MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

October 2, 2014

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

Re: Enclosed Reinspection Results - Project Number SL00531021

Dear Mr. Skillingstad:

On September 24, 2014 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 July 10, 2014, with orders received by you on August 8, 2014. 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 if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File 00531licr14

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00531	A. Building B. Wing	9/24/2014

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	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20265** Reg. # **MN Rule 4658.0085** LSC	Correction Completed **09/24/2014**	ID Prefix **20440** Reg. # **MN Rule 4658.0215** LSC	Correction Completed **09/24/2014**	ID Prefix **20530** Reg. # **MN Rule 4658.0300 Subp.** LSC	Correction Completed **09/24/2014**
ID Prefix **20545** Reg. # **MN Rule 4658.0400 Subp.** LSC	Correction Completed **09/24/2014**	ID Prefix **20565** Reg. # **MN Rule 4658.0405 Subp.** LSC	Correction Completed **09/24/2014**	ID Prefix **20830** Reg. # **MN Rule 4658.0520 Subp.** LSC	Correction Completed **09/24/2014**
ID Prefix **20900** Reg. # **MN Rule 4658.0525 Subp.** LSC	Correction Completed **09/24/2014**	ID Prefix **21015** Reg. # **MN Rule 4658.0610 Subp.** LSC	Correction Completed **09/24/2014**	ID Prefix **21390** Reg. # **MN Rule 4658.0800 Subp.** LSC	Correction Completed **09/24/2014**
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**	**Date:**	**Signature of Surveyor:**	**Date:**
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 7/10/2014	_____	**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?** **YES** **NO**

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Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6356 6429

July 31, 2014

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 SL00531021

Dear Mr. Skillingstad:

The above facility was surveyed on July 7, 2014 through July 10, 2014 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:

Brenda Fischer, Unit Supervisor
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557

Phone: (320) 223-7338
Fax: (320) 223-7348

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 Brenda Fischer at the number above.

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.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure(s)

cc: Licensing and Certification File L00531s1

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 _____	07/10/2014

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 July 7th, 8th, 9th, 10th, 2014, 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, Licensing and	2 000		

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2 000	Continued From page 1 Certification Program, 3333 West Division St, Suite 212, St Cloud, MN 56301.	2 000		
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 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.	2 265		

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2 265	Continued From page 2 This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to notify the physician of the change in condition for a resident (R37) in regards to development and worsening of a pressure ulcer. Findings include: The annual Minimum Data Set (MDS) dated 6/4/14, identified R37 had diagnoses of dementia with severe cognitive impairment, delusional disorder and psychosis. The MDS identified R37 as being totally dependent on staff for ADL's as well as having functional limitation to both upper extremities. Further the MDS identified R37 as having a pressure ulcer to the left inner thumb and was identified as a stage three (full thickness tissue loss without bone, tendon or muscle exposure) pressure ulcer measuring 0.7 centimeters (cm) in length, 0.4 cm in width and 0.1 cm in depth. The care area assessment (CAA's) dated 6/12/14, identified R37 as having a pressure ulcer to the left thumb which was monitored by wound rounds weekly and nursing staff to monitor daily. The CAA also identified R37 as having functional limitation in range of motion to upper extremities as causing complications and increasing risk for pressure ulcers. Review of progress notes from 3/29/14 to 7/9/14, indicated on 3/29/14, R37 had developed a pressure ulcer to the left hand thumb and index finger and a message had been left for the physical therapist (PT) and the evening RN was also updated. The progress note did not identify	2 265		

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2 265	Continued From page 3 any physician notification, of the new pressure ulcer. Furthermore, a progress note for wound rounds on 7/3/14, indicated the stage three pressure ulcer had worsened, measured 1.4 cm in length, 1.2 cm in width and was very deep. The note indicated the wound had bone apparent in the wound bed. There was no indication in the progress notes that R37's physician had been notified of the pressure ulcer or that the pressure had worsened exposing the bone in R37's thumb. Review of physician orders from 2/5/14 to 7/9/14, revealed no orders or mention of R37's pressure ulcer or treatment. Review of physician progress notes from 3/29/14 to 7/9/14, did not mention R37's pressure ulcer nor any concerns from facility staff. On 7/9/14, at 10:00 a.m. Director of Nursing (DON) stated she expected the staff to notify the physician of the onset of the pressure ulcer as well as when the pressure ulcer had increased in size and depth with bone exposure as that would be considered a change in R37's condition. Policy titled (Resident) Change of Status: Assessment/Documentation/Communication revised 4/11/14, indicated the physician was to be notified of resident's change of status and that skin problems which exacerbated would fit the criteria for a change of status. SUGGESTED METHOD OF CORRECTION: The DON or designee could work with the medical director to update policies and procedures for when to notify the physician of changes in the resident, and then could educate staff. The DON or designee could also perform audits of resident records to determine if the physician had been	2 265		

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2 265	Continued From page 4 notified as appropriate. TIME PERIOD FOR CORRECTION: Thirty (30) days	2 265		
2 440	MN Rule 4658.0215 Administration of Medications The right of residents to self-administer medications must be provided as allowed under part 4658.1325, subpart 4. Medications may be added to food only as provided under part 4658.1325, subpart 6. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to obtain a physician's order, and assess the residents ability to self-administer medication for 1 of 1 residents, (R82) who was observed to be left unsupervised while receiving a nebulizer treatment (an inhaled medication). During a medication pass observation on 7/7/14, at 4:34 p.m. Licensed practical nurse (LPN)-D dispensed liquid medication into the nebulizer medication chamber, removed R82's glasses and and ball cap, placed the nebulizer mask over R82's nose and mouth with the elastic band around the back of R82's head, to hold the mask in place. LPN-D left the room and continued with the medication pass, leaving R82 in the room unsupervised. During a second observation on 7/9/14, at 11:13 p.m. LPN-C dispensed liquid medication into the nebulizer medication chamber, removed R82's ball cap and glasses and applied the nebulizer	2 440		

