MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7008 1830 0003 8091 3779

February 10, 2009

Mr. Jon Skillingstad, Administrator
Minnesota Veterans Home Fergus Falls
1821 North Park
Fergus Falls, Minnesota 56537

Re: Enclosed State Nursing Home Licensing Orders - Project Number SL00531016

Dear Mr. Skillingstad:

The above facility was surveyed on January 26, 2009 through January 29, 2009 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction

and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 1505 Pebble Lake Road #300, Fergus Falls, Minnesota 56537. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,

Peggy Durham-Lien

Peggy Durham-Lien, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218) 332-5140 Fax: (218) 332-5196

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

MOH LtC 3201

SENDER: *COMPLETE THIS SECTION*

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Mr. Jon Skillingstad, Administrator
MN Veterans Home – Fergus Falls
1821 North Park
Fergus Falls, MN 56537

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Marcia Lieser ☒ Agent ☐ Addressee

B. Received by *(Printed Name)* Marcia Lieser
C. Date of Delivery 2/17/09

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☒ No

3. Service Type
☒ Certified Mail ☐ Express Mail
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? *(Extra Fee)* ☐ Yes

7008 1830 0003 8091 3779

Pls return in 5 days

PS Form 3811, February 2004 Domestic Return Receipt SL005 3/016 96 102595-02-M-1540

Minnesota Department of Health

Both MN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00531	A. BUILDING _____ B. WING _____	01/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME FERGUS FALLS	1821 NORTH PARK FERGUS FALLS, MN 56537

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On January 26, 27, 28, and 29, 2009, surveyors of this Department's staff visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders, and return the original to the Minnesota Department of Health, Division of Compliance Monitoring,	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

Minnesota Department of Health

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2.000	Continued From page 1 Licensing and Certification Program; 85 East Seventh Place, Suite 220; P.O. Box 64900, St. Paul, MN. 55164-0900.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the	2 265		

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2 265	Continued From page 2 development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on observation, record review, and staff interview the facility failed to consult the physician or nurse practitioner for 1 of 3 (#1) residents in the sample who developed a pressure ulcer. Findings include: Resident #1 had diagnoses including diabetes, hypertension, stroke with left side hemiparesis, dementia, history of deep vein thrombosis and incontinence. On 1/29/09 at 9:00 AM, with the ADON(Assistant Director of Nursing), it was observed that	2 265		

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2 265	Continued From page 3 Resident #1 had an area on the outer aspect of the left heel that appeared to be newly healed skin and an adjacent area with a dark scab. The ADON stated the wound may have been from the residents shoes and it was being kept dry and a protective boot was used. Review of the record of Resident #1 revealed a quarterly Minimum Data Set (MDS) assessment dated 12/23/08. The assessment indicated the resident had moderately impaired cognition, needed extensive assistance for bed mobility, transferring and did not walk. The MDS indicated the resident had a Stage III ulcer (a full thickness of skin lost). A progress note for Resident #1 stated on 12/03/08, "...Left heel has around 2 cm clear serous blister blister slightly raised. No issues with surrounding areas. (Resident #1) told us that he "needs new shoes". Not sure as to cause of blister. Is wearing heal protector now. Also checked scrotum. At the bottom of scrotum, there is a 5.7 wide by 2 cm long shallow open area, stage 2. Upper area is scabbed over. Team agrees is from pressure." Progress notes on 12/11/08 stated, "Seen by wound rounds on 12-10-08...also has 1.5 diameter stage 2 pressure area on left heel-covering over wound area intact-no drainage-is soft-with about a .25 cm white spot in the middle of the ulcer area - appears the ulcer may be deeper even than a stage 2-but unable to determine full depth at this time r/t(related to) intact skin - is using a Rooke boot to left foot at all times." The progress notes indicate Resident #1 was seen on weekly wound rounds. An entry on 1/26/09 stated, "Seen by wound rounds-continues with 1.5 cm long by .5 cm wide dry callous area on heel-other blister area completely healed-are leaving open to air	2 265		

