was asked, "How do you know if you are supposed to leave the Hoyer sling underneath residents?" NA-G responded, "We leave them under them when they [residents] are up in their chairs, we take them out when they lay down in bed." NA-G indicated relaying on what she sees other people doing in the facility with the Hoyer slings or would get the information from the nurse. During an interview on 8/4/16, at 9:49 a.m. licensed practical nurse (LPN)-B verified R3's Hoyer sling had not been removed from underneath R3. LPN-B stated the Hoyer slings should be removed from underneath the residents. LPN-B reported if the sling was to be left in place it should be in the care plan. During a subsequent observation on 8/4/16, at 1:02 a.m. R3 was located in the dining room. The Hoyer sling still had not been removed from underneath her body. During an interview on 8/5/16, at 1:50 p.m. director of nursing (DON) stated, residents should have an assessment completed to determine if the Hoyer pad can be left in the chair related to any pressure relieving devices the sling may interfere; the information would then be in the care plan, entered into the computer charting program as a task so front line staff would have that information. Facility policy Resident Rights and Dignity for All Nursing Procedures last revised March 2013 did not reflect policies/procedures for providing or promoting dignity of self for dependent cognitively	F 241		

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F 241	Continued From page 19 impaired residents.	F 241		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure resident assessed activities had been provided for 1 of 1 resident (R79) who was dependent on a ventilator reviewed for activities. Findings include: R79's diagnosis found on order recap report as well as physician progress note from 6/22/16 include: stroke with left side hemiplegia, ventilator and tracheostomy dependent and non-verbal. Observation on 8/4/16, at 8:38 a.m. R79 lying in bed. The TV was not on and no music was playing. On 8/4/16, at 10:27 a.m. R79 was observed to be lying in the same position in bed. TV was not on and music was not playing. On 8/4/16, at 2:19 p.m. R79 was observed to be lying in bed. No TV or music was on. 8/5/16, at 8:41 a.m. R79 was lying in bed. The TV was on and turned to a news station. R79's care plan with initiated date of 2/22/15, identifies R79 enjoys old country music and westerns. The focus for quality of life states, "My preference about attending facility activities are: I may not be able to attend activity groups due to	F 248	F248 Immediate corrective action: A “Resident Activity Form” and “Get to Know me” were developed and placed in the room for Resident R#79 to inform staff of resident’s activity interests. The Care Guide for resident R79 was updated to reflect activity interests. Action as it applies to others: Other tracheostomy and ventilator dependent residents will have “Resident Activity” and “Get to Know me” forms completed to inform staff of resident’s activity interests. Resident care guides will be updated to include activity interests for other tracheostomy and ventilator dependent residents. The policy and procedure titled “Meaningful Activities” was reviewed and remains current. Nursing and activity staff will be reeducated on the policy by September 12th, 2016 Date of completion: September 12th,	9/12/16

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	245223	A. BUILDING _____ B. WING _____	08/05/2016

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

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F 248	Continued From page 20 my dependence on respiratory equipment. Activities I pursue independently include: watching TV (western movies)." Interventions identified include: "staff assist [R79] to locate movies of his choice, staff and volunteers provide 1:1 attention and activities such as reading, music and aroma therapy. Staff will try and have [R79] up in his chair and out to lounge one time per week." Activity Participation Review dated 6/3/16 identifies R79 enjoys watching western movies and staff is to assist R79 to the lounge when able. Care guide (utilized by direct care staff to provide services to residents they are assigned for their work period), does not identify any activity interventions. Interview with nursing assistant, (NA)-B on 8/5/16, at 9:53 a.m. stated she didn't know what types of activities [R79] enjoys. NA-B stated she turns the TV on but wasn't aware that [R79] enjoys watching westerns. Interview with licensed practical nurse, (LPN)-C on 8/5/16 at 10:00 a.m. stated the TV should be on for activity and R79 enjoys westerns. Interview on 8/5/16 at 10:48 a.m. with activity (A)-A, stated R79 has 1:1 volunteer visits where someone comes in one time every other week to read to R79. A-A also stated music CDs should be played for R79 as well as westerns on the television. A-A stated the direct care staff should be assisting R79 with these activities and the activities should be listed on the care guides. Policy titled Providing Meaningful Activities Individual Programming dated July 21, 2016, identifies, "it is the goal to provide meaningful activities for our residents. Individual programming ensures all residents who are unable to participate in group programs have consistent, goal-oriented and individualized	F 248	2016 Recurrence will be prevented by: Random weekly visual audits will be completed on each unit to ensure staff are following each resident's individualized plan of care for activity interests for ventilator/trach dependent residents. Audits will be completed for a period of 90 days and audit results will be reviewed by the QA committee to determine the need for ongoing monitoring. The correction will be monitored by: Activity Director and/or designee.	

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F 248	Continued From page 21 recreation opportunities."	F 248		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the medical power of attorney/health care agent immediately upon change of condition for 1 of 1 resident (R42) reviewed for social services. Findings include: R42's family (F)-A had been interviewed on 8/4/16, at 3:29 p.m. family member (F)-A stated the facility did not notify her very much about anything and they didn ' t notify her in the change in R42's pressure ulcer. During an interview on 8/5/16, at 10:30 a.m. F-A stated they never notified her that R42 went to the hospital so F-A was sitting there all night alone, they called another sibling F-C who contacted me the next morning. F-A stated F-C is not involved with R42's care, he is only the financial power of attorney. F-A said she was to be notified for any medical concerns. During an interview on 8/5/16, at 10:35 a.m. F-B stated, on 8/4/16 they didn't call F-A about R42 going to the hospital, they called F-C. They are not supposed to do that. F-A is the healthcare	F 250	F250 Immediate corrective action: The R42 was discharged. Action as it applies to others: A review of other resident records will be completed by September 12th, 2016 to ensure residents with designated Healthcare Agents have the appropriate contact person listed as the primary contact for healthcare related concerns. The policy and procedure Notification in Change of Condition was reviewed and remains current. Licensed nursing and Social Service staff will be educated on the policy by Sept 12th, 2016. Date of completion: September 12th, 2016. Recurrence will be prevented by: Random weekly audits will be completed to ensure ongoing compliance with notification of change for residents with noted Healthcare Agents. Audits will be completed for a period of 90 days and audit results will be reviewed by	9/12/16

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F 250	Continued From page 22 agent for R42. F-B stated the facility intentionally calls the other sibling because they know F-C won't ask questions about anything they report to F-C. F-B stated she had been the healthcare agent however, that changed in 2012, R42 appointed F-A. R42's Minnesota Health Care Directive dated 5/1/2012 was signed and notarized by R42 and F-A. The directive included, "Make health care decisions for me even if I am able to decide or speak for myself." R42's Facility Admission record on 8/4/16 indicated F-C was the first person to contact even though F-A was listed as the healthcare agent." A copy of this record was requested, however, it had already been changed after discussion with facility. Progress note dated, 8/4/16, at 9:24 p.m. R42 was transferred to the hospital via ambulance. Progress note at 9:30 included, "Call to [F-C] for update and gave [F-C] hospital number." Progress note dated, 6/14/16 included, "Call to [F-C] and left message that resident out to the wound clinic and that there was new orders." Progress note dated, 5/13/16 included, "writer spoke with person served [R42] heath care agent [F-A] regarding recent events regarding family dynamics and who is involved in care decisions. Per most recent health care direction, person served [F-A] was appointed agent." During an interview on 8/5/16, at 1:59 p.m. director of nursing (DON) indicated staff need to call the healthcare power of attorney for changes.	F 250	the QA committee to determine the need for ongoing monitoring. The correction will be monitored by: Director of Social Services and/or designee.	
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a	F 253		9/12/16

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F 253	Continued From page 23 sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure each resident room was well maintained for a homelike environment, for 1 of 93 residents (R72) residents in the facility. Findings include: R72's room had been observed on 8/2/16, at 4:45 p.m. R72's room had 3 areas on the walls that had wallpaper torn off in large sections. R72's family (F)-A reported the resident had torn the wall paper off the walls and it has been like that for a year. F-A stated, "He didn't like it." An environmental tour was performed with the environmental director (ED) on 8/5/16, at 11:20 a.m., he verified the walls were in need of repair. ED further reported the resident had torn the paper off the walls and they were trying to move R72 to another room for repairs but F-A was not agreeable at the time of the request. ED verified there was a system in place for maintenance work requests and there were requests made to repair the walls/wallpaper in R72's room. Review of maintenance work order request forms indicated on 2/8/16 and 3/7/16 requests were made regarding wall paper pealing off the wall in R72's room, the status of the work orders was "closed." A facility policy for resident room maintenance was requested and it did not contain information	F 253	F253 Immediate corrective action: The wall repairs were performed in R72's room. Action as it applies to others: An audit will be completed to identify other resident rooms with torn wallpaper and a maintenance repair plan will be developed to perform needed repairs. Date of completion: September 12th, 2016. Recurrence will be prevented by: Weekly audits of maintenance work orders will be performed and verified by the ED once the work has been completed. Audits will be completed for a period of 90 days and audit results will be reviewed by the QA committee to determine the need for ongoing monitoring. The correction will be monitored by: Administrator and/or designee	

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F 253	Continued From page 24 in regards to wall repair.	F 253		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the plan of care with regard to a tube feeding that had been discontinued for 1 of 2 residents (R108) reviewed for tube feeding. In addition, failed to revise the plan of care to include identified interventions related to risk for bruises for 1 of 3 residents (R55) reviewed for skin conditions. Findings include:	F 280	RW – F 280 Immediate corrective action: The care plan for resident R#108 was updated. The physician's orders for R 108 related to tube feedings were discontinued. The care plan resident #R55 was updated to include risk for bruising. Corrective action as it applies to others: Other residents who are determined,	9/12/16

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F 280	Continued From page 25 R108 was admitted on 2/18/16, and had diagnoses that included dysphagia (difficulty swallowing), nontraumatic intracranial hemorrhage (bleeding to brain area), and gastrostomy (artificial opening into stomach) status. R108's quarterly Minimum Data Set (MDS) assessment dated 5/11/16, identified R108 as having a feeding tube and receiving 51 percent (%) or more of total calories through parenteral or tube feeding and an average fluid intake of 501 cubic centimeter (cc) per day or more. R108's care plan dated 5/25/16, indicated R108 had a feeding tube by interventions listed including: Monitor intake to assure an adequate fluid intake to prevent dehydration. Feeding tube. R108 is a tube feeding. Keep HOB (head of bed) elevated. Flushes/feeding as ordered. Staff monitor me for changes in tube feeding tolerance and further evaluate. Staff provide feeding and flushes as ordered. R108's physician order recap report for order dated 7/1/16-7/31/16 indicated Isosource HN (a tube feeding formula) was discontinued and gastrostomy (G-tube) was removed on 7/15/16. It further identified R108's water flushes before and after medications, water flush each shift to maintain patency of tube every shift, and G-site (gastrostomy site) care be discontinued. During observation on 8/4/16, at 8:31 a.m. R108 was noted to be eating regular consistency food and drinking fluids independently.	F 280	based on the most current skin assessment, to be at risk for bruising will have their care plans reviewed to ensure each care plan address risk for bruising. Other residents who have had feeding tubes discontinued while residing in the facility will have a care plan and MD order review completed to ensure they reflect the resident current nutritional status. The policy and procedure titled “Care Planning, IDT” was reviewed and remains current. Licensed nursing staff will be re-educated on the policy and procedure. Date of Completion: Recurrence will be prevented by: Random weekly audits will be conducted on each unit to ensure care plans are current and reflect resident’s individual needs regarding: risk for bruising and feeding tube status. Audits will be completed for a period of 90 days and audit results will be reviewed by the QA committee to determine the need for ongoing monitoring. The correction will be monitored by: DON/Designee	

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F 280	Continued From page 26 During interview on 8/4/16, at 2:17 p.m. nursing assistant (NA)-J indicated R108 had a feeding tube when he first was admitted but no longer did now. During interview on 8/4/16, at 3:00 p.m. the dietary manager (DM) stated R108 was initially on tube feedings but had stabilized and now was able to eat and drink on his own. During interview on 8/5/16, at 11:17 a.m. registered nurse (RN)-C verified R108's care plan was inaccurate and should have been revised. Stated, "I can't argue, I see exactly what you are talking about." A facility policy, Care Planning dated August 2014, identifies individual, resident-centered care planning be initiated upon admission and maintained by the interdisciplinary team throughout the resident's stay to promote optimal quality of life while in residence. R55's care plan dated 6/22/16, identifies R55 to need help with mobility which places her at risk of alterations in skin. Interventions include geri gloves/sleeves on both arms at all time to protect skin. Care guide (utilized by direct care staff to provide services to residents they are assigned for their work period) identifies, "skin fragile and tender to touch geri gloves on at all times." Progress notes were reviewed from June 2016 until August 5, 2016. No mention of bruising to R55's bilateral arms and hands with the exception of one progress note dated 6/10/16 at 2:31 p.m. which states, "Noted bruising in deep purple color on both arms." Observation on 8/3/16, at 2:13 p.m. R55 was	F 280		

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F 280	Continued From page 27 noted to have multiple bruises on bilateral hands and arms. On 8/4/16, at 7:21 a.m. R55 was observed in bed without arm sleeves on. R55 stated, "I have very sensitive skin." At 9:09 a.m. R55 eating breakfast in her bedroom, no arm sleeves present. Interview on 8/5/16, at 10:11 a.m. with registered nurse, (RN)-A stated R55 is to have arm sleeves on at all times. RN-A verified there was not a current treatment intervention(s) for monitoring bruises. Policy titled,Care Planning dated August 2014, identifies, "Individual, resident-centered care planning be initiated upon admission and maintained by the interdisciplinary team throughout the resident's stay to promote optimal quality of life while in residence."	F 280		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to follow resident specific activities interventions and provide oral care as care planned for 1 of 4 resident (R79) reviewed for activities of daily living: failed to provide care plan interventions for non-pressure related (bruising) and pressure ulcer care for 1 of 4 residents (R55); and failed to provide pressure ulcer treatments/cares for 1 of 2 residents (R63) with current pressure ulcers.	F 282	F 282 Immediate corrective action: A “Resident Activity Form” and “Get to Know me” were developed and placed in the room for Resident R#79 to inform all staff of resident’s activity interests. NA-B received Written counsel for failing to perform oral cares as directed by resident R79’s plan of care. Protective arm Sleeves/Gloves were	9/12/16