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2 440	Continued From page 5 mask with an elastic band which held the mask in place over R82's nose an mouth. R82 had diagnoses which included dementia, and chronic obstructed pulmonary disease (COPD). R82 was identified by the facility form titled Self Preservation Assessment, dated 7/7/14, as "forgetful/ short attention span...Partial disorientation....Occasional intervention with cues." The facility form titled Medication Review Report dated 7/9/14, (current physicians orders) identified R82 received DuoNeb Solution 0.5-2.5 (3) MG/ML (milligram/milliliter) inhalation 4 times a day. The orders did not direct for self-administration of the nebulizer treatment. R82's care plan dated revision 4/21/14, did not address self-administration of medications or treatments. Review of R82's chart and computer record review did not identify any assessment had been completed for self-administration of the nebulizer treatment. During an interview on 7/9/14, at 11:13 p.m. LPN-C confirmed R82 was routinely unsupervised while he received the nebulizer treatment. LPN-C also confirmed the EMAR (electronic medication record) did not direct R82 to be unsupervised for the nebulizer treatment and was unable to find an assessment or physician order for self-administration. During an interview on 7/9/14, at 2:45 p.m. the director of nursing (DON) confirmed a physician order and resident assessment was needed in order for a resident to be unsupervised during a nebulizer treatment. The DON confirmed neither an order nor an assessment was obtained for	2 440		

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2 440	Continued From page 6 R82's self-administration of the nebulizer treatment. The facility policy titled Medications/Treatments, Self-Administered dated revision 4/29/14, identified in section IV. Bullet B. A " resident requesting self-administration medication/treatments is assessed for his/her ability to administer the medication/treatment safely ....Specific orders from the attending physician must be obtained. " Section IV. Bullet E. " The resident 's ability to continue self-administration of medications/treatments is assessed and documented at least quarterly with care plan review. " SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review and revise the policies and procedures related to resident self-administration of medications. The Director of Nursing could educate the appropriate personnel to these policies and could appoint a designee to monitor the procedures to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Forty-five (45) days.	2 440		
2 530	MN Rule 4658.0300 Subp. 4 Use of Restraints Subp. 4. Decision to apply restraint. The decision to apply a restraint must be based on the comprehensive resident assessment. The least restrictive restraint must be used and incorporated into the comprehensive plan of care. The comprehensive plan of care must allow for progressive removal or the progressive use of less restrictive means. A nursing home must obtain an informed consent for a resident placed	2 530		

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2 530	Continued From page 7 in a physical or chemical restraint. A physician's order must be obtained for a physical or chemical restraint which specifies the duration and circumstances under which the restraint is to be used, including the monitoring interval. Nothing in this part requires a resident to be awakened during the resident's normal sleeping hours strictly for the purpose of releasing restraints. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to assess, obtain a physician order , and monitor use of physical restraint for 1 of 1 residents (R3) who utilized a wheel chair belt restraint. Findings include: R3 was continuously observation on 7/9/14, at 2:10 p.m. seated in his wheel chair in the day room, near the nurse's desk. R3 was leaning forward with hands on the wheel chair arms and raising himself slightly from the seat of the wheel chair but was unable to rise any farther because of a wheel chair seat belt across his lap. R3 then started to pull on the wheelchair seat belt, and turning it in his hands. He made numerous attempts to remove the seat belt without success. At 2:15 p.m. R3 continued to pull on the seat belt and stated, "Get a mechanic." The significant change Minimum Data Set (MDS), dated 3/20/14, identified R3 had severe cognitive impairment, required a wheel chair for all mobility, and utilized no physical restraints. The Care Area Assessment (CAA) signature date 3/27/14, identified R3 had delirium, decreased ability to make self-understood, had difficulty maintaining sitting balance, and had diagnoses which included Alzheimer's disease and mental health problems. Review of R3's chart identified a lack of	2 530		

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2 530	Continued From page 8 assessment, family consent, physician's order and monitoring of use of the wheel chair seat belt. During an interview on 7/9/14 at 2:03 p.m. the ADON stated the wheel chair seat belt had been in place for R3 " to slow him down " to remind him not to stand and keep him from pulling self out of the chair when pulling on the hand rails in the hall ways. The ADON confirmed a restraint assessment had not been completed for R3's use of the wheel chair seat belt, a risks versus benefits had not been reviewed with family, and a physician ' s order had not been obtained, as she did not consider the seat belt as a restraint. During an observation on 7/9/14, at 3:30 p.m. the ADON (assistant director of nursing) verbally cued R3 to remove the wheel chair seat belt. The ADON then turned the seatbelt 180 degrees and again cued R3 to open the seat belt with no success. During an interview on 7/9/14, at 2:45 p.m. the DON (director of nursing) confirmed she would expect staff to complete a restraint assessment for a wheel chair seat belt if the resident was not able to release the belt independently at all times. The facility policy titled Restraints: Positioning and Safety Devices revision date 5/14/14, bullet H. identified " The decision to use physical restraints requires: physicians order ...assessment ...family member conference ...informed consent " . SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure potential restraints are identified, comprehensively assessed and care planned to ensure they are the least restrictive restraints. The director of nursing (DON) or designee could educate all appropriate staff on the policies and	2 530		

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2 530	Continued From page 9 procedures. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Thirty (30) Days	2 530		
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; 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 interview and document review, the facility failed to complete a significant change in status assessment (SCSA) for 1 of 2 residents (R62) who had sustained a decline in activities of daily living (ADLs). Findings include: R62 was admitted to the facility on 11/17/2011, had diagnoses of Chronic airway obstruction, respiratory failure, obstructive chronic bronchitis with exacerbation and spinal stenosis (narrowing of one or more spaces in the spinal column). The quarterly minimum data set (MDS) dated 10/4/13 indicated a Brief Interview for Mental Status (BIMS) score 15/15, which showed no cognitive deficit. The MDS identified R62 was	2 545		