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2 265	Continued From page 4 and will continue with this treatment. Action/Plan: will discontinue from wound rounds at this time as no complications noted-will reassess if needed." On 1/29/08 at 9:15 AM during interview of the wound team RN confirmed the physician had not been consulted regarding the area on the heel. Review of the facility's policy/procedure, titled Skin Integrity: Assessment and Management, dated 4/16/08, stated, "5. Notify physician/nurse practitioner of changes in skin integrity." SUGGESTED METHOD FOR CORRECTION: The Director of Nursing could assure facility skin care policies are reviewed and revised and nurses responsible for each residents notifies the physician/nurse practitioner whenever a pressure ulcer occurs. Training could be provided as needed, and audits could be performed to ensure accuracy of the assessments. TIME PERIOD FOR CORRECTION: Thirty (30) days.	2 265		
2 540	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care as defined in part	2 540		

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2 540	Continued From page 5 4658.0405. Subp. 2. Information gathered. The comprehensive resident assessment must include at least the following information: A. medically defined conditions and prior medical history; B. medical status measurement; C. physical and mental functional status; D. sensory and physical impairments; E. nutritional status and requirements; F. special treatments or procedures; G. mental and psychosocial status; H. discharge potential; I. dental condition; J. activities potential; K. rehabilitation potential; L. cognitive status; M. drug therapy; and N. resident preferences. This MN Requirement is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that residents received the necessary care and treatment based on an accurate comprehensive skin assessment to prevent the development of pressure ulcers for 2 of 3 (#4, #5) residents in the sample identified as dependent on staff for repositioning and at risk pressure ulcer development; and failed to ensure that 2 of 4(#5, #6) residents in the sample who were incontinent of urine had a comprehensive or accurate bladder assessment completed to help prevent further loss of function and develop an individualized toileting program. Findings include: SKIN Resident #4 was not provided appropriate repositioning interventions to prevent the	2 540		

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2 540	Continued From page 6 development of pressure ulcers based on an accurate comprehensive skin assessment. Resident #4 had been admitted to the facility on 4/27/04 with diagnosis which included rheumatoid arthritis, glaucoma, osteoarthrosis and urinary frequency. Resident #4 lacked a current comprehensive assessment for repositioning times to maintain skin integrity and prevent the development of pressure ulcers. A Pressure Tolerance Test, dated 4/10/07, had been completed by the facility which noted Resident #4 was able to reposition himself when lying down. In addition, a second, not dated Pressure Tolerance Test had been completed by the facility which noted Resident #4 was able to reposition himself when sitting. The Pressure Tolerance Tests had failed to identify Resident #4 as dependent on staff for his repositioning needs while sitting, in order to develop an individualized repositioning schedule, despite the fact that Resident #4 was currently dependent on staff for all repositioning and transfers. Resident #4 was observed on the morning of 1/27/09 at 9:00 AM to receive morning cares. The resident was observed have an incontinence brief (dry) removed and perineal cares were provided by staff. His skin was observed to be intact without redness. The resident was dressed by staff and assisted by staff to sit up on the edge of the bed before being transferred from bed to the toilet by one staff with the use of a mechanical standing lift. Resident #4's most recent annual Minimum Data Set (MDS) assessment had been completed on 11/20/08. The MDS indicated resident #4's	2 540		

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2 540	Continued From page 7 cognitive status was moderately impaired, required limited physical assistance of one staff for transfers, and did not ambulate in the room. The MDS further indicated the resident had bilateral limitations on hands and legs. Resident #4's plan of care identified problems of self care deficits in mobility and transfer. No approaches for repositioning time frames had been developed to indicate when the resident required assistance from staff with repositioning in chair, other than, "assist of 2, or if stronger, with 1 and PAL (mechanical standing lift)." Interview with the Director of Nurses (DON) on 1/28/09 at 8:50 AM revealed that the "Pressure Tolerance" assessment, based on visual inspection for resident #4, failed to reflect his current status of dependency on staff for repositioning. The DON confirmed that the resident had declined in his abilities and now required staff assistance for transfers and mobility. The DON confirmed a tissue tolerance assessment should have been completed for Resident #4 in order to develop a individualized repositioning schedule to maintain skin integrity, to accurately reflect the current status of Resident #4. Resident #5, who was at risk for the development of pressure ulcers, and dependent on staff for repositioning, did not have documentation to indicate that a tissue tolerance assessment had been completed. Resident #5's diagnoses included morbid obesity, functional urinary incontinence, diabetes, cerebral vascular accident (stroke) and history of a stage II pressure ulcer on the left, lateral distal thigh on 9/08.	2 540		