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F 282	Continued From page 28 Findings include: R63's diagnosis found on the order summary report identifies, "muscle weakness, muscle Findings include: R79's diagnosis found on order recap report as well as physician progress note from 6/22/16 include: stroke with left side hemiplegia, ventilator and tracheostomy dependent and non-verbal. R79's care plan with initiated date of 2/22/15, identifies R79 enjoys old country music and television westerns. The focus for quality of life states, "My preference about attending facility activities are: I may not be able to attend activity groups due to my dependence on respiratory equipment. Activities I pursue independently include: watching TV (western movies)." Interventions identified include: "staff assist [R79] to locate movies of his choice, staff and volunteers provide 1:1 attention and activities such as reading, music and aroma therapy. Staff will try and have [R79] up in his chair and out to lounge one time per week." Activity Participation Review dated 6/3/16 identifies R79 enjoys watching western movies and staff is to assist R79 to the lounge when able. Observation on 8/4/16, at 8:38 a.m. R79 lying in bed. The TV was not on and no music was playing. On 8/4/16, at 2:19 p.m. R79 was observed to be lying in bed. No TV or music was on. Interview with nursing assistant, (NA)-B on 8/5/16, at 9:53 a.m. stated she didn't know what types of activities R79 enjoys. NA-B stated she turns the TV on but wasn't aware that R79 enjoys watching westerns. Interview on 8/5/16 at 10:48 a.m. with activity	F 282	placed on resident R55. PRAFO boots were applied for resident R55. NA-C received written counsel for failing to follow the plan of care for resident R63. LPN-B received written counsel for failing to follow physician's orders as prescribed. Action as it applies to others: The policy and procedure using the Care Plan was reviewed and remains current Nursing staff will be educated on the policy by September 12th, 2016. Date of completion: 11/12/16 Recurrence will be prevented by: Random weekly visual audits will be completed on each unit to ensure staff are following each resident's individualized plan of care for oral care, activity interests for ventilator/trach dependent residents, protective arm sleeves/geri gloves and pressure redistribution interventions. Audits will be completed for a period of 90 days and audit results will be reviewed by the QA committee to determine the need for ongoing monitoring. The correction will be monitored by: Director of Nursing and/or designee.	

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F 282	Continued From page 29	F 282		

staff, stated R79 has 1:1 volunteer visits where someone comes in one time every other week to read to R79. Activity staff also stated music CDs should be played for R79 as well as westerns. Activity staff stated the direct care staff should be assisting R79 with these activities and the activities should be listed on the care guides.
Policy titled, "Providing Meaningful Activities Individual Programming" dated July 21, 2016 identifies, "it is the goal to provide meaningful activities for our residents. Individual programming ensures all residents who are unable to participate in group programs have consistent, goal-oriented and individualized recreation opportunities".
LACK OF PROVIDING ORAL CARES EVERY FOUR HOURS AS CARE PLANNED:
R79's diagnosis found on order recap report and physician progress note dated 6/22/16 include ventilator and tracheostomy dependent, stroke with left side hemiplegia, left upper extremity contracture, generalized muscle wasting of both upper and lower extremities. Percutaneous endoscopic gastrostomy (PEG) tube for nutrition and medications.
R79's care plan dated 6/9/16, identifies a focus of "I have an alteration in ADL's [activities of daily living] -I am dependent upon staff for all ADL's r/t [related to] intracranial hemorrhage and C02 [carbon dioxide] narcosis." Interventions include: "I am dependent upon staff for all grooming and personal hygiene." Focus of "hygiene/ADL's/skin: I cannot complete my own oral hygiene tasks." Interventions include staff to complete all oral hygiene cares, cleansing upper and lower teeth with toothette.
Care guide (utilized by direct care staff to provide services to residents they are assigned for their work period), identifies oral care should be

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completed every four hours and as needed (PRN).
Observation on 8/5/16, at 9:53 a.m. of morning cares did not include oral care being completed for R79. Interview with nursing assistant, (NA)-B during this time stated we must have something to do with his mouth then said they would have to check. NA-B did not complete oral care even after bringing this to NA-B's attention.
Policy titled, "Mouth Care", dated January 2014 identifies, "the purpose of this procedure are to keep the resident's lips and oral tissues moist, to cleanse and freshen the resident's mouth, and to prevent infections of the mouth."
LACK OF FOLLOWING NON-PRESSURE RELATED SKIN CONDITION INTERVENTIONS:
R55's care plan dated 6/22/16, identifies, "I need help with mobility so I am at risk of alterations in my skin". Interventions include: " geri gloves/sleeves on both arms at all time to protect my skin, observe my skin with daily cares and weekly bathing."
Care guide(utilized by direct care staff to provide services to residents they are assigned for their work period) identifies, "skin fragile and tender to touch geri gloves on at all times."
Observation on 8/3/16, at 2:13 p.m. R55 was noted to have multiple bruises on bilateral hands and arms. Large quarter size scab noted to right forearm.
On 8/4/16, at 7:21 a.m. R55 was observed in bed without arm sleeves on. R55 stated, "I have very sensitive skin."
8/4/16, at 9:09 a.m. R55 eating breakfast in her bedroom, no arm sleeves present.
Interview on 8/5/16, at 10:11 a.m. with registered nurse, (RN)-A stated R55 is to have arm sleeves on at all times.
LACK OF FOLLOWING PRESSURE ULCER

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F 282	Continued From page 31 INTERVENTIONS: R55's care area assessment, (CAA) dated 6/20/15, identifies R55 scored a 15 (low risk) on the Braden scale (assessment used to determine risk of pressure ulcers). Care plan with an initiated date of 7/13/16, identifies, "I have pressure wounds on both heels and coccyx." Interventions include: "I have weekly wound assessments done, I wear prafo (they are pressure relief for foot and ankle device) boots at all times." Observed R55 on 8/2/16, at 5:21 pm. Sitting in wheelchair in bedroom. Feet flat on the floor, no prafo boots on either foot. 8/3/16, 1:53 p.m. R55 lying in bed, feet flat on bed, no prafo boots present on either foot. 8/4/16, at 9:09 a.m. R55 is sitting in her wheelchair eating breakfast, no prafo boots present on either foot. 8/5/16 at 10:11 a.m. observed wound care. Registered nurse, (RN)-A stated boots should be on at all times but staff might take them off to reposition or help with transfers but that they should be put back on as soon as they are finished. RN-A stated, "it would be a good idea" for feet to not be resting directly on the floor or bed. LACK OF FOLLOWING POSITIONING INTERVENTIONS FOR FLOATING HEELS AND WEARING FOOT PROTECTIVE DEVICE: R63's diagnosis found on the order summary report identifies, "muscle weakness, muscle wasting and atrophy, non-pressure chronic ulcer of other part of unspecified foot with unspecified severity." R63's TAR identifies, "float both heels every shift for skin integrity", dated 5/22/15. This was signed off by licensed staff as being completed on 8/3/16 and 8/4/16.	F 282		

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F 282	Continued From page 32 R63's care plan identifies interventions including: "float both heels in bed, PRAFO boot (pressure relief for foot and ankle device) right heel all times". Care guide (utilized by direct care staff to provide services to residents they are assigned for their work period), identifies "heel lift boot on right heel with pillow under." Observation on 8/2/16, at 5:07 p.m. R63 lying in bed, feet pushed up against the end of the bed, knees bent. Feet were not floating and Prafo boot was not in place. Observation on 8/4/16, at 7:26 a.m. R63 asleep in bed with feet bunched up near the foot of the bed, knees bent. Feet not floated on a pillow and no Prafo boot in place. Interview with nursing assistant, (NA)-C on 8/4/16, at 8:06 a.m. stated R63 doesn't wear boots while in bed. NA-C stated he knows how to care for R63 because of the care guides. NA-C verified the care guide identified R63 should have heels floated while in bed as well as a prafo boot on his right foot. Interview with licensed practical nurse (LPN)-B on 8/4/16, at 8:23 a.m. stated R63 doesn't require his heels to be floated in bed and R63 doesn't wear a prafo boot. LPN-B signed off in TAR that she had floated both of R63's heels per physician order. Even though this did not occur for R63.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		9/12/16

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F 309	Continued From page 33 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a pain assessment was completed prior to administration of as needed (PRN) pain medication, and failed to use non-pharmacological interventions for pain control, for 1 of 2 residents (R45) reviewed for pain control. In addition, the facility failed to provide necessary care and services related to monitoring and prevention of bruises for 1 of 3 residents (R55) reviewed for non pressure related skin conditions. Findings include: PAIN: R45 was interviewed on 8/3/16 at 3:26 p.m. At that time, R45 was observed to be lying in bed on his back with the head of his bed elevated to approximately 20 degrees. R45 stated the left side of his neck hurt and had been hurting for quite some time. He also stated he experienced chronic cramping in his legs and had a Baclofen pump to help with muscle spasms. R45 stated he had routine appointments at the pain clinic, but had missed his last appointment due to illness. R45 reported the physician had increased his narcotic pain medication recently but stated he did not know how much he was allowed to have. R45 first admission was 10/15/2009. The most recent readmission from the acute care hospital was dated 7/17/15 according to the five day Minimum Data Set (MDS) dated 7/20/16. This	F 309	F309 (D) Immediate corrective action: A pain assessment was completed for resident R45 which includes non-pharmacological interventions as a modality to provide pain relief and identifies R 45's acceptable level of pain, location, and character. Protective arm Sleeves/Gloves were placed on resident R55. The nurses caring for resident R55 on 8/4/16 received written counsel for failing to follow physicians' orders. An incident report was completed for resident R55 and an order was obtained to monitor the scab to R55's right forearm. Action as it applies to others: The policy and procedure Pain Management was reviewed and remains current. The Skin Program policy and procedure reviewed on 8/2/2016 and remains current. Licensed Nursing Staff will be re-educated on the policies by September 12th, 2016 Date of completion: September 12th, 2016. Recurrence will be prevented by: Random weekly audits will be completed to ensure residents with identified skin concerns have ongoing monitoring and documentation related to the identified issues. Random weekly pain assessment reviews	

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F 309	Continued From page 34 MDS also identified R45's diagnoses to include: malnutrition, multiple sclerosis, disease of spinal cord, and muscle wasting. The assessment indicated R45 had no cognitive impairment with a Brief Interview for Mental Status score of 15. The area on the MDS related to pain, indicated R45 received scheduled and as needed (PRN) pain medications and that non-pharmacological interventions for pain were also used. The MDS indicated R45 had indicated he was frequently in pain which made it difficult to sleep at night, and that the worst pain experienced during the assessment period had been at a rating of 10 (scale of 0-10 with 10 being the most excruciating pain). R45's current physician orders for pain management included: monitoring of R45's pain every shift for verbal and non-verbal symptoms; Baclofen 300 micrograms (mcg)/milliliters (ml), 100 mcg daily intrathecally (intrathecal administration is a route of administration for drugs via an injection into the spinal canal, or into the subarachnoid space so that it reaches the cerebrospinal fluid (CSF) and is useful in pain management applications), mixed with Bupivacaine 0.5% in pump (pump is managed at outside clinic); Diazepam 10 milligrams (mg) by mouth every 24 hours as needed for muscle spasms; Gabapentin 300 mg three times a day for pain; Oxycodone (narcotic) 5 mg every four hours for pain rated 1-5, and 10 mg for pain rated 6-10; Tylenol (used for control of mild pain) 1000 mg three time a day. R45's most current care plan provided by the facility on 8/4/16, reflected the following problem: Comfort/Pain/Sleep: pain free (is not) realistic. Usual manageable pain scale (0-10) is between 1 and 3, "I [R45] have muscle spasms related to MS [multiple sclerosis], I have a Baclofen pump	F 309	will be completed to ensure pain assessments include non-pharmacological interventions, acceptable pain level, location and character of pain. Audits will be completed for a period of 90 days and audit results will be reviewed by the QA committee to determine the need for ongoing monitoring. The correction will be monitored by: Director of Nursing and/or designee.	

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and I am on routine pain medications." Interventions were identified to include: routine pain management protocol, attempt drug weaning or alterations in therapy as indicated; Staff to evaluate restless or agitated behavior to determine the role pain plays in behavioral manifestation or escalation; repositioning; relaxation techniques and diversions to help prior to as needed medications; Muscle rub as ordered.

A physician's post hospitalization note dated 7/14/16 included, "He does report neck pain that he describes as aching. It is worse when he is up in his chair for extended periods. It is improved when he is lying in bed. He also complains of pain to his legs which is chronic. Currently 4 out of 10, which is acceptable to him." The note also indicated the neck pain had been evaluated during a recent hospitalization, "for complains of at times uncontrolled pain I [MD-A] am going to make a higher dose of oxycodone available for him and instead of being 5 mg every 4 hours as needed I will make it 5-10 [mg] every 4 hours as needed with parameters. We will reschedule pain clinic appointment."

A nursing progress note from 7/20/16 at 5:14 p.m., included: "Resident c/o [complain/of] neck pain when seeing therapist and therapist noted the way that resident was sitting in bed to watch TV (television). Therapy rearranged the room and tape on the floor to mark where the bed should be placed to assist resident to watch TV without causing neck pain."

A pain assessment completed 7/26/16, indicated R45 had non-verbal sounds and facial expressions of pain as well as verbal complaints

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of pain. The assessment indicated R45 had indicators of pain daily and received scheduled and as needed pain medication which R45 reported was sometimes effective. However, the assessment did not reflect whether non-pharmacological interventions had been identified or attempted as a modality for pain relief. In addition the assessment failed to evaluate R45's acceptable level of pain, and location and/or character of pain could not be determined.