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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) COMPLETE DATE
2 545	Continued From page 10 independent in bed mobility, transfers, walking in room and corridor, locomotion on and off the unit, eating, and required limited assistance of one person for dressing, toilet use, and personal hygiene. The quarterly minimum data set (MDS) dated 1/4/14 indicated a Brief Interview for Mental Status (BIMS) score 15/15, which showed no cognitive deficit. According to the quarterly MDS, R62 was independent in bed mobility, locomotion on the unit, eating, and required limited assistance of one person for transfers, dressing, toilet use, personal hygiene and activity did not occur for walking in room, corridor and locomotion off unit. The quarterly minimum data set (MDS) dated 4/2/14 indicated a Brief Interview for Mental Status (BIMS) score 15/15, which showed no cognitive deficit. The MDS identified a change for R62 was not independent with any ADL'Ss and required supervision and setup help only for eating, limited assistance of one person for bed mobility, personal hygiene, locomotion on unit, and required extensive assist of one person for locomotion off the unit. R62 required total dependence of two person's for transfers, dressing and activity did not occur for walking in room and corridor. During interview on 7/8/14 at 2:10 p.m. nurses aid (NA)-E confirmed that R62 requires total assist for most ADL and uses a ceiling lift for transfers. NA-E stated that R62 is able to verbalize what he wants and will ring for help. During interview on 7/9/14 at 11:10 p.m. registered nurse (RN)-B confirmed that resident had a slow decline in his ADL's and felt that it was	2 545		

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	00531	A. BUILDING: _____ B. WING _____	07/10/2014

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2 545	Continued From page 11 due to his obesity and respiratory failure. During interview on 7/9/14 at 1:14 p.m. RN-B confirmed MDS's and careplan and felt the MDS's must have been coded wrong and should have been coded different for R62's ADL. During interview on 7/9/14 at 1:40 p.m. NA-F confirmed that R62 needs 2 assist with dressing, transfers using the ceiling lift, toileting and needs set up help for meals. NA-F stated "he requires some type of assistance with most of his ADL's and he used to be pretty independent." During interview on 7/9/14 at 2:55 p.m. director of nursing (DON) confirmed the MDS's reviewed and verified that R62 should of had a significant change done for decline in ADL function and stated 'it was missed and we should of followed the policy." According to MDS manual 3.0 dated April 2012, a significant change has to be completed when, "There is a determination that a significant change (either improvement or decline) in a resident's condition from his/her baseline has occurred as indicated by comparison of the resident's current status to the most recent comprehensive assessment and any subsequent Quarterly assessments; and the resident's condition is not expected to return to baseline within two weeks." Review of facility policy titled, MDS 3.0, revised on 4/11/2011, directed the care team to assess the need for a significant change MDS. Nursing staff and NA's will assess for significant changes and the coordinator will assure a significant change has been identified quarterly with care conferences.	2 545		

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2 545	Continued From page 12 SUGGESTED METHOD OF CORRECTION: The DON or her designee could develop a system to identify when a significant change MDS should be completed and provide education to staff on when the MDS should be completed. The DON or her designee could develop a monitoring system of completed assessments to ensure no significant change assessments were missed. TIME PERIOD FOR CORRECTION: Thirty (30) Days	2 545		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide services in accordance with the resident's written plan of care, which included a floor alarm for 1 of 4 residents (R51) reviewed for falls. Findings include: R51 had diagnoses which included a degenerative neurological disorder with resultant symptoms of abnormal involuntary movements of the body. R51's quarterly minimum data set (MDS), dated	2 565		

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2 565	Continued From page 13 5/16/14, identified that R51 was severely cognitively impaired. The MDS further identified R51 was unsteady with movement and required assistance of facility staff for surface to surface transfer, personal hygiene and toileting. R51's care area assessment (CAA), dated 2/17/14, identified R51 had impaired balance during transition of positions, numerous involuntary movements, took medication that could affect balance and was at high risk for falls. R51's care conference summary dated 5/22/14, identified R51 had a history of falls and there was a laser alarm in R51's room to "prevent falls". R51's care plan, dated 5/5/14, identified R51 had an unsteady gait, a history of falls and was at risk for falls. The care plan identified R51 was no longer independent in his room, was unsteady due to neurological disease, and required a wheel chair for mobility. The care plan included directions for staff to ensure proper placement of the motion detecting alarm to detect movement of R51. The care plan further directed that when R51's family member was not present, the motion sensor was to be positioned pointing to the resident's bed, and to ensure the motion light was on and operating. R51's care sheet for staff dated 5/5/14, identified a safety risk related to falls. The care sheet directed care staff to ensure proper placement of the motion detection alarm to detect movement so staff would be aware R51 was attempting to get up. The care sheet further directed that the alarm was to be set directed to the bathroom when family present and to the resident's bed when family not present.	2 565		

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2 565	Continued From page 14 On 7/8/14, at 8:50 a.m., R51 was observed sitting in his darkened room on the edge of the bed facing the door. R51 was looking around the room and reaching down to the floor. there was a gray and white hard plastic box attached with velcro to R51's bedside stand. The vertical edge of the box was directed to the wall opposite the stand toward the foot of R51's bed. No alarm was sounding at the nurses' desk. A blue "post-it" note was observed affixed to the wall to the right of the room door on which was written, "be sure to re-activate the alarm". At 8:55 a.m., R51 continued to sit on the edge of the bed and moving his legs, no alarm was sounding at the nurses' desk. At 8:55 a.m., the surveyor informed licensed practical nurse (LPN)A that R51 was sitting up. LPN-A alerted staff to assist R51. At 9:00 a.m., nursing assistant (NA)-A and NA-G entered R51's room, brought a wheel chair to the bedside and encouraged R51 to transfer to the wheel chair to go to breakfast. Two NA's and the surveyor were moving about the room and no alarm sounded at the nurses' desk. At 9:10 a.m., during interview NA-B stated she knew R51 and had cared for him and confirmed the alarm had not sounded at the desk to alert staff that R51 was up. NA-B was aware of the use of the motion sensor alarm, however, stated the alarm was off and was not used because it disturbed R51. NA-B reviewed the care sheet for R51 and verified the direction to use the motion sensor alarm was part of R51's care plan. At 9:30 a.m., NA-C stated she had taken care of R51 and was not aware of the motion sensor alarm used as an intervention to prevent falls.	2 565		