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2 540	Continued From page 8 Resident #5, who was obese, was observed on 1/27/09 at 9:30 AM seated in his wheel chair. The resident had a splint on the left hand and leg present, and was able to speak. Resident #5 stated, at 10:40 AM on 1/27/09, that 2 staff had assisted him to use the toilet. Review of Resident #5's annual MDS, dated 3/25/08, and the quarterly MDS, dated 12/11/08, both indicated the resident's cognitive status was, "moderately impaired, required extensive physical assistance from 1 staff for mobility and transfers, and had functional limitations in range of motion in arms, hands, legs, and feet." Review of Resident #5's Braden Scale and Other Risk Factors skin assessment, dated 12/4/08, indicated the resident was able to make slight changes ion position, required moderate to maximum assistance in moving, and did not address a tissue (pressure) tolerance assessment (an evaluation of skin integrity after pressure to a susceptible area of skin and boney prominences have been reduced, or reassessed.) The Braden skin assessment was inconsistent with the MDS skin assessments. No documentation regarding a tissue tolerance, or Pressure Test assessment was present in Resident #5's record. Review of Resident #5's current Care Planning Report, evaluation date of 3/23/09, stated, "repositions self, needs reminders...." The care plan was inconsistent with the skin assessments. Review of the facility's policy/procedure, titled Skin Integrity: Assessment and Management, dated 4/16/08, stated, "2. Pressure Tests will be completed by the NUW (nursing universal	2 540		

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2 540	Continued From page 9	2 540		

worker) while the resident is siting up on the AM/PM shift and while lying down by the night shift....The Pressure Tolerance Test is completed on admission, yearly, and when a significant change is determined...."

Interview with the DON on 1/28/09 at 9:00 AM verified Resident #5's record did not address a tissue tolerance assessment, and the DON verified Resident #5 was not able to reposition himself as stated on the care plan.

BLADDER
Resident's #5 and #6, who were incontinent of bladder, and dependent on staff for incontinence cares, did not have accurate, comprehensive bladder assessments.

Resident #5's diagnoses included morbid obesity, overactive bladder, and functional urinary incontinence.

On 1/27/09 at 9:00 AM, Resident #5 was observed to be seated in a Rock and Go wheel chair seated in his room, watching television. At 10:45 AM, Resident #5 was interviewed about the need for staff to assist him to use the bathroom. Resident #5 stated that one staff had helped to use the toilet after he had eaten breakfast.

Review of Resident #5's annual Minimum Data Set (MDS), dated 3/25/08, and the quarterly MDS, dated 12/11/08, both indicated the cognitive status was, "moderately impaired, required 2 staff for limited physical assistance for toileting, and was occasionally incontinent of bladder- 2 or more times weekly, but not daily."

Review of Resident #5's Bladder and Bowel

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2 540	Continued From page 10 Questionnaire assessment, dated 4/1/08, stated, "usually continent- incontinent episodes once a week or less. One person physical assist for toilet use. Toilet every 2 hours" The assessment stated that no bladder diary had been completed, therefore, a toileting/incontinent pattern could not be established. The Bladder and Bowel Questionnaire assessment was inconsistent with the MDS bladder assessments. Interview with the Director of Nursing (DON), on 1/28/09 at 9:05 AM, verified Resident #5's bladder assessments were inconsistent, and incomplete. Resident #6's diagnoses included alzheimer's disease and mixed urinary incontinence. On 1/27/09 at 8:30 AM, Resident #6 was observed seated in his wheel chair. Interview with Nursing Universal Worker (NUW) "B" at 10:35 stated, "I just toileted Resident #6, who was also incontinent of urine." Review of Resident #6's annual MDS, dated 6/3/08, and the quarterly MDS, dated 11/20/08, both indicated the cognitive status was, "severely impaired, required 1 person physical, limited assistance with toileting, and was occasionally incontinent of bladder- 2 or more times a week, but not daily." Review of Resident #6's most recent Bladder and Bowel Questionnaire assessment, dated 6/4/07, stated, "one person physical assist to toilet, frequently incontinent-tended to be incontinent daily, but some control present. The assessment indicated a bladder diary had been evaluated. The Bladder and Bowel Questionnaire	2 540		