Although the physician had modified the dosages of oxycodone to treat R45's pain, review of the medication administration record (MAR) and/or nursing progress notes, did not reflect whether R45 received the appropriate dosage based on pain ratings given by R45.

During a follow up interview with R45 on 8/4/16 at 9:19 a.m., the resident was observed to be lying in bed and was receiving assistance by a nursing assistant to eat. R45 reported he had pain in his legs rated 7 out of 10, even after he had received Oxycodone. A follow up review of his record indicated the last dose of Oxycodone had been administered by a licensed practical nurse at 6:08 a.m. when he'd rated his pain 8 out of 10. The documentation lacked a complete assessment or documentation of non-pharmacological interventions having been attempted. In addition, the record lacked any assessment of effectiveness of the dose.

During an observation on 8/4/16 at 12:46 p.m., R45 was sitting in the dining room in his wheelchair. R45 stated he had neck pain which he rated 6 out of 10. When he stated this, a nursing assistant stated, "You can't have a pain

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pill because you had it one hour ago" then turned and walked out of the dining room.

During an interview on 8/5/16, at 2:19 p.m. director of nursing (DON) stated her expectation was that staff would manage a resident's pain by: following physician orders, performance of complete pain assessments, documentation of non-pharmacological interventions attempted prior to administration of as needed medications, and re-evaluation to determine effectiveness of as needed pain medications. The DON stated, "if pain is not at an acceptable level after all interventions have been attempted, then the physician needs to be contacted for further orders."

The facility's policy Pain Assessment and Management, last reviewed April 2016 included; "The purpose of this procedure is to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and to address the underlying causes of pain." The policy also included; "Pain management interventions shall be consistent with the resident's goals for treatment. Such goals will be specifically defined and documented. Pain management interventions shall address the underlying causes of the resident's pain. Monitor to determine if the resident's pain is being adequately controlled. If pain has not been controlled, the team including physician shall reconsider approaches and make adjustments as indicated. Document the resident's reported level of pain with adequate detail, enough information to gauge the status of pain and effectiveness of interventions. Upon completion of the pain assessment, record information into the medical record. Report

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F 309	Continued From page 38 prolonged, unrelieved pain to physicians." MONITORING AND PREVENTION OF BRUISES: R55 had been observed on 8/3/16, at 2:13 p.m. R55 was noted to have multiple bruises and multiple sizes located on bilateral hands and arms. Also a quarter size scab noted on right forearm. R55 stated it was caused during a transfer when her arm was caught on a staff member's watch. On 8/4/16, at 7:21 a.m. R55 was observed in bed without arm sleeves on. R55 stated, "I have very sensitive skin." 8/4/16, at 9:09 a.m. R55 eating breakfast in her bedroom, no arm sleeves present. R55's care plan dated 6/22/16, identifies, "I need help with mobility so I am at risk of alterations in my skin." Interventions include: "geri gloves/sleeves on both arms at all time to protect my skin, observe my skin with daily cares and weekly bathing." Care guide (utilized by direct care staff to provide services to residents they are assigned for their work period) identifies, "skin fragile and tender to touch geri gloves on at all times." Treatment administration record identifies geri gloves to both arms at all times, dated 6/10/16. This was signed off as completed for each shift X 3 on 8/4/16. Progress notes were reviewed from June 2016 until August 5, 2016. No mention of bruising or scabs to R55's bilateral arms and hands with the exception of one progress note dated 6/10/16 at 2:31 p.m. which states, "noted bruising in deep purple color on both arms." Interview on 8/5/16, at 10:11 a.m. with registered nurse, (RN)-A stated R55 is to have arm sleeves on at all times. RN-A stated she is responsible for	F 309		

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F 309	Continued From page 39 doing weekly skin assessments for the entire building. RN-A went on to state the nursing aides (NAs) are responsible for checking resident's skin during the weekly bath and then they document any bruises or skin tears. RN-A stated NAs should be documenting the bruises under tasks in PointClick care (computerized documentation program for facility). RN-A showed surveyor where the NAs would document bruises for R55. RN-A verified there were no bruises/scabs documented for R55. RN-A stated she only looks at resident's skin if she is notified by the NAs that there is a problem. RN-A stated an incident report should have been completed for the scab that was present on R55's right forearm. RN-A verified there was no documenting what occurred and no current treatment for monitoring bruises/scabs or skin tears was present. Interview with director of nursing (DON) on 8/5/16, at 11:16 a.m. stated the nurses should be assessing resident skin minimally once a week during baths and aides should be checking skin during cares in the morning and evening. DON stated, the expectation if there is a bruise or tear, a treatment should be started is applicable, documentation, notify physician and family. DON stated there should have been documentation in the chart related to the bruising and scab for R55. DON stated, "We understand there is a lack of assessments on a timely basis." Policy titled, Weekly skin checks, dated January 2014, read, "To assure residents skin is checked each week by the licensed nurse in order to promote healthy skin and early intervention if necessary. Weekly the licensed nurse will complete a full body check to also verify no new skin concerns. The results of the skin checks will be documented either on paper on the weekly skin check sheet or in POC by the bath aide and	F 309		

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F 309	Continued From page 40 verified by the licensed nurse."	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance with oral cares for 1 of 2 resident (R79) who was dependent on staff for activities of daily living (ADLs). Findings Include: R79's diagnosis found on order recap report and physician progress note dated 6/22/16 include ventilator and tracheostomy dependent, stroke with left side hemiplegia, left upper extremity contracture, generalized muscle wasting of both upper and lower extremities. Percutaneous endoscopic gastrostomy (PEG) tube for nutrition and medications. Oral/Dental Status dated 12/29/15, identifies, "staff will provide oral care every 4 hours and PRN (as needed)." R79's care plan dated 6/9/16, identifies a focus of "I have an alteration in ADL's-I am dependent upon staff for all ADL's r/t intracranial hemorrhage and C02 [carbon dioxide] narcosis." Interventions include: "I am dependent upon staff for all grooming and personal hygiene." Focus of "hygiene/ADL's/skin: I cannot complete my own oral hygiene tasks." Interventions include staff to	F 312	F312 Immediate corrective action: NA-B and NA-C caring for resident R79 received written counsel for failing to provide oral care in accordance with the resident's plan of care. NA-B and NA-C received education regarding the appropriate use of care cards when providing cares. Action as it applies to others: The policy and procedure for Nursing Care Standards was reviewed and remains current. Nursing Staff will be educated on the policy by Sept 12th, 2016 Date of completion: Sept 12th, 2016 Recurrence will be prevented by: Random weekly visual audits and resident interviews will be conducted on each unit to ensure residents are receiving assistance with oral care according to care planned interventions and that NA's have care cards available and in use while providing cares. Audits will be completed for a period of 90	9/12/16

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F 312	Continued From page 41 complete all oral hygiene cares, cleansing upper and lower teeth with toothette. Care guide (utilized by direct care staff to provide services to residents they are assigned for their work period), identifies oral care should be completed every four hours and as needed (PRN). Observation on 8/5/16, at 9:53 a.m. of morning cares did not include oral care being completed for R79. Interview with nursing assistant (NA)-B during this time stated we must have something to do with his mouth, I'd have to check. NA-B did not complete oral care after queried about R79 needing oral cares. NA-B stated she didn't have a care guide for R79 and wasn't sure where the care guides were kept. Interview with NA-C during this time verified she also did not have a care guide and stated she provides the same basic care for each resident. Interview on 8/5/16, at 10:40 a.m. with registered nurse, (RN)-A stated oral care should be completed for [R79] twice a shift. Policy titled, Mouth Care dated January 2014 identifies, "the purpose of this procedure are to keep the resident's lips and oral tissues moist, to cleanse and freshen the resident's mouth, and to prevent infections of the mouth."	F 312	days and audit results will be reviewed by the QA committee to determine the need for ongoing monitoring. The correction will be monitored by: Director of Nursing and/or designee.	
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and	F 314		9/12/16

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F 314	Continued From page 42 prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to conduct assessment and monitoring, timely positioning, evaluation of signs and symptoms of infection, and revision of care plan for 2 of 2 residents (R42 and R55) reviewed for pressure ulcers in an effort to reduce risk for, and/or deterioration of, pressure ulcers. As a result, R42 experienced harm. Findings include: R42's pressure ulcer located on the right thigh had increase from a stage 2 to a stage 4 within 3 months according to the wound assessments. R42 was observed on 8/3/16 at 11:30 a.m., and again on 8/4/16 at 11:40 a.m., R42's Hoyer sling was not removed from under her bottom after the transfer from her bed to the chair, she was noted to have the thick and stiff sling between her clothing and chair cushion. During an observation on 8/4/16, at 7:20 a.m. R42 was observed to have a wound vac in place with a clean dressing over it on the right lower buttock. Licensed practical nurse (LPN)-B and nursing assistant (NA)-D were providing morning cares for R42. R42 was repositioned to her left side and remained in that position until 9:51 a.m. (2 hours and 31 minutes). R42's annual Minimum Data Set (MDS) dated 6/28/16, indicated the resident has moderate cognitive impairment with a Brief Interview for Mental Status Score of 9, required extensive assist from two staff members for bed mobility and transfers, and had a current unstageable pressure ulcer. R42's current electronic care plan provided by the	F 314	F314 Immediate corrective action: Resident R42 is no longer a current resident. RN-A received re-education to follow facility policy and procedure for the prevention and healing of pressure ulcers. PRAFO boots were applied for resident R55. The nurses responsible to ensure prafo boots were applied for resident R55 on 8/2, 8/3, and 8/5/16 received written counsel for failing to ensure the physicians order was carried out. Action as it applies to others: A comprehensive skin assessment will be completed for all residents with current pressure ulcers as well as care plan and physician's order reviews to ensure appropriate treatment and services are provided to prevent and heal pressure ulcers. Ongoing wound monitoring guidelines will be implemented for all residents with current pressure ulcers to document, on an ongoing basis, the wound status. The policy and procedure Skin Program was reviewed and remains current Nursing staff will be reeducated n the policy by September 12th, 2016 Date of completion: September 12th 2016 Recurrence will be prevented by: Visual audits to ensure repositioning/off-loading and pressure	

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F 314	Continued From page 43 facility on 8/5/16 did not include or identify the stage 4 pressure ulcer (PU) nor the use of a wound vacuum intervention to help heal the stage 4 pressure ulcer located on R42's right lower buttocks. This stage 4 PU was first discovered in April 2016 and still present. The care plan did identify a PU located on right posterior thigh and left hip. The care plan informed staff R42 had multiple sclerosis (MS), diabetes, and had chronic diabetic/venous wounds and was at risk for skin breakdown related to incontinence and impaired mobility. The care plan also informed staff R42 could not reliably reposition herself to prevent skin breakdown while up in the wheelchair and required staff assistance for repositioning. Interventions included: - APMII mattress (specialty air mattress) first initiated 2/28/13 - I have a custom wheel chair with mapping of the seat from Gillette- first initiated 11/21/13. On 7/1/16 care plan indicated since the development of the stage 4 PU, R42 had been seen again by Gillette again for the wounds. - Braden (skin tool assessment for predicting risk of pressure ulcers (PU)) quarterly and prn [as needed] dated 1/31/16 - I am followed by the wound clinic- 7/1/16 - Deep padded cushion in wheelchair at all times dated 2/18/13 - Lay down 2-3 times a day. Bottom open to air no brief 2/13/16 - Staff of 2 assist to turn and reposition every two hours when in bed 12/26/12, however the care plan also directed staff to reposition every 2-3 hours while in bed 7/1/16. - Staff of 2 assist to offload (removing all pressure to the areas prone to develop pressure ulcers) every 1.5 hours for a minimum of 1 minute-while up in chair dated 12/26/12	F 314	ulcer treatment and prevention procedures are completed as care planned and ordered by the physician. Audits will be completed 3x weekly at various times on each unit for 90 days. Record review audits will be conducted 3x weekly at various times on each unit for 90 days which will consist of: care plan reviews to ensure appropriate treatment and services are provided, wound assessments are completed with any change in status and wound documentation reviews of current pressure ulcer status are completed according to facility policy and procedure. The results of these audits will be shared with the QA Committee for input on the need to increase, decrease or discontinue these audits. The correction will be monitored by: DON or Designee	

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F 314	Continued From page 44 - Staff to follow treatment plan per medical doctor/nurse practitioner dated 2/18/13 - Treatments as ordered, dated 11/18/15 - Staff to ensure placement of dycem (used to prevent slipping) in-between Hoyer sling and wheelchair cushion. Dated 4/18/13 - I see a wound nurse monthly 7/1/16 R42's undated nursing assistant care guide indicated R42 was incontinent of bowel and directed staff to; "lay down after breakfast, pay close attention for skin breakdown on buttocks, and to be up only 2-3 hours 2-3 times a day." Physician orders reflected changes to dressing along the wound course and included: · Check wound vac every shift to ensure running at 125 mm/hhg (millimeters mercury) with intensity of 10 every shift. Dated 7/29/16 (7 days after the wound vac was initiated- initiated on 7/22/16) · Lay down 2-3 times a day every shift · Limit sitting in wheelchair to no more than two hours at a time and limit of three hours per day · Nurse to make sure resident is laid down between meals every day and evening shift for wounds. R42's wound clinic visit note dated 6/14/16 ordered, "Patient must omit sitting in wheelchair more than 2 hours at a time and limit three times a day." R42's treatment administration records (TAR) for July and August 2016, reflected orders to check wound vac every shift and lay down 2-3 times a day. However, documentation recorded by check marks and initials did not indicate whether physician orders had been implemented. The record did not identify actual hours spent in the wheel chair, or whether/when the resident was laid down. R42's record did not reflect whether pressure	F 314		