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2 565	Continued From page 15 NA-C stated R51 had fallen in the past and did attempt to self transfer frequently. At 9:35 a.m., NA-A stated she was unaware of the use of the motion sensor alarm for R51 used to prevent falls, and stated she had cared for R51 and he did attempt to self transfer. At 2:30 p.m., LPN-A confirmed that motion sensor alarm had not sounded at the nurses' desk at 8:50 a.m., when R51 was up on the edge of the bed. LPN-B stated the alarm was to be activated when R51's family was not present, as an intervention to prevent falls. On 7/8/14, at 2:41 p.m., the assistant director of nurses (ADON) stated the motion sensor alarm had been a falls intervention since October of 2013, because R51 would become irritable when staff entered the room to check on him. ADON stated she did not know why the alarm had not sounded, however this had happened in the past when the sensor was turned the wrong direction which prevented detection of R51's movement in the room. ADON confirmed the current care plan and verified it would be expected that staff caring for R51 would be aware of and use the motion sensor alarm correctly as an intervention to prevent R51 from falling. SUGGESTED METHOD OF CORRECTION: The director of nursing could re-educate all staff to follow care plans in regards to specific resident cares and services, and could develop a system to audit and monitor for compliance. TIME PERIOD FOR CORRECTION: Thirty (30) days.	2 565		

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2 830	Continued From page 16	2 830		
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 observation, interview and document review, the facility failed to implement fall interventions for 1 of 4 (R51) residents reviewed for accidents. R51 had diagnoses which included a degenerative neurological disorder with resultant symptoms of abnormal involuntary movements of the body. R51's quarterly minimum data set (MDS), dated 5/16/14, identified that R51 was severely cognitively impaired. The MDS further identified R51 was unsteady with movement and required assistance of facility staff for surface to surface transfer, personal hygiene and toileting. R51's care area assessment (CAA), dated 2/17/14, identified R51 had impaired balance	2 830		

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2 830	Continued From page 17 during transition of positions, numerous involuntary movements, took medication that could affect balance and was at high risk for falls. R51's care conference summary dated 5/22/14, also identified R51 had a history of falls and there was a laser alarm in R51's room to "prevent falls". R51's care plan, dated 5/5/14, identified R51 had an unsteady gait, a history of falls and was at risk for falls. The care plan identified R51 was no longer independent in his room, was unsteady due to neurological disease, and required a wheel chair for mobility. The care plan included directions for staff to ensure proper placement of the motion detecting sensor alarm to detect movement of R51. The care plan further directed that when R51's family member was not present, the motion sensor was to be positioned pointing to the resident's bed, and to ensure the motion light was on and operating. R51's care sheet for staff dated 5/5/14, identified a safety risk related to falls. The care sheet directed care staff to ensure proper placement of the motion detection alarm to detect movement so staff would be aware R51 was attempting to get up. The care sheet further directed that the alarm was to be set directed to the bathroom when family present and to the resident's bed when family not present. On 7/8/14, at 8:50 a.m., R51 was observed sitting in his darkened room on the edge of the bed facing the door. R51 was looking around the room and reaching down to the floor. No alarm was sounding at the nurses' desk. A blue "post-it" note was observed affixed to the wall to the right of the room door on which was written, "be sure	2 830		

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2 830	Continued From page 18 to re-activate the alarm". At 8:55 a.m., R51 continued to sit on the edge of the bed and moving his legs, no alarm was sounding at the nurses' desk. At 8:55 a.m., the surveyor informed licensed practical nurse (LPN)-A that R51 was sitting up. LPN-A alerted staff to assist R51. At 9:00 a.m., nursing universal worker (NUW)-A and NUW-G entered R51's room, brought a wheel chair to the bedside and encouraged R51 to transfer to the wheel chair to go to breakfast. The two NUW's and the surveyor were moving about the room and no alarm was sounding at the nurses' desk. At 9:10 a.m., during interview NUW-B stated she knew R51 and had cared for him and confirmed the alarm had not sounded at the desk to alert staff that R51 was up. NUW-B was aware of the use of the motion sensor alarm, however, stated the alarm was not used all the time because it disturbed R51. NUW-B reviewed the care sheet for R51 and verified the direction to use the motion sensor alarm was part of R52's care plan. At 9:30 a.m., NUW-C stated she had taken care of R51 and was not aware of the motion sensor alarm used as an intervention to prevent falls. NUW-C stated R51 had fallen in the past and did attempt to self transfer frequently. At 9:35 a.m., NUW-A stated she was unaware of the use of the motion sensor alarm for R51 used to prevent falls, and stated she had cared for R51 and he did attempt to self transfer. At 2:30 p.m., LPN-A confirmed that motion sensor alarm had not sounded at the nurses' desk at	2 830		

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2 830	Continued From page 19 8:50 a.m., when R51 was up on the edge of the bed. LPN-B stated the alarm was to be activated when R51's family was not present, as an intervention to prevent falls. R51's progress notes and incident reports included the following: Progress note-10/18/14 10:11 a.m.,-resident found sitting on the floor in the room. Incident report-10/18/14-staff found R51 on floor sitting with back against wall next to recliner, silent alarm was not sounding. R51 stated fell into garbage can. Progress note 10/20/14 fall reviewed at falls committee. Motion sensor was turned wrong direction and did not sound. Remind staff not to move sensor-check to face right direction. Progress note-11/10/14,9:41 p.m.,-nurse called into R51's room as resident was lying on the floor next to the bed. Progress note-11/12/14-reviewed at falls committee, resident normally has a motion detector alarm on to alert staff that he is up. the resident had been watching TV and sitting on the edge of the bed-the alarm had been turned off so it would not continue to go off-will ensure that the alarm is turned on so staff are aware that the resident is moving out of bed. Progress note-1/5/14 10:09 p.m.,-R51 found sitting on the floor in front of recliner. Found motion detector rolled up in cloth on the bed, will continue to monitor. Incident report 1/3/14- Staff found R51 sitting on the floor next to the closet in the room yelling for help, stated was trying to get to the bed. On 7/8/14, at 2:41 p.m., the assistant director of	2 830		