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2 540	Continued From page 11 assessment was inconsistent with the MDS assessments, which indicated a decline in bladder function. Review of the facility's Bladder and Bowel Program policy/procedure, dated 9/11/06, stated, "Upon admission, annually, and if there is a change identified in the resident's elimination pattern, a comprehensive elimination assessment will be completed by the RN.... 8.... Three day bladder assessment will also be completed if a change is noted in elimination." Interview with the DON on 1/28/09 at 11:30 AM verified Resident #6's bladder assessments were inconsistent. The DON further stated Resident #6 should have had a Bladder and Bowel Questionnaire assessment completed in 2008, but it got missed. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing could assure facility skin care and incontinence care policies are reviewed/revised, and nurses responsible for the cares ensure the assessments are comprehensive, and accurate. Training could be provided as needed, and audits could be performed to ensure accuracy of the assessments. TIME PERIOD FOR CORRECTION: Thirty (30) days.	2 540		
2 545	MN Rule 4658.0400 Subp. 3 A-C Comprehensive Resident Assessment; Frequency Subp. 3. Frequency. Comprehensive resident assessments must be conducted: A. within 14 days after the date of admission;	2 545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00531	A. BUILDING _____ B. WING _____	01/29/2009

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2 545	Continued From page 12 B. within 14 days after a significant change in the resident's physical or mental condition; and C. at least once every 12 months. This MN Requirement is not met as evidenced by: Based on observation, record review, policy review, and interview, the facility failed to reassess skin for 1 of 3 (#1) residents in sample who developed a pressure ulcer. Findings include: Resident #1 had diagnoses including diabetes, hypertension, stroke, dementia, history of deep vein thrombosis and incontinence. On 1/2/09 at 9:15 AM the Resident #1 was observed in a wheelchair with his left arm on a positioning tray and the left foot on a footrest. At 10:33 AM a NUW (nursing universal worker) was observed to push the resident to his room. A PAL mechanical stand was used to assist Resident #1 to the toilet. NUW 'A' stated the mechanical lift was always used for Resident #1's transfers. During the care the NUW stated, and observation confirmed that an ulcer on the resident's scrotum was healed. On 1/29/09 at 9:00 AM, with the ADON (Assistant Director of Nursing), it was observed that Resident #1 had an area on the outer aspect of the left heel that appeared to be newly healed skin and an adjacent area with a dark scab. The ADON stated the wound may have been from the residents shoes and it was being kept dry and a protective boot was used. Review of the record of Resident #1 revealed a quarterly Minimum Data Set(MDS) assessment	2 545		

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2 545	Continued From page 13 dated 12/23/08. The assessment indicated the resident had moderately impaired cognition, needed extensive assistance for bed mobility, transferring and did not walk. The MDS indicated the resident had a Stage III ulcer (a full thickness of skin lost). A progress note for Resident #1 stated on 12/03/08, "...Left heel has around 2 cm clear serous blister blister slightly raised. No issues with surrounding areas. (Resident #1) told us that he "needs new shoes". Not sure as to cause of blister. Is wearing heal protector now. Also checked scrotum. At the bottom of scrotum, there is a 5.7 wide by 2 cm long shallow open area, stage 2. Upper area is scabbed over. Team agrees is from pressure." Progress notes on 12/11/08 stated, "Seen by wound rounds on 12-10-08...also has 1.5 diameter stage 2 pressure area on left heel-covering over wound area intact-no drainage-is soft-with about a .25 cm white spot in the middle of the ulcer area - appears the ulcer may be deeper even than a stage 2-but unable to determine full depth at this time r/t(related to) intact skin - is using a Rooke boot to left foot at all times." The progress notes indicate Resident #1 was seen on weekly wound rounds. An entry on 1/20/09 indicated the area on the scrotum was healed on 1/14/09. Review of the facility's policy/procedure, titled Skin Integrity: Assessment and Management, dated 4/16/08, stated, "2. Pressure Tests will be completed by the NUW (nursing universal worker) while the resident is siting up on the AM/PM shift and while lying down by the night shift....The Pressure Tolerance Test is completed on admission, yearly, and when a significant change is determined...."	2 545		

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2 545	Continued From page 14 On 1/29/08 at 9:15 AM interview of the wound team RN confirmed a Braden Scale and Other Risk Factors form (assessment for predicting pressure ulcer development) was not completed until 1/28/08; there was no other comprehensive skin assessment that would have included tissue integrity or other changes in the residents condition after the development of either pressure ulcer; and, the physician had not been informed of or assessed the area on the heel. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing could ensure facility skin care policies are reviewed and revised and nurses responsible for the cares ensure the assessments are comprehensive, and accurate. Training could be provided as needed, and audits could be performed to ensure accuracy of the assessments. TIME PERIOD FOR CORRECTION: Thirty (30) days.	2 545		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores	2 900		