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F 314	Continued From page 45 ulcer risk assessments were conducted when pressure ulcers declined. The record reflected Braden Scale Assessments on 4/19/16 and 6/28/16. The 4/19/16 and 6/28/16 assessments indicated R42 was at moderate risk for pressure ulcers. R42's progress note dated 4/17/16, at 11:44 p.m. included, "Resident c/o [complained] to her [family F-A) that her new chair was uncomfortable on her butt. Superficial o/a's [open areas] noted on gluteal folds. 5 x 4 et [and] 2 x 2 oa's noted on right gluteal et 2 x 1.5 cm [centimeters] noted on left gluteal fold. Areas cleansed et collagen placed on o/a's." R42's record indicated the wound was comprehensively assessed until 4/20/16, 3 days after discovery. The Initial Weekly Wound Documentation form dated 4/20/16 indicated, the physician was not notified of the discovery of a right buttock PU which measured 6.7 cm by 8.5 cm with superficial depth. The assessment indicated the PU was unstageable (considered stage 4 per MDS guide) related to 20% eschar present. The assessment also indicated there was associated pain. No wound treatment indicated at this time. R42's physician visit dated 4/21/16 included, "I find resident laying on her left side in her bed. Nursing staff has just completed her morning cares." The visit reported, "She requires a Hoyer lift with an assist of 2 for transfers and requires assist of 2 for repositioning in her bed and also requires assistance with propelling her wheelchair. She is unable to self- propel. She is in a broda chair for better positioning as she can no longer maintain sitting balance independently." Physician visit did not address the stage 2 pressure ulcer that was discovered on 4/17/16 located on the right thigh.	F 314		

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F 314	Continued From page 46 Weekly wound documentation on 5/3/16 (13 days after last assessment; however progress note dated 4/28/16 indicated wound size of 5.5 cm by 3 cm with dark wound bed, no stage indicated) indicated the wound was first observed on 5/3/16, the nurse practitioner (NP) was notified and the right posterior thigh wound measured 5 cm x 3 cm with 0.25 depth. The wound was classified as unstageable. Wound treatment included, cleanse apply skin prep and cover with foam. Weekly wound monitoring performed on 5/10/16 indicated no change to measurement but had green drainage. Treatment was changed to cleanse with wound cleanser, apply hydrogel to wound bed and cover with foam dressing, change daily. The next wound assessment not performed until 2 weeks later on 5/17/16, measurements 6 cm by 5 cm by 0.2 cm depth. Now a stage 2. Dressings orders were changed, reposition every 2-3 hours, wound nurse there and debridement the wound. 5/24/16 assessment measurements of 7.2 cm by 6.5 cm by 0.3 cm now a Stage 3 PU. Plan was to follow up with the specialty clinic for skin mapping for cushion and chair. Wound assessment dated 6/14/16 indicated PU worsening; 6 cm by 4 cm by 1.5 cm deep; categorized as unstageable. No new treatment plan indicated. Wound assessment dated 6/28/16 indicated worsening; 6 cm by 3.5 cm by 2 cm deep, categorized as unstageable; seen by wound nurse with treatment change. The next time and last wound assessment was performed on 7/22/16, and reflects worsening stage 4 PU now measured 5.6 cm by 3 cm by 7 cm deep, categorized as a Stage 4, wound vac now in place. Nurse's progress note concerning the PU stage 4 wound dated 5/25/16, at 12:22 a.m. included,	F 314		

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"Resident was seen by wound nurse on 5/24/16 for evaluation of right posterior thigh wound. Noted area had a foul odor and heavy serosanguinous drainage. Area is painful at times. History of pressure ulcers, wound heavy with drainage, notified [NP-A] and ordered culture." Progress notes reflect the culture was obtained and sent on 5/25/16 at 10:26 p.m.
Progress note on 5/28/16 indicated the culture grew out proteus mirabillis (infection organism) and antibiotics were initiated.
Nurse's Progress note dated 5/28/16, at 10:41 p.m. indicated the stage 4 PU appeared to be deeper with large amount of slough.
Nurse's Progress note dated 6/5/16 reported, "Right leg sore measures 1.5 cm deep by 7 cm in length and 5 cm wide. It has a dark colored hard eschar tissue and redness around edges. Resident c/o pain when area touched for measurement only."
Nurse's Progress note dated 6/8/16 reported, "Writer talked with [nurse] from Lifetime Specialty Clinic in St. Paul. He reported that resident had chair mapping done and in his opinion, the chair is not causing the problem. The problem in his opinion is the Hoyer sling. The Hoyer sling needs to be removed when resident is through being transferred, to avoid further breakdown."
R42's care plan was not updated to include the recommendation to remove Hoyer pad when not in use.
Nurses Progress note dated 6/14/16 reported, "Resident went to wound clinic. [family-A] went with to apt [appointment] at wound clinic. Resident returned with new orders for wound treatment. [F-A stated that the staff at the wound clinic stated that resident's wound was from not being turned. Resident is on an air mattress and has been for some time," "[F-A upset as she

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stated that resident was not on Oxycodone for pain with wound care and resident has an order for as needed Oxycodone," "Resident's wound was debrided at wound clinic today," "Resident was seen at Gillette for w/c issues and the Gillette staff stated that the w/c is not the issues with the wounds."

Nurse's Progress note dated 7/13/16 reported, "Resident's wound has a foul odor and has some yellowish/green drainage. Resident also has a fever of 100.0, talked with Doctor and reported findings." Progress note reflects NP-A gave new orders on the same day for wound culture. On 7/16/16 R42 was placed on isolation precautions related to a positive gram cocci (infection) and started on a course of antibiotics.

Late entry physician progress note dated 7/15/16 included, "I had the opportunity to view this wound today with the wound care team during their rounds. This is on her right ischium and measures 5 cm x 4 cm with a deep central area that is 7 cm in depth."

Late entry physician progress note dated 7/22/16 included, "I am seeing resident today for follow-up of a new increase in pain. Approximately 1 week ago she started complaining of severe pain bilateral legs. I saw her last Friday for not only pain but for her buttock ulcer. I had them obtain a wound culture which came back positive for E.coli, sensitive to Bactrim." Physician indicated the Baclofen was increased. Physician indicated diagnosis for stage 4 decubitus ulcer. Physician indicated a referral to neurology would be sent, does not believe the pain R42 experiencing related was related to pressure ulcer.

Nurse's Progress note dated 7/22/16 indicated new order for wound vac at 125 mm hg to be changed Mondays, Wednesdays, and Fridays.

Nurse's Progress notes from 6/14/16 through

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8/3/16 reflect a steady increase in pain and use of Oxycodone for pain.
Nurse's Progress notes on 8/4/16 indicated R42 had a change in condition, physician ordered labs. White blood cell count was 26.9 which was indicative of an infection. R42 was sent to the emergency room for possible sepsis.
During an interview on 8/4/16, at 1:11 p.m. NA-D stated, "we are supposed to reposition her every half hour, but she is not tolerating because of the pain, her pain has increased."
During an interview on 8/4/16, at 3:29 p.m. family (F)-A indicted R42 has a problem with bed sores and pain has been a problem with this one. F-A stated was not immediately notified after the stage 4 pressure ulcer worsened. F-A explained one day when at the facility a concerned staff member took her aside and wanted to show her something; how bad the pressure ulcer had become. F-A stated she had no idea that it had gotten that bad. F-A stated she couldn't exactly remember when the aide had showed her the ulcer, just remembered that it was bad.
During an interview on 8/5/16, at 10:35 a.m. F-B stated R42 was admitted to the hospital. F-B indicated this was the second pressure ulcer she has had since admission. Stated, R42 is so scared to ask for pain medication, she sits in pain. F-B stated, I had to call up there over last weekend because R42 called me in pain, and I had to call up to the facility to give her something. F-B stated the family did not know how bad the pressure ulcer was until the NA showed F-A. F-B stated, she had a wound clinic appointment the week of 7/19/16, so F-A was notified by the aide the prior week. F-B stated that wound clinic appointment was made without contacting family first. F-B stated R42's pain has substantially increased since the wound vacuum was added.

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F 314	Continued From page 50 During an interview on 8/5/16, at 11:10 a.m. registered nurse (RN)-A stated contracted company comes in and does rounds once a month and then we have another company that that comes out every 2 weeks to do wound rounds. RN-A stated the facility does not evaluate skin pressure tolerance to determine a repositioning schedule. During an interview on 8/5/16, at 1:59 p.m. director of nursing (DON) explained the process for skin assessment and wound monitoring. Indicated physician and family members are to be notified with changes immediately, indicated the wound needs to be monitored weekly and for worsening the doctor should be informed so orders can be adjusted. DON indicated residents need to be assessed to leave the Hoyer pad underneath making sure it does not interfere with the pressure reducing cushion. Facility policy Skin Program last revised 4/2016 included; the purpose of the policy, "To ensure a resident who enters the facility without pressure ulcers does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable. To provide care and services to prevent pressure ulcer development, to promote healing of pressure ulcers/wounds that are present, and prevent development of additional pressure ulcers." The policy included the following procedures: -In Minnesota (MN) a tissue tolerance assessment will be performed. In MN Tissue Tolerance Tests repeated with readmission, annually, with surface changes, or with a change in condition. -Braden will be completed with change in condition or surface -Reassess the wound at least weekly	F 314		

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F 314	Continued From page 51 R55 LACK OF ONGOING PU ASSESSMENTS: R55's care area assessment, (CAA) dated 6/20/15, identifies R55 scored a 15 (low risk) on the Braden scale (assessment used to determine risk of pressure ulcers). Care plan with an initiated date of 7/13/16, identifies, "I have pressure wounds on both heels and coccyx." Interventions include: "I have weekly wound assessments done, I wear prafo boots at all times." Treatment administration record, (TAR) identifies, "prafo boots to both heels at all times", dated 7/13/16. This was signed off as completed on three separate shifts on 8/2/16, 8/3/16 and 8/5/16. TAR also identifies a treatment for right heel: "cleanse with wound cleanser, apply skin prep to peri wound, apply hydrogel to wound, cover with foam and change daily", with a date of 7/28/16. Reviewed progress notes from 6/10/16 to 8/5/16. No documentation of pressure ulcer monitoring other than a physician progress note dated 7/22/16 at 3:44 p.m. identifies wounds to bilateral heels that are resolving. No measurements included. Reviewed weekly wound documentation forms. One documentation form dated 7/22/16 but was blank. Observed R55 on 8/2/16, at 5:21 p.m. Sitting in wheelchair in bedroom. Feet flat on the floor, no prafo boots on either foot. 8/3/16, 1:53 p.m. R55 lying in bed, feet flat on bed, no prafo boots present on either foot. 8/4/16, at 9:09 a.m. R55 is sitting in her wheelchair eating breakfast, no prafo boots present on either foot. 8/5/16, at 8:18 a.m. R55 sitting in wheelchair with feet flat on the floor, no prafo boots present on either foot. R55 stated her heel was sore and	F 314		

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stated staff hadn't ' put the boots on the night before.
8/5/16 at 10:11 a.m. observed wound care. Registered nurse, (RN)-A stated boots should be on at all times but staff might take them off to reposition or help with transfers but that they should be put back on as soon as they are finished. RN-A stated, "It would be a good idea" for feet to not be resting directly on the floor or bed. RN-A removed dressing from right heel wound and stated there was a small amount of greenish, yellow drainage. RN-A stated, "It stinks." RN-A stated, "slough in there, wound edges don't look too bad." Open area noted to be approximately 2 cm (centimeters) X (by) 2 cm (centimeters) with purulent drainage present. RN-A stated the wound is measured on a weekly basis and she measured it yesterday which is why she wasn't measuring today. RN-A stated the measurements from yesterday (7/29/16) were 1 cm X 1.5 cm, depth of 0.2 cm with 75% slough and the wound is classified as unstageable (coded as a stage 4 per MDS guide).
Interview with RN-A on 8/5/16 at 10:22 a.m. stated that she was responsible for the wound care in the facility and acknowledged the wound measurements were not in the computer under the weekly wound documentation. RN-A went to her office to retrieve paperwork. RN-A returned with a folder that contained loose slips of paper. One sheet of paper had 7/22/16 written at the top which was then crossed out with 7/29/16 written next to it. RN-A then stated the measurement from 7/29/16 were 0.8 cm X 1 cm X 0.3 cm with 100% slough. RN-A could not provide measurements with documentation from any other day. On asking for all measurements regarding the stage 4 PU from staff, none provided.