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2 830	Continued From page 20 nurses (ADON) stated the motion sensor alarm had been an intervention since October of 2013, and the alarm was utilized as an intervention to prevent falls, because R51 would become irritable when staff entered the room to check on him. ADON confirmed the current care plan and verified it would be expected that staff caring for R51 would be aware of, and use the motion sensor alarm correctly as an intervention to prevent R51 from falling. Manufacturer's instructions for the Wireless PIR motion detecting alarm, provided by the facility, directs that the alarm can be rotated in the bracket for desired motion detection. The instructions further direct that a beam test was to be performed after changing the position of the detector, the motion expected to be detected was to be duplicated and the alarm should sound loudly until the reset button is pressed or the power switch is set to the OFF position. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure resident falls are comprehensively assessed and intervention implemented in a timely manor. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Thirty (30) days.	2 830		

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2 900	Continued From page 21	2 900		
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 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 implement interventions to prevent increase in severity of a pressure ulcer for 1 of 5 residents, (R37), reviewed for pressure ulcers. Findings include: R37 annual Minimum Data Set (MDS) dated 6/4/14, identified diagnoses of dementia with severe cognitive impairment, delusional disorder and psychosis. R37 was totally dependent on staff for activities of daily living (ADL)'s as well as having functional limitation to both upper extremities. The MDS further identified R37 as having a pressure ulcer to the left inner thumb as a stage three (full thickness tissue loss without bone, tendon or muscle exposure) pressure ulcer measuring 0.7	2 900		

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2 900	Continued From page 22 centimeters (cm) in length, 0.4 cm in width and 0.1 cm in depth. The care area assessment (CAA's) dated 6/12/14, identified R37 had a pressure ulcer to the left thumb which was monitored by wound rounds weekly and nursing staff daily. The CAA also identified R37 was having functional limitations in range of motion to the upper extremities causing complications and increasing R37's risk for pressure ulcers. Review of R37's care plan, revised 12/19/13 indicated potential for skin breakdown with a goal of will be free from skin breakdown. Interventions were noted to assist to reposition in bed and wheelchair every two hours, apply lotion with cares, foam cushion was to be used in wheelchair. Intervention revised on 6/16/14 directed staff to keep skin clean, dry and free from pressure, wash and dry hands with cares, use of carrots to separate thumb and index finger. On 7/8/14, at 7:35 a.m. R37's wound care was observed with a registered nurse (RN)-E and nursing assistant (NA)-I were present. NA-I assisted to open R37's left hand thumb and index finger, RN-E removed the old dressing which consisted of tape, gauze and Actisorb (a dressing impregnated with silver on a moisture wicking fabric). There was a moderate amount of drainage noted on the old dressing and the area was cleansed with normal saline. The wound was deep, circular in shape with bone visible in the center of wound bed. The wound edges were moist and hard, there was no odor detected. The pressure ulcer was then re-dressed with Acticoat, gauze and tape. An inflatable carrot (an inflatable pressure relieving	2 900		

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2 900	Continued From page 23 device shaped like a carrot approximately six inches in length and covered with a removable blue felt cloth) was placed in R37's left hand, no pressure was observed between thumb and index finger with the carrot in place. On 7/9/14, at 10:10 a.m. R37's wound care was observed with wound team (members included RN-C, PT-A and RN-E. RN-C assisted to open hand, PT removed old dressing which exhibited minimal drainage, no odor was present. RN-C verified bone exposure in the center of the wound bed. PT cleansed wound with normal saline, skin was observed to be peeling away from the surrounding skin of the wound edges and down the thumb towards the hand. Wound bed was reddened. The ulcer measured 1.2 cm long by 1.0 cm wide by 0.3 cm deep. The right side of the ulcer was noted at that time to have had undermining present (a tunneling under the skin at the edge of a wound increasing ulcers severity). The team members discussed packing the wound due to it's depth, undermining, the exposed bone and decided they would implement a different dressing. The team decided to use Aquacel Ag (a fabric type dressing impregnated with silver, wicking type dressing) was packed into the ulcer a 4 cm by 4 cm squared gauze was placed over the Aquacel Ag and taped in place. The inflatable carrots were re-inserted, and the PT-A verified position and placement. Review of progress notes from 3/29/14 to 7/9/14, identified the following: On 3/29/14, R37 had a developed a new pressure ulcer between the left hand thumb and index finger. A message had been left for the physical therapist (PT) and the evening nurse was also updated. There was no indication the	2 900		

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2 900	Continued From page 24 PU was measured, staged, nor was the physician notified of the development nor was a treatment started. On 4/2/14, the writer had attempted to check R37's left hand between thumb and index finger; however, R37 would not let the writer check the pressure ulcer. On 4/6/14 R37 had been experiencing difficulty holding onto the mechanical lift with transfers and staff had been using a wash cloth in R37's left hand because it was becoming stiff. The writer would communicate to dietary and PT for other interventions. There was no indication the PU was measured, staged, or identified any ulcer characteristics or what treatment if any was being completed for the PU. On 4/17/14, the note indicated R37 had a small open sore on the left inner thumb, area was cleansed with "spray" and bacitracin (an over the counter antibiotic ointment) was applied. The area was left open to air, writer indicated will report and monitor as well as pass information onto AM shift. There was no mention, of size, characteristics or what stage the PU had developed into and there was no physician notification about the PU. On 4/18/14, R37's left hand contracture had become tighter and would not keep a rolled washcloth in the left hand. The note indicated R37 open area on the left inside of his thumb looked worse. An as needed (prn) cream clotrimazole (anti-yeast cream) had been applied to "yeasty smelling" insides of R37's palm and the rolled washcloth was placed back into R37's left hand. A voicemail had been left for PT and occupational therapy (OT) for suggestions on a	2 900		