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2 900	Continued From page 15 receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, record review, and staff interview the facility failed to complete a compressive reassessment for 1 of 3 (#1) residents in the sample who developed a pressure ulcer. Findings include: Resident #1 had diagnoses including diabetes, hypertension, stroke, dementia, history of deep vein thrombosis and incontinence On 1/2/09 at 9:15 AM the Resident #1 was observed in a wheelchair with his left arm on a positioning tray and the left foot on a footrest. At 10:33 AM a NUW (nursing universal worker) was observed to push the resident to his room. A PAL mechanical stand was used to assist Resident #1 to the toilet. NUW 'A' stated the mechanical lift was always used for Resident #1's transfers. During the care the NUW stated, and observation confirmed that an ulcer on the resident's scrotum was healed. On 1/29/09 at 9:00 AM, with the ADON(Assistant Director of Nursing), it was observed that Resident #1 had an area on the outer aspect of the left heel that appeared to be newly healed skin and an adjacent area with a dark scab. The ADON stated the wound may have been from the residents shoes and it was being kept dry and a protective boot was used. Review of the record of Resident #1 revealed a quarterly Minimum Data Set(MDS) assessment	2 900		

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2 900	Continued From page 16 dated 12/23/08. The assessment indicated the resident had moderately impaired cognition, needed extensive assistance for bed mobility, transferring and did not walk. The MDS indicated the resident had a Stage III ulcer (a full thickness of skin lost). A progress note for Resident #1 stated on 12/03/08, "...Left heel has around 2cm clear serous blister blister slightly raised. No issues with surrounding areas. (Resident #1) told us that he "needs new shoes". Not sure as to cause of blister. Is wearing heal protector now. Also checked scrotum. At the bottom of scrotum, there is a 5.7 wide by 2 cm long shallow open area, stage 2. Upper area is scabbed over. Team agrees is from pressure." Progress notes on 12/11/08 stated, "Seen by wound rounds on 12-10-08...also has 1.5 diameter stage 2 pressure area on left heel-covering over wound area intact-no drainage-is soft-with about a .25cm white spot in the middle of the ulcer area - appears the ulcer may be deeper even than a stage 2-but unable to determine full depth at this time r/t(related to) intact skin - is using a Rooke boot to left foot at all times." The progress notes indicate Resident #1 was seen on weekly wound rounds. An entry on 1/20/09 indicated the area on the scrotum was healed on 1/14/09. On 1/29/08 at 9:15 AM interview of the wound team RN confirmed a Braden Scale and Other Risk Factors form (assessment for predicting pressure ulcer development) was not completed until 1/28/08; there was no other comprehensive skin assessment that would have included tissue integrity or other changes in the residents condition after the development of either pressure ulcer; and, the physician had not been informed of or assessed the area on the heel.	2 900		

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2 900	Continued From page 17 Review of the facility's policy/procedure, titled Skin Integrity: Assessment and Management, dated 4/16/08, stated, "2. Pressure Tests will be completed by the NUW (nursing universal worker) while the resident is siting up on the AM/PM shift and while lying down by the night shift....The Pressure Tolerance Test is completed on admission, yearly, and when a significant change is determined...." SUGGESTED METHOD FOR CORRECTION: The Director of Nursing could ensure facility skin care policies are reviewed and revised and nurses responsible for each residents care reassess the resident whenever a pressure ulcer occurs. Training could be provided as needed, and audits could be performed to ensure accuracy of the assessments. TIME PERIOD FOR CORRECTION: Thirty (30) days.	2 900		
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure that	2 905		

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2 905	Continued From page 18 resident's received the necessary care and treatment to prevent the development of pressure ulcers for 2 of 3 (#4, #5) residents in the sample identified as dependent on staff for repositioning and at risk pressure ulcer development. Findings include: SKIN Resident #4 was not provided appropriate repositioning interventions to prevent the development of pressure ulcers based on an accurate comprehensive skin assessment. Resident #4 had been admitted to the facility on 4/27/04 with diagnosis which included rheumatoid arthritis, glaucoma, osteoarthrosis and urinary frequency. Resident #4 lacked a current comprehensive assessment for repositioning times to maintain skin integrity and prevent the development of pressure ulcers. A Pressure Tolerance Test, dated 4/10/07, had been completed by the facility which noted Resident #4 was able to reposition himself when lying down. In addition, a second, not dated Pressure Tolerance Test had been completed by the facility which noted Resident #4 was able to reposition himself when sitting. The Pressure Tolerance Tests had failed to identify Resident #4 as dependent on staff for his repositioning needs while sitting, in order to develop an individualized repositioning schedule, despite the fact that Resident #4 was currently dependent on staff for all repositioning and transfers. Resident #4 was observed on the morning of 1/27/09 at 9:00 AM to receive morning cares. The resident was observed have an incontinence brief (dry) removed and perineal cares were provided	2 905		

