00531
NH

Protecting, Maintaining and Improving the Health of Minnesotans

November 9, 2012

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

Re: Enclosed Reinspection Results - Project Number SL00531019

Dear Mr. Skillingstad:

On October 23, 2012 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 30, 2012. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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 with any questions related to this letter.

Sincerely,

Colleen Leach

Colleen Leach, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
PO Box 64900
Saint Paul, Minnesota 55164-0900

Telephone: (651)201-4117 Fax: (651)215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

AH Form Approved
10/23/2012

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00531	A. Building B. Wing	10/23/2012

Name of Facility	Street Address, City, State, Zip Code
MN VETERANS HOME FERGUS FALLS	1821 NORTH PARK FERGUS FALLS, MN 56537

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix 20830 Reg. # MN Rule 4658.0520 Subp. LSC	10/08/2012	ID Prefix 20900 Reg. # MN Rule 4658.0525 Subp. LSC	10/08/2012	ID Prefix 21400 Reg. # MN Rule 4658.0810 Subp. LSC	10/08/2012
ID Prefix 21980 Reg. # MN St. Statute 626.557 Sul LSC	10/08/2012	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor: Virginia M. Meyer	Date: 10/23/12
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 8/30/2012

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7009 2250 0002 0399 5490

September 18, 2012

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number SL00531019

Dear Mr. Skillingstad:

The above facility was surveyed on August 28, 2012 through August 30, 2012 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, Suite 300, Fergus Falls, MN 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,

Pam Kerssen, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: 218-308-2129 Fax: 218-308-2122

Enclosure

cc: Original - Facility
Licensing and Certification File

Minnesota Department of Health

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 ______	08/30/2012

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

(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) COMPLETE DATE
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 8/28/12 through 8/30/12, surveyors of this Department's staff, visited the above provider and the following licensing orders were 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, Licensing and	2 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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2 000	Continued From page 1 Certification Program; 1505 Pebble Lake Rd, Suite 300, Fergus Falls, MN 56537.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure confused residents were adequately supervised and necessary care was provided to reduce the risk of falls for 1 of 4 residents (R2), who had fallen from a bed left in the high position and sustained a right femur fracture. Findings include: R2 had diagnoses to include diabetes mellitus, osteoarthritis and hip fracture. The quarterly Minimum Data Set (MDS) dated 6/20/12, identified R2 had severe cognitive impairment, did not ambulate and required assistance with all activities of daily living. The Risk for Falls	2 830		

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2 830	Continued From page 2	2 830		

Assessment form dated 6/21/12, identified R2 was at risk for falls, had a history of 1-2 falls in the last six months, had intermittent confusion and agitation, required assistance with elimination, had decreased muscular coordination and required assistance with transferring. R2's care plan dated as revised on 8/14/12, identified R2 was at risk for falls and directed staff to place R2's bed in the lowest position while in bed.

Review of R2's clinical record and nursing progress notes from 6/24/12, through 8/7/12, revealed the following:
- On 6/24/12, a nursing progress note indicated, "Resident [R2] confused, asking staff to take bunny out of his room and digging through the garbage."
- The Resident Care Review dated 7/3/12, identified R2 had a cognitive score of three which indicated he had severe cognitive impairment. The review indicated R2 was more confused and R2 was both mentally and physically unable to cope with a changing environment, or a potentially harmful situation.
- On 7/19/12, a nursing progress note indicated R2 continued to be very confused and became angry and verbally abusive to staff.
- On 7/25/12, a nursing progress note indicated R2 had episodes of "extreme confusion."
- On 8/1/12, a nursing progress note indicated R2 was weak, tired and had varying levels of confusion.
- On 8/2/12, a nursing progress note indicated R2 was found lying on the floor on his right side, "[R2] asking to be sent to emergency room due to possible fracture of right hip. [R2] unable to move right leg." The nursing progress note further indicated the position of R2 ' s bed at the time of the fall was "approximately 3 feet up."

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2 830	Continued From page 3	2 830		

- The Incident Report dated 8/2/12, identified R2 was found on the floor next to his bed when the nursing staff was "looking for a mechanical lift." The report identified R2's bed was in the "high position," and R2 had been "more confused and anxious lately." The report further indicated R2 was sent to the emergency room for a possible hip fracture.
- On 8/5/12, a nursing progress note indicated, "[R2] had surgery yesterday, very difficult case, had a plate and screws inserted, only 2 of screws the DR (doctor) was confident with as the bone was not very good reported that the surgery may not be successful. Resident currently has a lot of pain."
- The Post Fall Analysis dated 8/7/12, indicated R2 had fallen from his bed which resulted in a hospitalization and surgery for a right femur fracture. The analysis indicated prior to the fall, R2 had been more confused and anxious. The analysis further concluded the probable cause of the fall was an "unexpected move from bed."