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2 900	Continued From page 25 more efficient device. There was no indication the PU was measured, staged, or identified any ulcer characteristics, nor was the physician notified even though it was "yeasty smelling." On 4/21/14, a note authored by the certified occupational therapy assistance (COTA) revealed placement of a left palm protector as R37 had a history of removing wash cloths and carrot. The interventions would be tried and would follow up with unit staff. On 4/25/14, a late entry wound rounds note for 4/24/14, revealed a pressure ulcer on R37's left inner thumb due to holding fingers clasped together and measurements of 0.5 cm long by 1.0 cm wide. The note indicated the pressure ulcer was very superficial, was macerated (moist, soft skin which is easily peeled), around the opening of the pressure ulcer. There had been dead loose skin around the wound bed. The pressure ulcer had been cleansed, an Allevyn (an adhesive dressing with fabric inside to wick moisture) dressing was applied and a rolled wash cloth had been placed in R37's left hand. The note revealed that R37 denied pain and the pressure ulcer would be re-assessed at next wound rounds. On 5/5/14, a late entry wound round note for 5/1/14, revealed R37 continued to have a stage two pressure ulcer to the left inner thumb with clear yellow drainage, no odor yet the hand was moist and had a slight odor. The note indicated measurements of 0.6 cm by 0.8 cm no depth measurements indicated. The ulcer was cleansed and re-dressed with an Allevyn Adhesive dressing and a rolled wash cloth was placed in R37's left hand. The note further indicated that the inflatable	2 900		

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2 900	Continued From page 26 carrot would be tired for better hand positioning and had been ordered. A Wound round note on 5/8/14, revealed stage two pressure ulcer with slight yellow drainage and odor from form moist clenched hand. Wound had appeared macerated around the edges, measured 0.6 cm long by 0.8 cm wide, area was cleansed and re-dressed with Allevyn dressing and a rolled washcloth was placed in R37's left hand to help keep hand dry and for positioning. On 5/15/14, a wound note divulged R37 continued to have a stage two pressure ulcer to left inner thumb with moderate drainage, odor noted from hand, appeared moist and macerated, measured 0.4 cm long by 0.7 cm wide. The note revealed the skin surrounding the ulcer opening was reddened. The writer had applied bacitracin to the ulcer and re-dressed with Allevyn dressing. An inflatable carrot was applied to decrease pressure on thumb and first finger. Even though R37 pressure ulcer had an odor, and was macerated the facility continued to apply the Alleyn dressing, and did not change the treatment plan even though they had continued this same treatment since April 25, 2014. On 5/19/14, a high nutrition risk note revealed risk had been present due to poor skin integrity and that R37 had a stage two pressure ulcer to left inner thumb which had been slightly wider. Nutrition interventions included whole milk and fortified breakfast cereal. A similar note had also been written on 5/20/14 as a summary note. Review of Braden scale dated 5/20/14, reveled moderate risk for skin breakdown with the following risk factors; slightly limited sensory	2 900		

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2 900	Continued From page 27 perception, skin was occasionally moist, R37 was confined to a wheelchair, mobility was very limited, nutrition was adequate and friction and shear were a potential problem. On 5/29/14, a wound note revealed R37 continued to have a pressure "area" to left thumb measuring 0.4 cm long by 0.6 cm wide by 0.1 cm deep. The ulcer had a scant amount of drainage, maceration was noted around wound bed, though wound bed was white. An Acticoat dressing (a antimicrobial barrier dressing) was applied. On 6/5/14, a wound note revealed R37 had a pressure area to the left thumb, scant amount of drainage and some odor had been present. Measurements of the ulcer were 0.7 cm long by 0.4 cm wide and red tissue was noted in the middle of the open area. An Acticoat dressing and gauze had been applied to the ulcer and covered with tape. The inflatable carrots were again inserted to prevent pressure. There was no indication the physician had been notified of the PU, even though there was On 6/12/14, a wound note revealed R37 had an unstagable ulcer (an open area with full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, white, tan or gray matter) or covered by eschar (black, brown or tan matter) thus being unable to measure the depth of the wound and cannot be staged). The note revealed measurements of 0.8 cm long by 0.7 am wide. The depth was unable to be determined due to the wound bed not being visible. The note indicated the pressure ulcer appeared to be healing and was less deep. The pressure ulcer was cleansed and re-dressed with Actisorb, gauze and tape. The note directed the dressing	2 900		

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2 900	Continued From page 28 was to be changed daily. The wound note on 6/19/14 revealed R37 had a healing unstagable ulcer to left thumb, measured 0.7 cm long by 0.6 cm wide by 0.1 cm deep, moderate drainage, white tissue was noted in the wound bed along with granulation (new skin tissue presented as pink, red, fleshy tissue which can have a granular appearance (grit type appearance) tissue. Area was cleansed and redressed with Anticoat, gauze and tape. The wound note on 6/26/14, (entered on 7/8/14, as had been put in the wrong chart) revealed pressure ulcer measured 0.7 cm long by 0.6 cm wide and 0.1 cm deep. Scant amount of drainage noted, no sough tissue noted and the area was noted to appear more healthy and had been healing. The pressure ulcer was cleansed and re-dressed with Acticoat, gauze and tape. The wound note on 7/3/14, revealed stage III pressure ulcer that was worse, measured 1.4 cm long by 1.2 cm wide and was very deep. Furthermore the note divulged R37's thumb had exposed bone observed in the wound bed. The pressure ulcer was cleansed, re-dressed with Actisorb, gauze and tape. Inflatable carrots were placed in hands with direction to have R37 use carrots 24/7 due to continuously clenched hands which caused pressure. Although, R37 PU had developed into a stage III, the physician had not been contacted nor was their a change in the treatment for the PU which had worsened. On 7/8/14, at 7:50 a.m. RN -E stated the pressure ulcer developed gradually as R37's left hand contracture had become tighter. RN-E confirmed R37's thumb was contracted against	2 900		