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2 905	Continued From page 19 by staff. His skin was observed to be intact without redness. The resident was dressed by staff and assisted by staff to sit up on the edge of the bed before being transferred from bed to the toilet by one staff with the use of a mechanical standing lift. Resident #4's most recent annual Minimum Data Set (MDS) assessment had been completed on 11/20/08. The MDS indicated resident #4's cognitive status was moderately impaired, required limited physical assistance of one staff for transfers, and did not ambulate in the room. The MDS further indicated the resident had bilateral limitations on hands and legs. Resident #4's plan of care identified problems of self care deficits in mobility and transfer. No approaches for repositioning time frames had been developed to indicate when the resident required assistance from staff with repositioning in chair, other than, "assist of 2, or if stronger, with 1 and PAL (mechanical standing lift)." Interview with the Director of Nurses (DON) on 1/28/09 at 8:50 AM revealed that the "Pressure Tolerance" assessment, based on visual inspection for resident #4, failed to reflect his current status of dependency on staff for repositioning. The DON confirmed that the resident had declined in his abilities and now required staff assistance for transfers and mobility. The DON confirmed a tissue tolerance assessment should have been completed for Resident #4 in order to develop a individualized repositioning schedule to maintain skin integrity, to accurately reflect the current status of Resident #4. Resident #5, who was at risk for the development of pressure ulcers, and dependent on staff for	2 905		

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2 905	Continued From page 20	2 905		

repositioning, did not have documentation to indicate that a tissue tolerance assessment had been completed.

Resident #5's diagnoses included morbid obesity, functional urinary incontinence, diabetes, cerebral vascular accident (stroke) and history of a stage II pressure ulcer on the left, lateral distal thigh on 9/08.

Resident #5, who was obese, was observed on 1/27/09 at 9:30 AM seated in his wheel chair. The resident had a splint on the left hand and leg present, and was able to speak. Resident #5 stated, at 10:40 AM on 1/27/09, that 2 staff had assisted him to use the toilet.

Review of Resident #5's annual MDS, dated 3/25/08, and the quarterly MDS, dated 12/11/08, both indicated the resident's cognitive status was, "moderately impaired, required extensive physical assistance from 1 staff for mobility and transfers, and had functional limitations in range of motion in arms, hands, legs, and feet."

Review of Resident #5's Braden Scale and Other Risk Factors skin assessment, dated 12/4/08, indicated the resident was able to make slight changes ion position, required moderate to maximum assistance in moving, and did not address a tissue (pressure) tolerance assessment (an evaluation of skin integrity after pressure to a susceptible area of skin and boney prominences have been reduced, or reassessed.) The Braden skin assessment was inconsistent with the MDS skin assessment.

No documentation regarding a tissue tolerance, or Pressure Test assessment was present in Resident #5's record.

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2 905	Continued From page 21 Review of Resident #5's current Care Planning Report, evaluation date of 3/23/09, stated, "repositions self, needs reminders...." The care plan was inconsistent with the skin assessments. Review of the facility's policy/procedure, titled Skin Integrity: Assessment and Management, dated 4/16/08, stated, "2. Pressure Tests will be completed by the NUW (nursing universal worker) while the resident is siting up on the AM/PM shift and while lying down by the night shift....The Pressure Tolerance Test is completed on admission, yearly, and when a significant change is determined...." Interview with the DON on 1/28/09 at 9:00 AM verified Resident #5's record did not address a tissue tolerance assessment, and the DON verified Resident #5 was not able to reposition himself as stated on the care plan. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing could assure facility skin care policies are reviewed/revised, and nurses responsible for the cares ensure the assessments are comprehensive, and accurate. Training could be provided as needed, and audits could be performed to ensure accuracy of the assessments. TIME PERIOD FOR CORRECTION: Thirty (30) days.	2 905		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the	2 910		