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F 314	Continued From page 53 Policy titled, skin program, dated April 2016, identifies, "When a skin ulcer is identified, a comprehensive wound assessment will be completed. This assessment will include, a) site, stage, size, appearance of wound bed, (use %) undermining, depth, drainage, (amount, color, type, consistency and odor) and status of peri-would tissue; b) treatment of the pressure ulcer, (cleansing, debridement, dressings); C0 use of a PUSH tool (or similar pressure ulcer monitoring tool) to assess pressure ulcer healing. Reassess the wound at least weekly: include a)-c) above."	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interveiw and record review, the facility failed to provide indwelling catheter cares/services to prevent urinary tract infections (UTIs) for 1 of 1 resident (R63) who had an indwelling foley catheter. Findings include: R63's diagnosis found on the order summary report identifies, "Sepsis, unspecified organism;	F 315	F315 Immediate corrective action: The Foley catheter and drainage bag for resident R63 was changed and covered. The NAR who provided care for resident R 63 on 8/4/16 at 8:24 a.m. was reeducated on keeping the catheter bag below the level of the resident's bladder.	9/12/16

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F 315	Continued From page 54 Urinary Tract Infection; Neuromuscular dysfunction of bladder; Neurogenic bladder." R63's last urinary tract infection was in March of 2016. Treatment Administration Record (TAR) identifies R63 to receive Foley care twice daily every day and evening shift. This was signed off as being completed on 8/4/16 by licensed nursing staff. Also identifies to change Foley catheter every 4 weeks and as needed. R63's care plan interventions include, "Foley cath, keep bag below level of balder and covered, observe for changes in my urinary status, drainage bag changed weekly." Observation on 8/4/16, at 8:14 a.m. foley catheter drainage bag has the date 7/11/16 identifying when it was last changed. Foley catheter tubing unable to see through, urine has a large amount of sediment present. Interview with licensed practical nurse, (LPN)-B during this observation, stated the catheter tubing and drainage bag appeared as though they hadn't been changed in a while. LPN-B stated she could not see through the tubing. LPN-B stated the tubing and drainage bag are changed twice a month. 8/4/16, at 8:24 a.m. catheter bag was hooked on to the hoyer sling during a transfer from the bed to R63's wheelchair. Catheter bag was higher than R63's bladder which could allow urine to backflow into bladder. 8/4/16 at 8:32 a.m. R63 was taken to the dining room in his wheelchair without a cover on the foley catheter bag. Interview on 8/5/16, at 8:49 a.m. with LPN-A stated the aides are responsible for foley catheter care. LPN-A acknowledged licensed nursing staff are signing off on the TAR that the foley catheter care is being completed but verified licensed nursing staff don't completed daily checks of	F 315	Action as it applies to others: Other residents with urinary catheters will be reviewed to ensure care and services are being provided to prevent urinary tract infections including a review of care planned interventions and physician's orders. The policy and procedure Urinary Catheter Care was reviewed and remains current. Nursing staff will be reeducated on the policy by September 12th, 2016 Date of completion: September 12th 2016 Recurrence will be prevented by: Weekly random audits will be conducted to ensure residents who use indwelling Foley catheters are receiving necessary care and services to prevent UTI's. Audits will be completed for a period of 90 days and audit results will be reviewed by the QA committee to determine the need for ongoing monitoring. The correction will be monitored by: DON or Designee	

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F 315	Continued From page 55 catheter's or complete daily catheter care which the order directs them to do. LPN-A stated he only looks at catheters if an aide alerts him there is a problem. Policy titled, "Urinary Catheter Care", dated November 2014, identifies "the purpose of this procedure is to prevent catheter-associated urinary tract infections. The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder. Check the urine for unusual appearance. Review the care plan to assess for any special needs of the resident."	F 315		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide range of motion (ROM) services, apply assistive device and follow therapy program to prevent further decrease in ROM for 1 of 2 residents (R79) who had physical limitations and was dependent on staff. Findings include: R79's diagnosis found on order recap report and physician progress note dated 6/22/16 include	F 318	RW – F 318 Immediate corrective action: Resident R79 was evaluated by Occupational Therapy and a soft WHO device was provided. Corrective action as it applies to others: Other residents with a noted limited range of motion will be evaluated by therapy services for the need for restorative nursing services to attain or maintain the	9/12/16

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F 318	Continued From page 56 ventilator and tracheostomy dependent, stroke with left side hemiplegia, left upper extremity contracture, generalized muscle wasting of both upper and lower extremities. Therapy to Nursing Communication form dated 3/3/16, identifies to initiate range of motion to left upper extremity, followed by left soft wrist hand orthotic (WHO), daily, off at night. Person served up in wheelchair 1-2 hours twice a day as tolerated. R79's care plan with date initiated 1/22/16, identifies, Restorative nursing with interventions including, Apply splints as ordered to decrease contracture progression, soft pro hand/wrist orthotic apply during the day, left upper extremity (LUE) after passive range of motion (PROM) of same. Care guide (utilized by direct care staff to provide services to residents they are assigned for their work period), identifies, Up as tol (tolerated); Soft WHO to left hand on during days, off at night. Observation on 8/4/16, at 7:19 a.m., R79 asleep in bed with no brace or splint located on left arm/wrist. 8/4/16, at 8:38 a.m. R79 awake in bed with no brace or splint located on left arm or wrist. 8/4/16, at 10:27 a.m. R79 awake in bed with no brace or splint located on left arm or wrist. On 8/4/16, at 11:39 a.m. R79 awake in bed, no brace or splint in place. 8/4/16, at 1:19 p.m. R79 awake in bed, no brace or splint in place. 8/5/16, at 8:41 a.m. R79 awake in bed, no brace or splint in place. Interview with nursing assistant, (NA)-B stated R79 is unable to grab anything with his left hand. NA-B stated R79 doesn't have any device for his left hand/wrist. Interview with licensed practical nurse, (LPN)-C,	F 318	residents highest practicable level of range of motion. The policy “Restorative Nursing Program” was reviewed and remains current. Nursing staff will be re-educated on the policy by 6/30/2015. Recurrence will be prevented by: Weekly random audits will be conducted on each unit to ensure restorative nursing programs are being completed and documented according to the resident’s individualized plan of care. Audits will be conducted for 90 days and audit results will be shared with the QA committee for their input on the need for continued monitoring. The correction will be monitored by: Director of Nursing and/or designee.	

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F 318	Continued From page 57 stated R79 doesn't have a splint or brace for his left hand/wrist and R79 doesn't have a contracture. Interview on 8/5/16, at 11:15 a.m. with occupational therapist assistant, (OTA), stated R79 is supposed to have a left hand splint and is on a program where nursing is supposed to have R79 up in his chair daily as well as completing range of motion exercises and wearing a splint.	F 318		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively	F 322	F322 Immediate corrective action:	9/12/16

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F 322	Continued From page 58 evaluate hydration status that were demonstrating signs and symptoms of dehydration for 1 of 2 residents (R45) reviewed for feeding tubes. Findings included: R45 had been observed and interviewed on 8/3/16, at 3:02 p.m. R45 was lying in bed, lips were cracked, dry, and pale pink. R45's oral cavity appeared dry and teeth were covered with a white film. R45 stated, he does not feel like he gets enough fluids, feels thirsty, and lately his mouth feels dry and lips are cracked and dry. During an observation on 8/4/16, at 8:31 a.m. R45 was lying in bed, an unidentified staff member was assisting to eat. The enteral feeding bag was half full with 350 cc's of formula. R45 stated, he disconnected it and turned it off last night because the nurse couldn't get it to stop beeping because it was plugged and he wanted to go to sleep. The tubing of the feeding was not capped, and large amounts of air were noted to be in the tube at two different locations in the tube. R45 admitted to the facility on 7/17/2015 according to five day Minimum Data Set (MDS) dated 7/20/16. The MDS identified diagnoses of malnutrition, multiple sclerosis, disease of spinal cord, and muscle wasting. The assessment indicated R45 had no cognitive impairment with a Brief Interview for Mental Status score of 15. The assessment included a height of 75 inches and a body weight of 116 pounds. The MDS indicated R45 required extensive assistance from one staff member for eating a mechanically altered diet related to swallowing difficulties, required feeding tube where an average of 51% or more daily required calories were consumed and average fluid intake through the tube was 501 cubic	F 322	The Registered Dietician was updated for resident R45 regarding fluid replacement related to refusal of supplemental shakes. Fluid intake tracking was added to the POC Corrective action as it applies to others: Other residents who receive supplemental hydration through enteral tubes and have oral intake will be reviewed by the RD to ensure adequate fluid intake and record reviews will be completed to ensure fluid intake and output is tracked daily. The policy for Enteral nutrition was reviewed and remains current. Nursing staff will be re-educated on the policy by September 12th, 2016 Date of completion: September 12th, 2016. Recurrence will be prevented by: Random weekly chart reviews will be conducted to ensure residents are receiving adequate hydration according to MD orders and RD recommendations. Audits will be conducted for 90 days and audit results will be shared with the QA committee for their input on the need for continued monitoring. The correction will be monitored by: Registered Dietician and/or designee.	

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F 322	Continued From page 59	F 322		

centimeters (cc) or more a day.
R45's current electronic care plan informed staff he could not feed himself without assistance and indicated a history of refusing fluids prior to the feeding tube placement. The nutritional plan of care dated 8/4/15 indicated the daily fluid requirement was 1650-1900 cc with a goal of staying hydrated and not suffer from thirst and the body mass index indicated R45 was underweight with a goal of gaining weight. The nutrition care plan directed staff to monitor for changes in normal food/fluid intake and further evaluate. The care plan indicated on 6/10/16 R45 relied on tube feedings for a portion of food and fluid needs, with interventions that included, "staff provide fluid and formula flushes per MD [medical doctor] order."
R45's current electronic physician orders included,
· Enteral feed at bedtime Resource 2.0, 65 cc/hour for 12 hours from 7:00 p.m. to 7:00 a.m.
· 250 cc water flush every four hours during the day four times a day for dietary during the day.
· 90 cc flush before and after feeding and medications.
R45's record reflected hospital intensive care admission from 5/19/16 through 5/22/16. Hospital visit note indicated diagnoses on admission included urinary infection, sepsis likely caused by urinary infection, dehydration poor oral intake, and encephalopathy from hypoxia and dehydration. The note indicated on physical exam R45 appeared dehydrated. This visit was prior to the placement of the feeding tube.
R45's dietary progress note dated 7/25/16 included, "RDN asked if he is still consuming the nutritional shakes he receives and he states no. He reports being sick of them and stated he told nursing to d/c [discontinue] them last week. RDN

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F 322	Continued From page 60 will notify senior service team. RDN recommended another small increase in tube feeding rate and person served was agreeable." R45's record from 7/20/16 until 7/25/16 does not reflect fluid replacement/supplementation related to refusal of the shakes to ensure recommended fluid goals are met. The record did not reflect notification to either the physician or the registered dietician. R45's Registered Dietician Nutritional assessment completed on 7/26/16 indicated total fluid intake at meals and between meals was 1600 cc via tube feeding and flushes, fluids offered were 2200 with 1600 cc via tube feeding, and estimated fluids daily fluids required were 1650-1900 cc. R45's record did not reflect tracking or evaluation 24 hour fluid consumption and output to ensure daily recommended fluid goals were met. R45's July 2016 and August treatment administration records (TAR) reflects output monitoring related to the indwelling urinary catheter and reflects physician orders for the enteral tube feeding and the water flushes; the TAR shows "check marks" in the designated boxes but not the actual amount of fluid was given. During an interview on 8/5/16, at 2:13 p.m. director of nursing (DON) explained facility "expectation would be they have a 24 hour intake and output." DON explained the facility had a 24 hour registered nurse on call just for support and education, the nurse should have called if there was an issue with the feeding pump. If R45 had clinical symptoms of dehydration then a reassessment should be done for increase in fluid needs. Request for a policy for tube feeding and/or hydration was not requested and none provided.	F 322		

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F 328	Continued From page 61	F 328		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a physician order for capping of a tracheostomy for 1 of 1 resident (R74) reviewed for tracheostomy care. Findings include: R74's annual Minimum Data Set (MDS), dated 5/24/16, identified diagnosis of respiratory failure and special treatments of tracheostomy care, oxygen, suctioning and ventilator. On 8/4/16, at 7:42 a.m., R74 was observed sitting in his room in a wheelchair, sleeping. R74 had a tracheostomy. R74's care plan, print date 8/5/16, indicated R74 had a tracheostomy, require heated humidity, oxygen and as needed (PRN) suctioning. Interventions change trach (trachea) ties three time a week, trach cares twice daily, have been	F 328	RW – F 328 Immediate corrective action: The order for trach capping for resident R74 was resumed. Corrective action as it applies to others: Other tracheal dependent residents will be reviewed to ensure tracheal capping devices are used if indicated and ordered by the physician. The policy and procedure for tracheal capping was reviewed and remains current. Staff will be educated on the policy for tracheal capping by September 12th, 2016. Recurrence will be prevented by: Random weekly audits will be conducted on each unit to ensure staff remain complaint with the policy and procedure for Tracheal Capping. Audits will be conducted for 90 days and	9/12/16

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F 328	Continued From page 62 trying the red cap on my trach, and only would want to wear it when my wife is present. The red cap has been on hold at this time. R74's Treatment Administration Record (TAR), dated 7/16, identified may be trach capped for a total of two hours in the morning and two hours in the afternoon including therapy session, hold date from 8/1/16 to 9/1/16. R74's physician orders, print date 8/4/16, did not include the order to cap trachea. On 8/4/16, at 10:09 a.m., licensed practical nurse (LPN)-E stated R74 will only allow trach capping to be done when family member (FM)-I was here. When FM-I is here she applies the trach cap and R74 tolerates it. LPN-E reviewed R74's physician orders and stated the order for trach capping was on hold and there was not a current physician order for the treatment of trach capping. LPN-E stated she had last seen FM-I apply the trach cap last week on Friday. On 8/4/16, at 12:17 p.m., registered nurse (RN)-A stated the facility had no registered therapist (RT) on board right now. RN-A stated R74's RT order was on hold 7/5/16 and R74 does not see a RT therapist right now. On 8/4/16, at 12:24 p.m., speech therapist (ST)-J stated R74 was on case load about two years and she had discontinued speech therapy for R74 on 1/4/16, due to hospitalization. ST-J stated at the time she had discharged R74 from speech therapy the trach capping was limited to four hours per day. ST-J stated she did not pick R74 back up when he returned to the facility due to no changes in status for needing speech therapy. ST-J reviewed R74's orders and stated it looks	F 328	audit results will be shared with the QA committee for their input on the need for continued monitoring. The correction will be monitored by: Director of Nursing and/or designee.	

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F 328	Continued From page 63	F 328		

like the order for trach capping was on hold. ST-J stated she did not know why the trach capping was on hold. ST-J stated at the time R74 was discharge from speech therapy R74 was tolerating the trach capping, nursing was providing trach capping and the FM-I was providing trach capping for R74.

On 8/4/16, at 12:47 p.m., FM-I stated I do apply the cap to the trach. FM-I stated she was here almost every day currently and she applied the cap at 10:00 a.m. and removed the cap between 12:00 p.m. and 12:30 p.m. She then applied the cap back on around 2:00 p.m. or 3:00 p.m. and removes the cap back off about 6:30 p.m. FM-I stated some days the cap is on all day long. FM-I stated R74 did not like to have the cap on when he was in bed or when he is by himself. FM-I stated she had seen LPN-C apply the trach cap and staff encourage him to have the trach cap applied more often than when I am here.