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2 900	Continued From page 29 index finger and multiple interventions had been tried such as wash cloths with no improvement. RN-E stated that some improvement in the pressure relief had been seen with the use of the carrots. An interview with Dietician on 7/8/14, at 2:10 p.m. revealed R37 nutritional interventions were in place such as in between meal snacks, whole milk and super cereal (high calorie, high protein cereal). The dietician stated she had not initiated Juven (high nutrient powder added to fluids used to aid in healing skin issues) as resident was gaining weight and intakes were over 75% on average. The dietician confirmed R37's pressure ulcer had increased in size and depth, and they should added the JuVen to assist in healing. An interview with RN- C and physical therapist (PT)-A on 7/8/14, at 2:40 p.m. indicated RN-C confirmed the pressure ulcer had worsened, though had been looking fairly okay until July, 2014. RN-C confirmed R37 had not been seen by the physician for the pressure ulcer, nor had the physician been notified when the bone became exposed and the current treatment was no longer effective. The PT-A stated she had looked at other interventions for the pressure relief such as palm protector, wash cloths and was unaware of any type of splint that could be used to relieve thumb to index finger pressure. Both RN-C and PT-A had confirmed they felt R37 should be seen by nurse practitioner or MD. At 3:15 p.m. PT-A verbalized that Juven would be started twice daily to promote healing. On 7/9/14, at 1:15 p.m. NA-J verified they used the carrots daily, and had recently received re-education on continuous use of carrots, and	2 900		

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2 900	Continued From page 30 verbalize the process of applying carrots, small end up through thumb and index finger so the thumb and index finger do not touch. During observations of R37 throughout the survey revealed consistent use of carrots to both hands and repositioning per the care plan. On 7/9/14, at 10:00 a.m. director of nursing (DON) stated the expectations for skin care were to follow care plan, if a pressure ulcer was present the wound team would initiate the facilities wound protocol. The DON stated her expectations were per the policy of the facility. The DON did confirm she expected the physician would have been notified upon onset of a pressure ulcer and when a pressure ulcer had become worse as these would be considered a change in resident status. Although R37 had developed a pressure ulcer on 3/24/14, the facility had not consistently monitored the pressure ulcer on a weekly basis to identify staging, size, depth, presence, location and extent of undermining, edudate if present, pain, wound bed, edges and surrounding tissue. Also, the facility did not change the plan of treatment, when the PU was not improving or contacted the physician when the ulcer develop and when the PU was deteriorating. Policy titled Skin Integrity: Assessment and Management revised 7/1/14, revealed the standard of care and practice for skin integrity will be utilized throughout the facility and is the responsibility of the nursing staff and the wound management team. The policy directed the implementation of Standing orders for Wound Care Protocol. The Standing Orders for Wound Care Protocol	2 900		

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2 900	Continued From page 31 revised 7/1/14, and signed by medical director on 7/7/14, directed the wound management team to the management of skin care and treatment of pressure ulcers, also directing the team to notify physician within 24 hours after initial assessment, then weekly thereafter if no improvement and every two weeks if area would be improving. In cases of stage three pressure ulcers the policy directed staff to notify MD of the pressure area and in situations of stage four pressure ulcer (full thickness loss with extensive destruction with damage to bone or supporting structure, undermining may be associated with stage IV pressure ulcers. The Policy directed staff to obtain orders from the physician. SUGGESTED METHOD OF CORRECTION: The DON or designee could develop policies and procedures to ensure residents who are admitted without a pressure ulcer do not develop a pressure ulcer while in the facility. The DON or designee could educate all appropriate staff on these policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days	2 900		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced	21015		

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21015	Continued From page 32 by: Based on observation, interview and document review, the facility failed to serve food in a sanitary manner to prevent the spread of food borne illness for 47 of 47 residents who were served food in this manner in the main dining room. Findings include: The main dining room meal service was observed on 7/7/14, at 5:10 p.m. Nursing assistants (NA) and dietary associates (DA) were bringing the resident's food order slips from the resident's tables to a silver shelf located above the food serving area. Dietary associate (DA)-A with gloves on both hands opened up a hotdog bun, placed a hotdog in the bun with tongs, and placed the item on a resident plate. DA-A then touched the resident's food order slip with her gloves hands, and slid the food order slip over with the resident served plate to DA-B who was served the remainder of the food items the resident requested for the meal. DA-A continued the same process of using the soiled gloves, touching the resident's food slips, and touching the hotdog bun with the same soiled gloves until she completed serving all the residents in the main dining room. DA-A was not observed to change her soiled gloves or wash her hands after touching the resident's order slips. This procedure continued through out the meal from 5:10 p.m. to 5:17 p.m. and from 5:17 p.m. to 5:30 p.m. In addition, during continuous observation DA-B at 5:30 p.m. had took over DA-A job duty of dishing up the hotdog in the bun. DA-B was observed to have gloves on both hands and opened the hotdog bun with her gloved hands then touched the resident food order slip with one	21015		

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21015	Continued From page 33 of her gloved hands. DA-B repeated this process of touching the buns with her soiled gloves and then touching the food order slips. DA-B had not washed her hands, or removed her soiled gloves before touching the hotdog buns. She continued this process until meal service was completed at 5:30 p.m. The above observation was discussed with the dietitian on 7/8/14, in the afternoon, and stated this was not the standard practice to touch ready to eat food with soiled gloves. The gloves should have been removed, hands washed and a new pair of gloves on if other items are being touched. On 7/9/14, in the afternoon, DA-A stated in reflecting back she shouldn't have touched the slips then the buns with the same gloved hands. DA-B also confirmed the serving slips had been touched with the gloved hands and then she had touched the buns with the same gloves that had touched the paper diet slips. Review of the facility policy titled, Food Handling Techniques, number 3 indicated it is important that in preparation and handling of food, every effort is made to prevent the introduction of contamination and the growth of disease causing bacteria. SUGGESTED METHOD FOR CORRECTION: The director of dietary or designee could review and revise as necessary the policy and procedure regarding handling of ready to eat foods. The director of dietary or designee could provide training for all appropriate staff on theses policies and procedures. The director of dietary or	21015		

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21015	Continued From page 34 designee could monitor to assure the ready to eat foods are handled appropriately. TIME PERIOD FOR CORRECTION: Thirty (30) days.	21015		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced	21390		