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2 910	Continued From page 22 unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. 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 MN Requirement is not met as evidenced by: Based on observation, record review, policy review, and interview, the facility failed to provide incontinence cares based on a comprehensive bladder assessment for 2 of 4 (#5, #6) incontinent residents in the sample who were dependent on staff for incontinence cares. Findings include: Resident's #5 and #6, who were incontinent of bladder, and dependent on staff for incontinence cares, did not have accurate, comprehensive bladder assessments. Resident #5's diagnoses included morbid obesity, overactive bladder, and functional urinary incontinence. On 1/27/09 at 9:00 AM, Resident #5 was observed to be seated in a Rock and Go wheel chair seated in his room, watching television. At 10:45 AM, Resident #5 was interviewed about the need for staff to assist him to use the bathroom. Resident #5 stated that one staff had helped to	2 910		

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2 910	Continued From page 23 use the toilet after he had eaten breakfast. Review of Resident #5's annual Minimum Data Set (MDS), dated 3/25/08, and the quarterly MDS, dated 12/11/08, both indicated the cognitive status was, "moderately impaired, required 2 staff for limited physical assistance for toileting, and was occasionally incontinent of bladder- 2 or more times weekly, but not daily." Review of Resident #5's Bladder and Bowel Questionnaire assessment, dated 4/1/08, stated, "usually continent- incontinent episodes once a week or less. One person physical assist for toilet use. Toilet every 2 hours" The assessment stated that no bladder diary had been completed, therefore, a toileting/incontinent pattern could not be established. The Bladder and Bowel Questionnaire assessment was inconsistent with the MDS bladder assessments. Review of Resident #5's current Care Planning Report, evaluation date 3/23/09, stated, "One person physical assist for toileting....During there noc. (night) uses urinal every 2 hours.... toilets after breakfast. Toilets again in the afternoon around 4:00 PM. Toilets again at 7:00 PM and at 10:00 PM, uses urinal." The care plan was inconsistent with the MDS and bladder assessment. Interview with the Director of Nursing (DON), on 1/28/09 at 9:05 AM, verified Resident #5's bladder assessments were inconsistent, and incomplete. Resident #6's diagnoses included alzheimer's disease and mixed urinary incontinence.	2 910		

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2 910	Continued From page 24 On 1/27/09 at 8:30 AM, Resident #6 was observed seated in his wheel chair. Interview with Nursing Universal Worker (NUW) "B" at 10:35 stated, "I just toileted Resident #6, who was also incontinent of urine." Review of Resident #6's annual MDS, dated 6/3/08, and the quarterly MDS, dated 11/20/08, both indicated the cognitive status was, "severely impaired, required 1 person physical, limited assistance with toileting, and was occasionally incontinent of bladder- 2 or more times a week, but not daily." Review of Resident #6's most recent Bladder and Bowel Questionnaire assessment, dated 6/4/07, stated, "one person physical assist to toilet, frequently incontinent-tended to be incontinent daily, but some control present. The assessment indicated a bladder diary had been evaluated. The Bladder and Bowel Questionnaire assessment was inconsistent with the MDS assessments, which indicated a decline in bladder function. Review of Resident #6's current Care Planning Report, evaluation date of 2/25/09, stated, "one person physical assist for toileting.... Occasionally incontinent of bowel and bladder.... Toilet with am cares, after lunch-before supper and @ (at) hs (evening)." The plan of care was inconsistent with the MDS bladder assessments, and did not address how frequently to toilet, or check/change Resident #6. Review of the facility's Bladder and Bowel Program policy/procedure, dated 9/11/06, stated, "Upon admission, annually, and if there is a change identified in the resident's elimination pattern, a comprehensive elimination assessment	2 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00531	A. BUILDING _____ B. WING _____	01/29/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 910	Continued From page 25 will be completed by the RN.... 8.... Three day bladder assessment will also be completed if a change is noted in elimination." Interview with the DON on 1/28/09 at 11:30 AM verified Resident #6's bladder assessments were inconsistent. The DON further stated Resident #6 should have had a Bladder and Bowel Questionnaire assessment completed in 2008, but it got missed. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing could assure facility incontinence care policies are reviewed/revised, and nurses responsible for the cares ensure the assessments are comprehensive, and accurate. Training could be provided as needed, and audits could be performed to ensure accuracy of the assessments. TIME PERIOD FOR CORRECTION: Thirty (30) days.	2 910		