On 8/29/12, at 10:52 a.m. a registered nurse (RN)-B confirmed R2 had an unwitnessed fall out of the bed when the bed was "up at least 3 feet from the floor." RN-B stated R2 had been care planned to keep the bed in high position so he could reach for a urinal off the bedside stand. However, the written plan of care had conflicting information and directed staff to leave the bed in the lowest position due to safety concerns. RN-B verified R2 had increased confusion prior to the fall and had multiple additional health problems. RN-B stated she was "sure he had broken a bone (after falling from his bed being left in the high position)."

The facility's Resident Fall Assessment policy dated as revised on 5/15/12, identified each

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2 830	Continued From page 4 resident would be assessed after a fall for injury and be provided treatment for any injuries from the fall. However, the policy lacked procedures for identification of residents at risk for falls and implementation of appropriate fall prevention techniques and interventions, such as keeping the bed in the low position to ensure resident safety. On 8/29/12, at 2:52 p.m. RN-A confirmed R2's care plan directed staff to leave his bed in the high position so he could reach items on the bedside table prior to his fall on 8/2/12. She confirmed the current facility policy and confirmed R2's most recent assessment identified severe cognitive impairment with increased confusion and anxiety. RN-A stated leaving a bed in the high position was not an "appropriate" intervention to ensure safety for confused residents. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure supervision and fall prevention interventions are implemented based on a comprehensive assessment for confused resident. The DON or designee could educate all appropriate staff on the policies and procedures to ensure confused residents are supervised to prevent potential falls. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	2 830		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers	2 900		

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2 900	Continued From page 5	2 900		

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 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, interview and document review, the facility failed to comprehensively assess, to develop interventions and to implement interventions to promote the healing of avoidable pressure ulcers on the bony prominence's of the coccyx area and both heels; in addition, the facility failed to adequately monitor the healing of pressure ulcers for 1 of 3 residents (R2).

Findings include:

R2 had diagnoses to include diabetes mellitus, osteoarthritis and a hip fracture. The quarterly Minimum Data Set (MDS) dated 6/20/12, identified R2 had severe cognitive impairment, did not ambulate and required assistance with all activities of daily Living (ADL's). The MDS identified R2 had two stage two unhealed

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2 900	Continued From page 6	2 900		

pressure ulcers.

On 8/28/12, from 5:30 p.m. to 7:44 p.m. (two hours and 14 minutes) R2 was observed to be seated in a high backed wheelchair in a lounge of the facility. R2 remained seated in the chair and did not change positions for the entire observation period. At 7:44 p.m. R2 was assisted to transfer into bed with the use of a total mechanical lift device and two staff. R2 was observed to have a two inch dressing at the coccyx, a beige dressing over left heel, a rigid dark blue cast from toes to below right knee which covered the right heel.

On 8/29/12, from 9:22 a.m. to 11:54 a.m. (two hours and 32 minutes) R2 was observed to be seated in a high backed wheelchair at the nursing station. R2 remained seated in the high backed wheelchair without changing position for the entire observation period. At 3:40 p.m. R2 was observed lying in bed on his back covered with a blanket, both feet were resting on the surface of the bed. At 3:34 p.m. nursing assistant (NA)-A confirmed R2 had an open area on coccyx and stated there were no specific interventions for repositioning R2. NA-A stated the facility practice was to "try" to reposition all residents in the facility every two hours. At 4:01 p.m. R2 remained on his back in bed.

Review R2's clinical record and nursing progress notes from 6/1/12, through 8/28/12, revealed the following:
- On 6/5/12, a nursing progress note indicated R2 had stage two pressure ulcers on the left heel and lateral area of the left foot; an unstageable pressure ulcer on the right heel and had received antibiotics in the recent past due to an infection.
- On 6/19/12, a nursing progress note identified