On 8/05/16, at 9:51 a.m., licensed practical nurse (LPN)-C stated she always asks R74 if he would like to be capped for his tracheostomy. LPN-C stated R74 prefers to wait for FM-I to cap the tracheostomy. If we do cap him we bring him up here by the nurse's station. LPN-C verified R74's MAR and TAR show the trach capping was on hold. LPN-C stated per R74's physician orders the trach capping was put on hold 2/8/16. LPN-C reviewed R74's orders and stated there was not a current physician order for trach capping.

On 8/5/16, at 12:10 p.m., registered nurse (RN)-A stated R74 does not want capping for his tracheostomy to be done. When queried if R74 had a current order for trach capping, RN-A reviewed R74's orders and stated R74's orders

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F 328	Continued From page 64 showed the trach capping was on hold. RN-A reviewed R74's medication and treatment administration records (MAR/TAR) and stated the MAR/TAR records show the trach capping was on hold. RN-A stated she did not know why the trach capping was on hold. RN-A stated how the system works was when a resident goes onto the hospital all orders for the resident are put on hold, then when the resident returns we put things back into place. RN-A reviewed R74's record and stated it looks like the trach capping order was put on hold for R74 on 2/8/16 after R74 was readmitted to the facility on 2/10/16. RN-A stated the trach capping order should have been addressed when R74 was readmitted on 2/10/16. RN-A stated if trach capping was currently being done she would expect there to be a physician order for the trach capping. On 8/5/16, at 10:36 a.m., the director of nursing stated she would expect a physician order for the treatment of trach capping. A facility policy for trach capping was requested, but not provided.	F 328		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.	F 329		9/12/16

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F 329	Continued From page 65 Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on document review and interview the facility failed to complete a comprehensive sleep assessment, monitor, and periodically assess effectiveness for a medication used for sleep for 1 of 5 residents (R74) reviewed for unnecessary medications. Also failed to follow physicians orders in regards to bowel management with use of Dulcolax Suppository for 1 of 1 resident (R74) who was on a bowel regimen due to chronic constipation. Findings included: R74 FAILED TO COMPLETE A COMPREHENSIVE SLEEP ASSESSMENT: R74 had diagnosis of insomnia according to the facility electronic diagnoses list. R74's annual Minimum Data Set (MDS) dated 5/24/16 indicated R74 had moderate cognitive impairment (staff assessed) and had unclear speech; only able to make self-understood sometimes and able to only understand others sometimes. The MDS indicated R74 had trouble	F 329	F329 Immediate corrective action: A Comprehensive Sleep Assessment was completed for resident #74. The care plan was updated to include non-pharmacological interventions for sleep, neurogenic bowel and an order was obtained to monitor the number of hours of sleep each shift. The MD was updated for resident 74's change in condition. Action as it applies to others: Bowel assessments will be completed for other residents with Neurogenic Bowel to ensure appropriate care planning and interventions are implemented to address bowel status. Other residents with active orders for Hypnotic medications will be reviewed to ensure non-pharmacological interventions are care planned and that monitoring of	

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F 329	Continued From page 66 falling asleep, staying a sleep or sleeping too much. R74's electronic physician's orders included Remeron 15 milligrams (mg) for insomnia and depressive disorder. R74's care plan reflected diagnosis of insomnia, however the care plan did not reflect a plan of care for sleep that would include non-pharmacological interventions for sleep. R74's record did not reflect a comprehensive sleep assessment, monitoring, or evaluation of sleep integrity. During an interview on 8/4/16, at 8:11 a.m. registered nurse (RN)-A reported R74 did not have a sleep assessment or sleep monitoring. RN-A said she was unaware a sleep assessment was required for any one receiving sleeping medication(s). During an interview on 8/5/16, at 1:35 p.m. director of nursing (DON) indicated the protocol for sleep monitoring and assessments included a care plan for sleep, sleep monitoring, and monitoring for effectiveness of the medication. Facility policy Psychopharmacological Medication Assessment and Review last revised April 2016 included the purpose of the policy; "To assure all psychopharmacological medications are reviewed to assess for effectiveness, minimal effective dose, potential side effects, potential drug interactions, goals for use, and need for a gradual dose reduction." The policy also included, 1) Each resident receiving any of the aforementioned medications (included hypnotic) will have an initial assessment prior to a medication being initiated, at admission, quarterly, annually and with a change in condition. 4) All residents on a psychopharmacological medication required the resident specific reason for its use monitored.	F 329	the number of hours of sleep each shift is implemented. The policy and procedure “Psychological Medication Assessment and Review” was reviewed and remains current. Facility bowel protocol was reviewed and remains current. Licensed Nursing Staff will be reeducated on the policies by September 12th, 2016. Date of completion: September 12th, 2016. Recurrence will be prevented by: Random weekly chart audits will be conducted to ensure residents with active Hypnotic Medication orders have appropriately care planned non-pharmacological interventions to promote restful sleep and to ensure monitoring of the number of hours of sleep each shift is implemented. Additionally, record review audits will be completed to ensure ongoing compliance with facility bowel protocol and to ensure PRN bowel medications are administered as ordered by the prescribing physician. Audits will be conducted for 90 days and audit results will be shared with the QA committee for their input on the need for continued monitoring. The correction will be monitored by: Consultant Pharmacist and/or DON	

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F 329	Continued From page 67 5) All psychopharmacological medication must have care planned non-pharmacological interventions attempted prior to administering the medications. R74 FAILED TO MONITOR EFFECTIVENESS OF BOWEL MEDICATIONS: R74 had a diagnosis of neurogenic bowel according to the electronic diagnoses list. R74's annual Minimum Data Set (MDS) dated 5/24/16 indicated R74 had moderate cognitive impairment (staff assessed) and had unclear speech; only able to make self-understood sometimes and able to only understand others sometimes. The MDS indicated R74 was always incontinent of bowel and was dependent on staff for toileting. It was also learned the resident is on a tube feeding regimen. R74's current electronic care plan lacked a completed individualized plan of care for neurogenic bowel. The care plan informed staff: R74 was incontinent of bowel and bladder with a goal of, "I am unable to recognize toileting urges and I am incontinent. I would like staff to anticipate and meet my hygiene needs." The care plan also included; · R74 could not alert staff when he needed help getting to the bathroom. · R74 responded to questions with nods or shakes of head to yes or no questions. · R74 could not tell staff when in pain; staff were to evaluate restlessness or agitated behavior and watch for non-verbal signs of pain. R74's physician orders included: · Dulcolax Suppository 10 milligrams (mg) rectally every 48 hours related to constipation. · Miralax Powder 17 grams via percutaneous endoscopic gastrostomy (PEG) tube every 24 hours as needed for constipation. R74's July 2016 and August medication	F 329		

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F 329	Continued From page 68	F 329		

administration records (MAR) reflect administration of the Dulcolax suppository as ordered. The MAR indicated R74 had a bowel movement on 7/22/16 after administration of the suppository. Nursing assistant bowel documentation indicated R74 next had a bowel movement 11 days later on 8/3/16. Even though R74 went 11 days without having a bowel movement, the MAR did not reflect administration of the Miralax which had a start date of 2/10/16. R74's nurse progress notes and assessment reviewed from 7/22/16 through 8/4/16 did not reflect monitoring, assessment or reassessment of physician's ordered bowel regimen to determine effectiveness of the medications. Furthermore, the record did not reflect physician notification of the change in the condition.

During an interview on 8/4/16, at 8:11 a.m. registered nurse (RN)-A said she had not documented bowel movements for R74 between 7/23/16 and 8/2/16. RN-A confirmed R74 had a large loose bowel movement on 8/3/16. RN-A stated a bowel assessment should have been completed if no bowel movement after the suppository which was given every two day with out results. RN-A stated the doctor should have been notified. RN-A explained, she didn't like to see any more than three days without a bowel movement.

During an interview on 8/5/16, at 1:36 p.m. director of nursing (DON) was asked, "What are your expectation for monitoring bowel movements?" DON replied, I expect floor staff are monitoring and charting the date of bowel movement, size, and consistency, if the resident has diarrhea or abnormal stool, the aides are to inform the nurse and the nurse to inform physician for treatment. DON indicated staff should be monitoring, recording, and following

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F 329	Continued From page 69 bowel management per policy. DON stated bowel medications should be monitored for effectiveness. DON indicated constipation should have a care plan. Facility protocol Bowel Protocol not dated directed staff to perform the following if no bowel movement; · On morning of day two- complete and document bowel assessment and perform rectal check. · On morning of day three- complete and document bowel assessment and perform rectal check. Then in evening give laxative (milk of magnesia) · On morning of day four- complete and document bowel assessment and perform rectal check, administer suppository. In the evening monitor for results. · On morning of day five- administer enema and contact medical doctor if no results, complete and document bowel assessment and perform rectal check.	F 329		
F 354 SS=F	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.	F 354		9/12/16

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F 354	Continued From page 70 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide a registered nurse (RN) eight consecutive hours per day, seven days a week and this could affect all 78 residents in the facility. Findings include: On 8/5/16, at 12:54 p.m., the director of nursing (DON) stated there was one day 7/3/16, the facility had no RN coverage. The DON stated registered nurse (RN)-C was supposed to be in the building to work and she had no answer for why RN-C was not. Review of the actual staffing and the staff postings revealed: -Staff posting dated 7/3/16, indicated number of staff working, licensed staff RN for night shift, day shift and evening shift, a zero was entered for each shift. The number of hours per classification for licensed staff RN all three shifts, a zero was entered for each shit. -Actual staff schedule, dated 7/3/16, there was no indicated RN identified for staff listed on the schedule. Facility provided policy Sufficient Staffing last revised 1/2015 did not reflect need for RN coverage without a waiver.	F 354	F353 Immediate corrective action: Immediate education was provided to facility staffing coordinator and DON regarding the requirement to staff RN coverage 8 consecutive hours, 7 days a week. Action as it applies to others: Daily staffing meetings will be held Monday through Friday to ensure adequate RN coverage, this will ensure adequate weekend RN coverage as well. In the event that an RN is unavailable, due to a call-off, or other event, an on-call RN rotation schedule will be developed and implemented to ensure the requirement for RN coverage is met. Ongoing recruitment and hiring initiatives will continue in an effort to recruit and hire additional RN's on staff. Date of completion: September 12th, 2016 Recurrence will be prevented by: Daily review of staffing will continue as a standard of practice in the facility to ensure ongoing compliance with RN coverage. Results will be shared with the QA committee for review and input to ensure continued compliance. The correction will be monitored by: Administrator / DON / Staffing Coordinator.	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH	F 425		9/12/16

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F 425	Continued From page 71 The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to follow manufacturers directions when administering insulin by a pen for 1 of 1 resident (R137) observed to receive a Novolog insulin by an insulin pen. Also failed to transcribe pain medication as ordered to control moderate to severe pain for 1 of 4 residents (R136) reviewed for unnecessary drugs. Findings include: R137: FAILURE TO FOLLOW MANUFACTURERS DIRECTIONS WHEN GIVING INSULIN BY PEN: R137's admission record indicated that he was admitted to the facility on 7/29/2016.	F 425	F425 Immediate corrective action: Immediate education was provided to RN-D regarding the administration of insulin using an insulin pen. A medication error report was completed for resident R74 for the fentanyl patch not being administered as ordered. DON received reeducation regarding investigating and reporting medication errors. RN-A, RN-B and HUC-F received reeducation regarding transcription of medication orders.	

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F 425	Continued From page 72 R137's diagnosis report, reviewed on 8/4/2016, indicated that he had been diagnosed with type two diabetes mellitus. Insulin dependent. R137's order recap report, dated 8/1/2016, indicated that the physician prescribed Novolog insulin with his meals. During an observation on 8/3/2016 at 5:27 p.m. registered nurse (RN)-D stated that R137's blood sugar was 207 and she was going to administer 4 units of his Novolog insulin before he went out to eat with his family. RN-D Gathered the insulin pen, needles, alcohol wipe and a gauze dressing and then knocked on R137's door and explained to the resident that she was ready to administer his insulin. RN-D Washed her hands, applied latex gloves and then affixed a needle to the tip of the insulin pen. She drew up 4 units of Novolog insulin and showed to this surveyor and stepped closer to the resident. When asked if she was going to administer the insulin she stated that she was. At this moment surveyor asked the nurse to step outside the room before insulin was given. When asked if the facility required the nursing staff to prime insulin pens prior to administration RN-D Asked, "What's that?" Priming the insulin pen as directed by the manufacturers recommendations was given. RN-D Stated that she had never done this before. RN-D then primed the pen drew up correct dose and gave to R137 with out error. When interviewed on 8/3/2016 at 5:56 p.m. the director of nursing (DON) stated that it would be her expectation that the nursing staff would follow the manufacturer's instructions regarding the proper administration of an insulin pen. She reiterated that it would be her expectation that the nursing staff would follow the current standards of practice.	F 425	Action as it applies to others: Other residents who report moderate to severe pain according to their most recent MDS will be reviewed including a review of current physician's orders and medication administration records to ensure pain medications are administered as ordered. The policy and Procedures for insulin pen delivery systems, transcription of medication orders and medication errors were reviewed and remain current. Licensed nursing staff will be re-educated on the policies by September 12th, 2016. Date of completion: September 12th, 2016 Recurrence will be prevented by: As an ongoing practice, medication errors will be documented in accordance with facility policy and the IDT will review medication error reports the next business day following the incident. Additionally, random weekly visual audits will be conducted to ensure ongoing compliance with the correct administration of insulin via insulin pens. Random weekly medication order audits will be completed to ensure the accurate and timely transcription of medication orders. Audits will be completed for a period of 90 days and audit results will be reviewed by the QA committee to determine the need for ongoing monitoring. The correction will be monitored by: Administrator / DON	

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When interviewed on 8/3/2016 at 6:25 p.m., the DON stated that she shared the state surveyors concerns regarding the nursing staff not administering insulin correctly. She stated that the facility instituted mandatory education for all licensed nursing staff on how to correctly administer insulin. She stated that RN-D received education and that R137 received his insulin correctly.