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21390	Continued From page 35 by: Based on observation, interview, and document review, the facility failed to implement proper infection control measures for the use of personal protective equipment to prevent the spread of infection within the facility for 1 of 1 residents (R62) observed who required isolation precautions. In addition the facility failed to follow infection control practices with soiled linen handling and use of shared resident equipment in a manner to prevent cross contamination for 1 of 3 residents (R3) observed during personal cares. Findings include: ISOLATION PRECAUTIONS R62 had diagnoses of Methicilin Resistant Staph Aureus (MRSA) in his sputum and required isolation precautions involving gloving, gowning and masking when entering room per current care plan. On 7/8/14 at 2:00 p.m. nurses aid (NA)-E was observed coming out of R62's room wearing a long yellow cloth gown over her clothing, a blue disposable mask on her face covering her mouth and nose region, and clear disposable gloves on both of her hands. She exited R62's room turned right and walked approximately 58 feet to the clean linen cart around the corner from the nurses station on the west wing of the facility. NA-E opened the door to the linen cart, grabbed a white blanket off the shelf, and then proceeded to walk back into R62's room carrying the white blanket in her right hand. NA-E then exited R62's room again wearing the same gloves, gown and mask while carrying a red bag in her right hand, she proceeded to walked approximately 16 feet	21390		

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21390	Continued From page 36 directly across the hallway from R62's room with the red bag in her right hand and opened the door on left side of her labeled soiled utility room. NA-E came out of the soiled utility room still wearing the same gloves, gown and mask, and proceeded to walk back to R62's room where she started taking her gloves, gown and mask off in the hallway outside of R62's room. During interview on 7/8/14 at 2:10 p.m. NA-E confirmed that she had gone into the clean linen cart to get R26 a blanket, then returned to his room, and then went to the soiled utility room with dirty linen while wearing her personal protective equipment the entire time on the west wing of the facility. NA-E stated "normally I would not do this but I needed a clean blanket and did not even think about it". Furthermore she verified that R62 does have MRSA in his sputum and is currently on isolation precautions. During interview on 7/8/14 at 2:15 p.m. registered nurse (RN)-B confirmed that R62 needed isolation precautions and verified that staff should not be walking in the hallways with their gloves, gown and mask on after coming out of a resident room and stated "they should disrobe when they come out of the residents room". Furthermore RN-B verified this was not good infection control practices. During interview on 7/9/14 at 2:20 p.m. RN-C confirmed that staff should be removing all items (gloves, gown, and mask) then washing their hands before they leave a room requiring isolation precautions. RN-C also stated "This is bad infection control practice and this should not happen". During interview on 7/9/14 at 2:55 p.m. director of	21390		

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 _____	07/10/2014

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21390	Continued From page 37 nursing (DON) confirmed the facility staff are expected to glove, gown and mask before entering a isolation room and removing their gloves, gowns and masks before leaving a residents room that requires isolation precautions and not walking in the hallways with it on. Furthermore the DON stated "they should be following the policy and this is not good infection control practice". Review of facility policy titled, Methicilin Resistant Staph Aureus (MRSA) Guidelines, revised on 4/13/2009, direct staff to dispose of gloves in resident's room. DO NOT LEAVE ROOM WITH GLOVES ON. Review of facility policy titled, Employee Exposure Control Plan, revised on 4/6/2009, directed staff to remove all personal protective equipment (gloves, gown and masks) will be removed and placed in a designated container for storage, washing, decontamination or disposal before leaving the work area. SOILED LINEN During an observation on 7/7/14, at 5:00 p.m. NA-G carried a plastic garbage bag and a large bundle of soiled bed linens against the front of her uniform top while walking down the hall to the soiled utility room. In the utility room NA-G placed the plastic bag, the soiled bedding and comforter in separate bins. During an interview on 7/7/14, at 7:30 p.m. NA-G confirmed the linens she carried against her uniform top were soiled with urine. During an interview on 7/8/14, at 2:35 p.m. the DON confirmed the transportation of linens held against staff clothing was not appropriate. Review of the facility's policy titled Linen	21390		

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21390	Continued From page 38 handling/Distribution, dated revision 4/20/09, identified the objective, "To define infection control standards for the proper handling of linen....section VI. A. 1. Linen is to be carried away from the body." SOILED GLOVES AND EQUIPMENT During an observation on 7/7/14, at 6:34 p.m. NA-G and RN-D assisted R3 with toileting. R3 was seated on the toilet with a mechanical lift (a device to aid in moving a resident from one surface to another) positioned directly in front of R3. R3's soiled pants lay crumpled on the floor by the wall, to his left. RN-D handled the catheter tubing and leg strap with her right and left hand, turned and secured it to the bag and then the leg strap. NA-G assisted with the catheter tubing and leg strap then with the same gloves held the safety strap of the mechanical lift and secured R3 to the lift. RN-D without changing gloves after catheter care, handled the safety strap of the mechanical lift, placed it under R3's left arm and secured it to the lift. RN-D then held R3's left hand opened his fingers and placed them around the hand grip of the lift. RN-D and NA-G completed the transfer of R3 to the wheel chair and then returned the lift to the storage room without disinfecting any areas of the lift. During an interview on 7/7/14, at 6:43 p.m. NA-E confirmed R3's soiled pants were placed directly on the floor in the shared bathroom, and further clarified this was not the usual practice. NA-E confirmed catheter cares were provided for R3, multiple surfaces of the lift were touched while wearing the same soiled gloves and the lift was returned to the storage room for possible use for another resident without disinfecting the soiled lift. During an interview on 7/7/14, at 7:10 p.m. RN-D	21390		

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21390	Continued From page 39 confirmed handling R3's catheter tubing due to urine leakage, and touching multiple areas of the mechanical lift and body strap were not appropriate and the mechanical lift should have been disinfected after being touched. During an interview on 7/8/14, at 2:35 p.m. the DON confirmed the soiled linen placed directly on the bathroom floor would be an infection control problem. The DON confirmed she would expect staff to use appropriate hygiene and glove use by washing hands after cares and not touching other surfaces with soiled gloves, to prevent contamination of other surfaces. Review of the facility's policy titled Linen handling/Distribution dated revision 4/20/09, identified" B. Soiled linen 3. Linen should never be placed on the floor." Review of the facility's policy titled Gloving procedure, dated revision 4/23/07, identified II. F "gloves must be replaced after a dirty procedure and before a clean procedure." SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure infection control standards are being met in the facility. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Thirty (30) Days	21390		