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2 900	Continued From page 7 R2 developed an open area on the sacral/coccyx area from moisture and the open area was painful. The multiple pressure ulcers on both heels were again noted. - The Braden Scale and other Risk Factors form dated 6/21/12, identified R2 was chairfast, had very limited mobility, was unable to make frequent or significant position changes, had a problem with friction and shearing from moderate to maximum assistance with moving, was cognitively impaired, had poor skin turgor, had a history of pressure ulcers and was at risk for further development of pressure ulcers. Although R2's risk factors were identified, the clinical record lacked an assessment of the current open areas and lacked documentation of interventions to promote healing and prevent development of further pressure ulcers. - On 6/29/12, a nursing progress note indicated R2 continued to have an "open slit" on the coccyx which measured 1.7 centimeters (cm) x 0.4 cm wide and 0.3 cm and described the open area as "deep and painful." The plan identified to change the treatment of the area from dressing changes, to apply a cream to the area with brief changes. The plan directed to encourage R2 to sleep on his sides when in bed to allow for air flow and less pressure on bottom. - On 7/6/12, and 7/20/12, the nursing progress notes indicated R2 had an open area on the coccyx/sacral area which continued to be painful. - On 7/24/12, a nursing progress note indicated R2's open area on the coccyx was "possibly a little worse, not better," and the area measured 1.5 cm by 0.3 cm wide and 0.3 cm deep with yellow slough in the wound bed and "is quite painful." - On 8/9/12, a nursing progress note indicated the open area on the coccyx measured 1.4 cm x 0.4 cm wide and 0.2 cm deep with yellow slough	2 900		

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2 900	Continued From page 8	2 900		

and was painful. The plan at that time identified to continue to monitor dressings, and use suspension boot on the left heel. The clinical record lacked any further interventions to attempt to promote healing of the open area on coccyx.
- On 8/21/12, a nursing progress note identified R2 continued to have an open area on the coccyx which measured 1.5 cm long by 0.4 cm wide and 0.3 cm deep. The note indicated a gauze packing was placed in the wound and it was covered with a dressing.
On 8/29/12, at 2:33 p.m. the registered nurse (RN)-B confirmed R2 had developed an open area on the bony prominence of the coccyx on 6/20/12. RN-B confirmed R2 was unable to reposition himself and stated she would expect interventions for R2 to include assistance with repositioning every 1 ½ to two hours and to avoid sitting or lying on the coccyx area.

The facility's Skin Integrity: Assessment and Management policy dated as revised on 5/5/12, identified all residents would be assessed for risk for development of pressure ulcers. The policy identified residents at highest risk for development of pressure ulcers had risk factors which included immobilization, a history of stage three or stage four pressure ulcers, bladder and bowel incontinence, mental impairment, being over 70 years of age or were experiencing chronic illness. The policy further identified a pressure ulcer as a localized injury to the skin and/or underlying tissue, usually over a bony prominence. The policy indicated a care plan would be developed based on an evaluation of the Braden scale, the pressure tolerance test sitting and lying, other risk factors and complete skin assessment. The policy indicated appropriate treatments such as an individual turning/repositioning schedule and preventative

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2 900	Continued From page 9 measures would be determined. In addition, the policy identified when a pressure ulcer developed, the wound team would view all pressure ulcers weekly, and documentation of the progress of the pressure ulcer healing would be completed. On 8/29/12, at 2:52 p.m. registered nurse (RN)-A confirmed the current facility policy and confirmed R2 had pressure ulcers on both heels and on his coccyx. RN-A confirmed R2 was chair fast, did not reposition himself and confirmed the open area on the coccyx was over the bony prominence. RN-A confirmed R2 utilized a gerichair for most of the day and indicated when the open area developed on the coccyx at the facility. RN-A stated she felt it was from excoriation and had not considered a pressure problem. RN-A stated wound rounds were conducted routinely for R2 to change dressings and to obtain measurements of current open areas. She confirmed R2 had not been assessed regarding pressure related to use of the geri chair and need for repositioning. RN-A stated she would expect R2 to be on a routine repositioning schedule, to encourage lying on sides and to avoid sitting or lying on his back. RN-A confirmed R2 utilized a rigid cast on his right foot, had a recent appointment with the surgeon for follow up of fracture to the right leg, however the facility was unable to determine if the right heel pressure ulcer worsened or improved over the last three weeks. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure residents at risk or who develop pressure ulcers are comprehensively assessed, interventions are developed and implemented to address the risk factors. The	2 900		

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MN VETERANS HOME FERGUS FALLS	**1821 NORTH PARK FERGUS FALLS, MN 56537**