Review of the document titled, Insulin and Non-Insulin Pen Delivery Systems (March 2016), it stated in order to assure that each dose of insulin was administered completely and safely, air must be expelled from the cartridge by giving 'airshot' before each injection. It described the process of removing air by setting the dial on the pen at 2 units and then expelling the 2 units then drawing up the ordered dose of insulin.

R136 FAILED TO PROVIDE PAIN MEDICATION AS ORDERED:
R136's physician orders, dated 7/14/16, identified diagnosis of malignant neoplasm of penis and included an order for Fentanyl Patch (a narcotic pain medication) 75 mcg (microgram) every 72 hours and handwritten next to the Fentanyl order was applied at 1630 (4:30 p.m.) on 7/13/16. In addition the orders had handwritten check marks alongside of each medication listed on the orders. R136's medication administration record (MAR), dated July 2016, included Fentanyl Patch 75 mcg apply one patch transdermally (application of medicine through the skin) one time a day every three days and identified the patch having been applied on 7/19/16 (6 days after the last patch had been applied). The MAR identified pain monitoring every shift and when as needed

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Morphine (a narcotic pain medication) was given. R136 had pain (scale of 0 to 10 with 10 being excruciating) ranging from 0 to 9 at the highest from 7/14/16 through 7/19/16. R136's progress notes indicated the Morphine was effective after administration.
The facility lacked a medication error report for the Fentanyl patch not being administered as ordered.
On 8/5/16, at 10:31 a.m., the director of nursing (DON) stated,"Yes" she was aware of the Fentanyl patch not being applied as ordered.

On 8/5/16, at 11:54 a.m., registered nurse (RN)-A stated R136 was being followed by Hospice and the hospice registered nurse (RN)-G brought the order for the Fentanyl patch after R136 was admitted. RN-A verified R136's orders dated 7/14/16, included an order for the Fentanyl patch.. RN-A verified R136's MAR identified the patch had been applied on 7/19/16. RN-A stated the Fentanyl patch should have been changed on 7/16/16 and not on 7/19/16.

On 8/5/16, at 12:43 p.m., conversation via telephone RN-G confirmed she was the person who talked to the facility staff about the Fentanyl patch. RN-G stated R136 was admitted to the facility on 7/14/16 and the Fentanyl patch was started and applied on 7/13/16. RN-G stated the Fentanyl patch should have been changed by the facility on 7/16/16. RN-G stated she was at the facility on 7/15/16 and had talked to the NP-D on 7/15/16 to make sure there was an order for the Fentanyl patch and NP-D had written a prescription for the Fentanyl patch. On 7/18/16, RN-G was at the facility and checked R136 to make sure the patch was in place as he was having horrific pain over the weekend. The patch

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that was on R136 was the one I applied on the 13th. When surveyor asked the RN-G if she had checked on 7/18/16 to see if the Fentanyl Patch medication was in the facility medication cart and available for the resident RN-G stated no I did not check to see if the medication was available in the cart to be honest, I would not have thought to do that. RN-G stated she then talked to RN-B and asked what happened, R136 does not have a new Fentanyl patch on and RN-B replied R136 does not have an order for it. RN-G informed RN-B he does because I gave it to you on Friday (7/15/16). I had called NP-D on 7/15/16 and talked to her on the phone and she was in the process of writing the prescriptions. On Monday 7/18/16, HUC-F had the prescriptions in a drawer and the prescriptions were all dated 7/15/16. The prescription had not been filled yet and that is why R136 went without the Fentanyl patch over the weekend.

On 8/5/16, at 12:54 p.m. the DON stated they need to reeducate staff. The HUC-F does the orders and the nurse signs off on the orders. I talked to RN-A and RN-B about needing to make sure orders are co-signed. I visited with HUC-F and talked about the process and does she understand the process or orders and being sure they are accurately in the chart. I only did education with RN-A, RN-B and HUC-F (regarding the Fentanyl patch). To me it was a transcription error not a medication apply error.

On 8/5/16, at 1:31 p.m., conversation via telephone with the pharmacy staff (PS)-E stated the Fentanyl patch prescription was received at the pharmacy on 7/18/16, at 4:17 p.m. The Fentanyl patch was delivered to the facility on 7/18/16, at 11:47 p.m.

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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 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		9/12/16

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	245223	A. BUILDING _____ B. WING _____	08/05/2016

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F 441	Continued From page 77 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper infection control practices during the provision of tracheostomy care for 1 of 1 resident (R74) observed receiving tracheostomy cares. In addition, failed to wear gloves when administering medications through a percutaneous endoscopic gastrostomy (PEG) tube for 1 of 1 resident (R120) reviewed for medication administration. Findings include: R74: LACK OF PREVENTATIVE MEASURES INCLUDING WASHING HANDS AT APPROPRIATE TIME DURING TRACHEAL SITE CARES: R74 had been observed for tracheostomy (trachea)cares on 8/4/16, at 9:02 a.m. by licensed practical nurse (LPN)-E. LPN-E then entered R74's room and set up supplies on a tray table for R74's trachea cares to be provided. LPN-E donned gloves and proceeded to suction R74 through his tracheostomy. LPN-E removed gloves after providing suctioning. LPN-E donned gloves, removed the gauze dressing from around R74's trachea site and removed gloves. LPN-E donned gloves, obtained wet gauze and wiped the gauze in the folds of R74's neck on both sides then with the same gauze cleansed directly around R74's trachea site. LPN-E then with the same soiled gloves obtained a Q-tip cleaner and cleaned the inside of R74's trachea site with the Q-tip and wiped the gauze around the trachea site again after cleaning with the Q-tip. LPN-E with the same soiled gloves applied a clean gauze dressing around R74's trachea site and	F 441	F441 Immediate corrective action: LPN-E received retraining regarding hand washing and the provision of tracheostomy cares. LPN-E received retraining regarding the administration of medications via feeding tubes. Action as it applies to others: The policies and procedures for the administration of medications via enteral tubes and the provision of tracheostomy cares were reviewed and remain current. Licensed nursing staff will receive retraining on the provision of tracheostomy cares and the administration of medications via feeding tubes by September 12th, 2016. Date of completion: September 12th, 2016. Recurrence will be prevented by: Random weekly visual audits will be conducted to ensure ongoing compliance with the administration of medications via feeding tubes and the provision of tracheostomy cares in accordance with facility policy and procedure. Audits will be completed for a period of 90 days and audit results will be reviewed by the QA committee to determine the need for ongoing monitoring. The correction will be monitored by: DON or Designee	

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F 441	Continued From page 78	F 441		

secured the dressing. LPN-E removed the pair of soiled gloves. LPN-E applied clean gloves and proceeded to brush R74's teeth. LPN-E obtained an emesis basin (which had a layer of visible white substance on the bottom base of the basin), placed some water in the basin, applied toothpaste to R74's toothbrush and set the toothbrush into the water of the basin. LPN-E removed gloves after providing oral cares for R74. LPN-E washed hands.

LPN-E failed to wash hands prior to providing trachea cares, failed to wash hands between removing soiled gloves and applying clean gloves and failed to provide a clean emesis basin used to provide oral cares.

On 8/4/16, at 9:35 a.m., LPN-E verified she had not washed hands during the procedure of providing tracheostomy cares when removing soiled gloves and applying clean gloves. LPN-E verified she had cleaned R74's neck first and then used the gauze to clean the trachea site. LPN-E verified the emesis basin had white substance in it and stated it was probably toothpaste. LPN-E stated staff should make sure the basin is cleaned after use.

On 8/5/16, at 10:36 a.m., the director of nursing (DON) stated she would expect hands to be washed prior to providing trachea cares and handwashing to be done during trachea cares when going from dirty procedure to clean procedure. In regards to cleaning the neck first and then the trachea site with the same gauze, the DON replied I would have to review the policy to answer that. The DON stated she would expect staff to use a clean emesis basin when providing oral cares.

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F 441	Continued From page 79 The facility policy Protocol for Cleaning Tracheostomy Tube, Suctioning and Stoma Care, dated 7/14, indicated Purpose: To provide safe and consistent practices of care for tracheotomized residents requiring stoma care and suctioning to maintain a patent airway and reduce risk of infection. Procedure: 1. Wash hands, put on clean gloves. 4. Remove soiled drainage sponge and soiled trachea tie and dispose of in plastic bag. 5. Remove gloves and dispose plastic bag. 6. Perform hand hygiene and put on new non-sterile gloves. 7. Open trachea kit and prepare solutions. 8. Clean stoma site using 4 x 4 gauze and cotton swabs dipped in hydrogen peroxide and saline mixture 9. Rinse stoma site using 4 x 4 gauze and cotton swabs dipped in sterile water or saline 10. Dry site with clean 4 x 4 gauze 13. Remove gloves and perform hand hygiene and put on new pair of gloves. 14. Place a clean drainage sponge around the stoma site. Suctioning: 7. Put on sterile gloves 12. g. Clear secretions from catheter and suction tubing h. Discard catheter, gloves and saline in plastic bag j. wash hands R120: FAILED TO USE INFECTION CONTROL PRACTICES WHEN ADMINISTERING MEDICATIONS THROUGH A FEEDING TUBE R120's admission record indicated that the resident came to the facility on 4/5/2016. R120's diagnosis report, dated 4/5/2016, indicated that the resident had a gastrostomy tube. R120's medication administration record (MAR), reviewed from 7/1/2016 through 8/3/2016 indicated that the resident received medications through his gastrostomy tube. During an observation on 8/4/2016 at 7:26 a.m.,	F 441		

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F 441	Continued From page 80 licensed practical nurse (LPN)-E had washed her hands in a sink by the nurses station prior to preparing R120's medications. She then proceeded to prepare his medications one by one. Once the medications were prepared, LPN-E Entered R120's room and introduced self. LPN-E Explained that she was going to administer his medications. LPN-E did not don gloves. LPN-E Turned off the tube feeding and disconnected the feeding tube that he had been receiving when she entered the room. She then filled up a canister of water and took the end of the gastrostomy tube with her left hand and flushed the tube with 30 ml (milliliters of water) and then proceeded to administer R120's medications. All this time, LPN-E Did not wear a pair of gloves but handled the tube with her bare hands. When interviewed on 8/4/2016 at 7:42 a.m. LPN-E Stated that the facility had never required the nursing staff to wear gloves when administering medications through a gastrostomy tube. Even though there is a chance to come in direct contact with secretions from tube feeding. When interviewed on 8/4/2016 at 2:42 p.m., registered nurse (RN)-A, stated that the nurse should have worn gloves when administering medications through a gastrostomy tube. Review of the facility document titled, Medication Administration through Gastric tube (Nov 2015), it stated to prepare medications, wash hands and dry thoroughly and then wear clean gloves prior to medication administration.	F 441		
F 465 SS=C	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABL	F 465		9/12/16

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F 465	Continued From page 81 E ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the condition of the ceiling tiles for 7 of 7 bathrooms (2-065, 2-077, 3-066, 3-075/3-077, 3-079, 3-093/3-095, 3-097) which residents currently use. Findings include: During observations on 8/5/16, at 11:20 a.m. p.m. the following resident bathrooms had ceiling tiles which were stained brown and/or discolored: Room #: 2-065, 2-077, 3-066, 3-075/3-077, 3-079, 3-093/3-095, 3-097 (some were shared by more than one resident). A tour was conducted with the maintenance director on 8/5/16, at 11:39 a.m. It was confirmed the stains on the ceiling tiles in resident bathrooms were a result of water damage related to sweating pipes and condensation. The maintenance director verified the ceiling tiles needed to be replaced.	F 465	F465 Immediate corrective action: The ceiling tiles in the following rooms were replaced: 2-065, 2-077, 3-066, 3-075, 3-077, 3-093, 3-095, 3-097. Action as it applies to others: An audit of other resident bathrooms will be completed and stained ceiling tiles will be replaced. Date of completion: September 12th, 2016 Recurrence will be prevented by: Ongoing monthly maintenance audits will be conducted on an ongoing basis to identify resident bathrooms with stained ceiling tiles. Tiles will be replaced as needed. Audit results with be shared during the facility QAPI meeting. The correction will be monitored by: Maintenance Director	

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	245223	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/03/2016**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey dated 8-3-2016, Red Wing Health Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/02/2016

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

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K 000	Continued From page 1 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Red Wing Health Center is a 3-story building with a partial basement. The building was constructed at 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 fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification.	K 000		

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K 000	Continued From page 2 The facility has a capacity of 141 beds and had a census of 95 at the time of the survey.	K 000		
K 025 SS=D	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barrier wall in accordance with the following requirements of 2000 NFPA 101, Section 19.3.7.3, and 8.3.4.1. Findings include: On facility tour between 09:00am and 12:00 PM on 08/03/2016, observation revealed the following in the smoke barrier walls: 1. The 1st floor and 2nd floor smoke barriers have open penetrations around piping above the ceiling areas.	K 025	It is the policy of Red Wing Healthcare Facility to maintain Smoke barrier wall Requirements for all barriers Within the facility according to 8.3, 19.3.7.3, 19.3.7.5 Corrective Action: 1st, 2nd and 3rd floor smoke barriers were All checked for compliance. 1st and 2nd floors revealed open Penetrations around piping Above the ceiling areas. On 8/3/16, the penetrations Through smoke barriers were Sealed with flame buster Silicone. Monitoring Mechanism: Building has ongoing monitoring Through regularly scheduled Maintenance rounds, and monthly	9/12/16

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K 025	Continued From page 3 NOTE: All smoke barrier walls shall be checked for this deficiency. This deficient practice was confirmed by the Facility Maintenance Director (DP) at the time of discovery.	K 025	Quality Improvement rounds to Ensure preventative maintenance For all smoke barriers. Responsible Person: Director of Maintenance and Administrator.	
K 046 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1. This STANDARD is not met as evidenced by: Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1. Findings include: On facility tour between 09:00 AM and 12:00 PM on August 3, 2016, based on observation and interview the emergency lights on the 3rd floor west stairs and 2nd floor annex hallway did not operate when tested. This deficient practice was confirmed by the Plant Operations Director (DP) at the time of discovery.	K 046	It is the policy of Red Wing Healthcare Facility to maintain Emergency lighting of at least 1 ½ hour duration automatically According with 7.9. 18.2.9.1, 19.2.9.1. Corrective Action: All emergency lighting was tested on 8/3/16. The emergency lighting on the 3rd floor west stairs and 2nd floor annex hallway did not operate when tested. New lights were installed on both the 3rd floor west stairs and 2nd floor annex Hallway. Monitoring Mechanism: Building has ongoing monitoring Through regularly scheduled Maintenance rounds, and monthly Quality Improvement rounds to Ensure preventative maintenance For all smoke barriers. Responsible Person: Director of Maintenance and Administrator.	9/12/16

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K 047 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1, 19.2.10.1 (Indicate N/A in one story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This STANDARD is not met as evidenced by: Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1, 19.2.10.1 (Indicate N/A in one story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Findings include: On facility tour between 09:00 AM and 12:00 PM on 8/3/2016, based on observation and interview the exit sign on the 1st floor hallway is blocking the door found closing on activation of the fire alarm system. This deficient practice was confirmed by the Plant Operations Director (DP) at the time of discovery.	K 047	It is the policy of Red Wing Healthcare Facility that exit and Directional signs are displayed in Accordance with 7.10 with Continuous illumination also served by the emergency lighting system. 18.2.10.1, 19.2.10.1 Corrective Action: On 8/3/16, a facility tour was Completed and all exit and directional Signs were checked. The exit sign On the 1st floor hallway was blocking The door found closing on activation Of the fire alarm system. The exit Sign is now moved 6 inches so The door clears the sign. Monitoring Mechanism: Building has ongoing monitoring Through regularly scheduled Maintenance rounds, and monthly Quality Improvement rounds to Ensure preventative maintenance For all exit and directional signs. Responsible Person: Director of Maintenance and Administrator.	9/12/16
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 062		9/12/16

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K 062	Continued From page 5 Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Findings include: On facility tour between 09:00 AM and 12:00 PM on 8/3/2016, based on observation and interview revealed there are missing ceiling tiles in the locker room and annex basement storage room. This deficient practice was confirmed by the Plant Operations Director (DP) at the time of discovery.	K 062	It is the policy of Red Wing Healthcare Facility that sprinkler Systems are continuously Maintained in reliable operating Condition and are inspected and Tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Corrective Action: On 8/3/16, a facility tour was Completed and revealed missing Ceiling tiles in the locker room and Annex basement storage area. On 8/3/16, the ceiling tiles in the Locker room and the missing annex Basement storage area were Replaced. Monitoring Mechanism: Building has ongoing monitoring Through regularly scheduled Maintenance rounds, and monthly Quality Improvement rounds to Ensure preventative maintenance For all sprinkled areas. Responsible Person: Director of Maintenance and Administrator.	
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's	K 067		9/12/16

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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 067	Continued From page 6 specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observations and staff interviews, it was verified that the facility's general ventilating and air conditioning system (HVAC) is not installed in accordance with the LSC, Section 19.5.2.1 and NFPA 90A, Section 2-3.11 and 3-4.7. A noncompliant HVAC system could affect all 95 residents. Findings include: On facility tour between 09:00 AM and 12:00 PM on 08/03/2016, based on observation and interview revealed that the ventilation system on the 1st, 2nd, and 3rd floors in the 1965 addition utilizes the egress corridor as the return air for the resident rooms. There was no balancing report available. This deficient practice was confirmed by the Plant Operations Director (DP) at the time of discovery.	K 067	A Life Safety Code Waiver is Being applied for from CMS for The following reasons: 1) There will be no adverse Effect on the health and Safety of the facility's residents And staff since: a. The building is protected Throughout by an Addressable supervised Automatic fire alarm system Installed in accordance with NFPC 72 inn corridors, Hazardous areas, and spaces Open to the corridor. b. The building has automatic Shutdown of all ventilation Fans upon detection of Smoke or activation of the Building fire alarm system. c. Annual service and maintenance Contracts exist to service All the facility's fire protection Systems (e.g. fire alarm system, Sprinkler system, and portable Extinguishers.) as applicable. d. The building fire alarm system System is monitored to provide automatic fire department notification. e. Fire safety training is provided On an annual basis for all employees And during orientation for all New hires. f. Fire drills are conducted quarterly On each shift.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/03/2016**

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 067	Continued From page 7	K 067	g. The building is protected by a Sprinkler system.	
K 069 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Findings include: On facility tour between 09:00 AM and 12:00 PM on August 3, 2016, based on observation and interview revealed the power to stoves in both Physical Therapy and Occupational therapy are not secured from being turned on. This deficient practice was confirmed by the Plant Operations Director (DP) at the time of discovery.	K 069	It is the policy of Red Wing Healthcare Facility that cooking Facilities are protected in Accordance with 9.2.3. 19.3.2.6, NFPA 96 Corrective Action: On 8/3/16, a facility tour was Completed and revealed the Power to stoves in both physical Therapy and occupational therapy Are not secured from being turned On. On 8/3/16, the power switch For the physical therapy stove is Now turned off and the stove in occupational therapy has been removed. Monitoring Mechanism: Building has ongoing monitoring Through regularly scheduled Maintenance rounds, and monthly Quality Improvement rounds to Ensure cooking facilities are protected. Responsible Person: Director of Maintenance and Administrator.	9/12/16

Whitney, Marian (DPS)

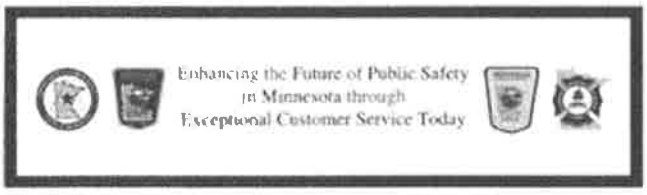
From: Linhoff, Tom (DPS)
Sent: Monday, September 19, 2016 4:15 PM
To: Dehler, Robert (MDH); Dietrich, Shellae (MDH); Henderson, Mary (MDH); Fiske-Downing, Kamala (MDH); Johnston, Kate (MDH); Leach, Colleen (MDH); Meath, Mark (MDH); Whitney, Marian (DPS); rochi_lsc@cms.hhs.gov; Kingsley, Roy (DPS)
Cc: cathy.scoville@welcov.com
Subject: Red Wing HCC - Annual waiver request
Attachments: Waiver Request Red Wing HCC-signed.pdf

This is to inform you that Red Wing Healthcare Center, 245223, is again requesting an annual waiver for K- K067. The exit date was 08-03-2016. No changes.

I am recommending that CMS approve this waiver request.

Tom Linhoff
Fire Safety Supervisor

MN State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Office phone: 651-201-7205
Phone: 651.430.3012
Fax: 651.430.3012
Cell: 651-769-7778
Email: Tom.Linhoff@state.mn.us
Web: www.fire.state.mn.us



Name of Facility
Red Wing Healthcare Center

2000 CODE

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

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

PROVISION NUMBER(S)	JUSTIFICATION
K84 K067	An annual waiver is requested for the following reasons: 1) There will be no adverse effect on the health and safety of the facility's residents and staff since: a. The building is protected throughout by an addressable supervised automatic fire alarm system installed in accordance with NFPC 72 in corridors, hazardous areas, and spaces open to the corridor. b. The building has automatic shutdown of all ventilation fans upon detection of smoke or activationof the building fire alarm systems. c. Annual service and maintenance contracts exist to service all the facility's fire protection systems (e.g. fire alarm system, sprinkler system, and portable extinguishers) as applicable. d. The building fire alarm system is monitored to provide automatic fire department notification. e. Fire safety training is provided on an annual basis for all employees and during orientation for all new hires. f. Fire drills are conducted quarterly on each shift. g. The building is protected by a sprinkler system. 2) Compliance with this provision will impose an unreasonable hardship to the facility since: a. The $53c,000 cost to implement such a system is prohibitive as evidenced by the financial loss shown on our most recent cost report which is from 2015 and is included for your reference. b. WHV estimates that the work will disrupt the normal use of patient areas for 6 months. c. There is about one year left on the facility's lease which means we would not be able to recover any meaningful portion of the cost. d. Since the building is leased there is no collateral to pledge for the needed financing. e. The lease on the building runs out in about 1 yr making the remaining useful life of the building after the 6 month project about 6 months.

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)* Thomas Linhoff 12424	Title Fire Safety Supervisor	Office State Fire Marshal Division	Date 09-19-2016

WELCOV HEALTHCARE LLC
Redwing Healthcare Community Medicare Cost Report
For the Twelve Months Ending Thursday, December 31, 2015

800-89125	Benefits-Dental Deductions	(9,873.24)		(9,873.24)			
800-89130	Benefits-Disability	3,340.63		3,340.63	3,288.31		3,288.31
800-89135	Benefits-Other Employee Insurances	175.45		175.45			
800-89140	Benefits-FICA & Medicare	301,263.69		301,263.69	326,327.30		326,327.30
800-89150	Benefits-Unemployment	38,111.58		38,111.58	44,187.22		44,187.22
800-89160	Benefits-401K	18,012.11		18,012.11	19,619.07		19,619.07
800-89170	Benefits-Deferred Comp	6,726.50		6,726.50	6,468.98		6,468.98
800-89180	Benefits-Flex	3,670.70		3,670.70	418.50		418.50
800-89190	Benefits-Worker's Comp	168,728.59		168,728.59	181,190.93		181,190.93
800-89200	Benefits-Tuition Reimbursement				1,914.08		1,914.08
800-89210	Benefits-Uniform Allowance	3,520.32		3,520.32	5,601.38		5,601.38
800-89220	Benefits-Employee Appreciation	8,894.91		8,894.91	9,118.82		9,118.82
800-89240	Benefits-Drug Test/Background Checks	683.81		683.81	645.32		645.32
800-89250	Benefits-Employee Vaccinations	472.07		472.07			
	TOTAL BENEFITS	**713,275.00**	**0.00**	**713,275.00**	**927,905.53**	**0.00**	**927,905.53**
	CAPITAL RELATED COSTS - BUILDING GROUP 01-2						
810-89500	Depreciation & Amortization-Land Improvements				17,291.88		17,291.88
810-89510	Depreciation & Amortization-Building				212,671.10		212,671.10
810-89520	Depreciation & Amortization-Leasehold Improvements	191.57		191.57	674,512.42		674,512.42
810-89550	Depreciation & Amortization-Financing Costs				7,657.20		7,657.20
820-89600	Interest-Capital Lease				17,791.81		17,791.81
820-89605	Interest-Lease Contract				326,862.80		326,862.80
700-83800	G & A-Property Insurance	28,365.33		28,365.33	42,599.36		42,599.36
750-84000	Property & Related-Facility Rent	808,004.88		808,004.88			
750-84010	Property & Related-Property Taxes	47,261.15		47,261.15	45,722.76		45,722.76
750-84040	Property & Related-Insurance MIP	20,865.48		20,865.48	21,209.76		21,209.76
	TOTAL CAPITAL RELATED COSTS-BUILDING	**904,688.41**	**0.00**	**904,688.41**	**1,366,319.09**	**0.00**	**1,366,319.09**
	CAPITAL RELATED COSTS - MOVABLE EQUIPMENT GROUP 02-2						
500-82150	Nursing-Equipment Rental	110,215.47		110,215.47	80,152.17		80,152.17
700:709-82150	G & A-Equipment Rental	20,969.83		20,969.83	25,747.49		25,747.49
820-89630	Interest-Other	2,605.20		2,605.20	792.90		792.90
810-89530	Depreciation & Amortization-Equipment	2,096.63		2,096.63	246,537.68		246,537.68
	TOTAL CAPITAL RELATED COSTS- MOVABLE	**135,887.13**	**0.00**	**135,887.13**	**353,230.24**	**0.00**	**353,230.24**
	TOTAL EXPENSES	**10,642,347.99**	**0.00**	**10,642,347.99**	**11,652,465.18**	**0.00**	**11,652,465.18**
	TOTAL NET (INCOME) LOSS	**(319,646.96)**	**0.00**	**(319,646.96)**	**172,774.17**	**0.00**	**172,774.17**

Winona Heating & Ventilating, Inc.

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

Rochester Office
1712 Third Ave. SE
Rochester, MN 55904
Phone 507.280.4201
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1202 Caledonia St.
La Crosse, WI 54603
Phone 608.782.6550
www.whvr.com

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9/15/2016

Red Wing Health Care Center
1412 West 4th St.
Red Wing, MN 55066

Attn: Cathy Scoville

Subject: Return Air

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

To extend the return air duct to each room would be extremely costly, if it can even be done. This is due to the many issues that would be encountered such as the following:
-Quantity of rooms
-Constraints above the ceiling as there will be little to no room for duct. Note, need to stay with the headroom compliance in the corridors
-Penetration of smoke and load bearing walls
-Unknowns such as structural, insulation, disturbance

The approximate cost to do the return air project would be $530,000.00 However, this is based on being able to do the work, of which is not yet established as possible to conduct the work above.

Thank you for the opportunity to serve. *This Budget is valid for 60 days from the dated above.* If you have any questions or revisions, please feel free to contact me anytime at (507) 280-4201. If the above is acceptable please sign below and return to address below or email to jgentling@whvr.com Thank you,

Sincerely,

Jesse Gentling
WHV, Inc.

Accepted by _____

Date _____