(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) COMPLETE DATE
2 900	Continued From page 10 DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 900		
21400	MN Rule 4658.0810 Subp. 1 Resident Tuberculosis Program Subpart 1. Pursuant to Minnesota Rule 4658.0040, and as defined in Minnesota Department of Health Informational Bulletin 09-02 Tuberculosis Prevention and Control Guidelines:Nursing Homes, Minnesota Rule 4658.0810 Subpart 1 Resident Tuberculosis Program is waived. Conditions of Waiver: - All residents must receive baseline TB screening within 72 hours of admission or within 3 months prior to admission. TB Screening must include an assessment of the resident's risk factors for TB, and any current TB symptoms, and a two-step TST or a single interferon gamma release assay (IGRA) for M. tuberculosis (e.g., QuantiFERON ® TB Gold or TB Gold In Tube, T-SPOT ®.TB). Routine serial TB screening of residents may be done at the discretion of the infection control team. - All reports and copies of resident tuberculin skin tests (TSTs), results from IGRAs for M. tuberculosis, medical evaluations, and chest radiograph results must be maintained in the resident's medical record. Consult current CDC recommendations for the diagnosis of TB for	21400		

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21400	Continued From page 11	21400		

recommended follow-up of residents who display signs or symptoms of active TB disease.

This MN Requirement is not met as evidenced by:
Based on interview and document review, the facility failed to conduct timely tuberculosis(TB) screening within 72-hours after admission for 4 of 4 residents (R11, R6, R4, R10) in the sample.

Findings include:

Review of resident records revealed the facility failed to conduct symptom screening for active TB (such as night sweats, bloody sputum, weight loss, fatigue, and poor appetite) for newly admitted residents within 72-hours of admission.

R11 was admitted to the facility on 10/26/11, received a two step TB skin test timely. However, R11 was not screened for active symptoms of TB until 4/30/12, a total of six months and four days after admission.

R6 was admitted to the facility on 12/20/11, and received the two step TB skin test. However, R6 was not screened for active symptoms of TB until 4/8/12, a total of three months and 19 days after admission.

R4 was admitted to the facility on 11/7/11, and

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21400	Continued From page 12 received the two step TB skin test. However, R4 was not screened for active symptoms of TB until 1/5/12, a total of one month and 29 days after admission. R10 was admitted to the facility on 3/21/12, and received the two step TB skin test. However, R10 was not screened for active symptoms of TB until 4/1/12, a total of 11 days after admission. The facility's Tuberculosis Screening, Evaluation and Management: Residents policy and procedure dated as revised on 10/15/09, identified a baseline screening tool (screening for risk factors and symptoms of active TB disease) would be completed for residents upon admission. On 8/29/12, at 10:45 a.m. the registered nurse (RN)-A confirmed the current facility policy and confirmed the above findings. RN-A stated a two step TB skin test should be initiated upon admission and stated the usual facility practice was to complete the screening for active symptoms of TB "sometime within the first 14 days after admission." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure screening for active TB symptoms is completed within 72-hours of admission to the facility. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21400		

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21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that	21980		

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21980	Continued From page 14 the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to report a vulnerable adult incident involving serious injury for 1 of 1 residents (R14) in the facility. As required by law, the facility was to report such incidents immediately to the Common Entry Point (CEP). Findings include: R14's quarterly Minimum Data Set (MDS) dated 8/30/12 indicated poor short and long term memory with no Brief Interview of Mental Status (BIMS) conducted. The MDS further indicated R14 as independent with bed mobility, transfers, walking, and eating, but needing limited assistance with dressing and personal hygiene. R14 did not require the use of a walker or cane. Diagnoses were Alzheimer's disease, dementia, depression, and psychotic disorder. R14's plan of care indicated he had a tendency to wander and suffered from impaired cognition. Safety was also included on the plan of care with a goal indicating "resident will not fall" and interventions included: roam alert to left ankle, call light within reach, and gripper socks at	21980		

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21980	Continued From page 15 bedtime. R14 suffered a serious injury from a fall on Saturday,12/3/11 at 8:30 a.m. The internal incident report described R14 was walking independently then all of a sudden fell over. He was sent to the emergency department, spent the night in the hospital with a head bleed, and returned back to the Veterans Home Sunday. The incident report included "brain bleed" as the injury sustained. The internal investigation included contributing factors such as cardiovascular disease, cognitive disorder, and use of psychotropic medications. The report indicated the incident was reported to the Common Entry Point (CEP) on 12/5/11 at 8:30 a.m., two days later. An interview with the Director of Nursing (DON) was conducted at 10:30 a.m. on 8/30/12. She verified she did not report the incident until she returned to work Monday, 12/5/11. She further verified this incident should have been reported immediately, as described in the Minnesota Statute 626.557. She indicated she needed to change her policy to reflect this. Lastly, she explained she is currently working on a better system for reporting to their CEP on weekend and/or holidays. The facility policy entitled Vulnerable Adults Act dated 6/16/10 indicated the DON shall call the incident to the CEP within 24 hours. The policy did not include literature regarding such serious incidents which required immediate reporting to the CEP, as required by law.	21980		