Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6357 1324

September 14, 2015

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number SL00531022

Dear Mr. Skillingstad:

The above facility was surveyed on August 25, 2015 through August 28, 2015 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, Health Regulation 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 <u>only a suggestion</u> 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:

Kathryn Serie, Unit Supervisor
Mankato Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street
Marshall, Minnesota 56258-2529
Email: kathryn.serie@state.mn.us
Telephone: (507) 537-7158 Fax: (507) 344-2723

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 Kathryn Serie at telephone number or email detailed 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, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

Enclosure(s)

#1
Fergus Falls
Mark

09/15/15

U.S. Postal Service™
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Postage	$
Certified Fee	
Return Receipt Fee (Endorsement Required)	
Restricted Delivery Fee (Endorsement Required)	
Total Postage & Fees	$

Postmark Here

Sent To: Mr. Jon Skillingstad, Administrator
MN Veterans Home Fergus Falls
Street, Apt. No., or PO Box No.: 1821 North Park
City, State, ZIP: Fergus Falls, MN 56537
Project SL00531022

PS Form 3800,

MDH L+C

SENDER: *COMPLETE THIS SECTION*

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

1. Article Addressed to:

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

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Heidi Nygaard ☐ Agent ☐ Addressee

B. Received by (*Printed Name*): Heidi Nygaard
C. Date of Delivery: 9-18-15

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

3. Service Type L+C
☒ Certified Mail® ☐ Priority Mail Express™
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ Collect on Delivery

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

2. Article Number
7013 2250 0001 6357 1324

PLEASE RETURN IN 5 DAYS

PS Form 3811, July 2013 Domestic Return Receipt

SL00531022

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 ______	08/28/2015

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 August 25, 26, 27 and 28, 2015, 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		

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, P.O. Box 64900 St. Paul, MN 55164-0900	2 000		
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 interview and document review, the facility failed to implement the plan of care related to dialysis access site care for 1 of 1 resident (R13) reviewed who required dialysis services. Findings include: R13's current care plan dated 7/4/15, identified R13 received dialysis therapy routinely every Monday, Wednesday and Friday. The care plan listed various interventions which included: check for thrill, bruit and send blue communication folder with resident to dialysis. The care plan also directed staff to care and monitor access site, for signs or symptoms of infection. If noted redness, swelling, pain at site, drainage or bleeding, notify nurse practitioner/medical doctor and dialysis. Review of R13's current physician orders dated 7/13/15, did not identify any monitoring of R13's access site as directed by the care plan. Review of R13's current medication administration record (MAR) dated 8/1/15,	2 565		

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2 565	Continued From page 2 revealed documentation was lacking to indicate staff was monitoring R13's access site as directed by the care plan. Review of R13's current treatment record dated 8/1/15, revealed documentation was lacking to indicate staff was monitoring R13's access site as directed by the care plan. Review of progress note dated 1/31/15 read "has thrill in dialysis site right crook of arm." -dated 3/3/15 read "does have site for dialysis on his right arm. -dated 3/18/15 read "he has his dialysis port in his right arm. -dated 3/24/15 read "intact dialysis port mid arm, within normal limits. -dated 5/23/15 read "does have a port for dialysis on his left upper arm. -dated 6/16/15 read "nurses check dialysis sit for thrill/flow. -dated 7/2/15 read "he has a port on his left arm for dialysis. -dated 8/4/15 read " intact skin with no rash or bruising. Bandages to dialysis shunt intact. During observation on 8/25/15, at 3:25 p.m. R13 access site on his right arm was covered with white gauze with tape until R13 went to bed for the evening at approximately 7:00 p.m. During observation on 8/26/25, at 4:15 p.m. R13 was sitting in the door way of his room wheel chair and the access site located on his right arm was covered with white gauze and taped to his skin. During observation on 8/27/15, at 7:05 a.m. R13 was seated in his wheel chair in his room with the access site on his right arm covered with white	2 565		

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2 565	Continued From page 3	2 565		

gauze and taped to his skin.

When interviewed on 8/26/15, at 4:17 p.m. licensed practical nurse (LPN)- B confirmed R13 has scheduled dialysis on Monday, Wednesday and Friday. She also verified that R13 leaves around 6:15 a.m. and usually returns to the facility around 11:00 a.m. on dialysis days.

During interview on 8/27/15, at 12:15 p.m. registered nurse (RN)-A confirmed R13 goes to dialysis on Monday, Wednesday, and Fridays. RN-A also verified R13 current care plan and confirmed that staff were not documenting or monitoring R13 access site to his right arm and stated ""I know we are not documenting it." RN-A could not provide any documentation to verify staff were routinely checking R13's access site post-dialysis treatments for infection, redness, swelling, pain at site, drainage, bleeding, thrill and bruit.

During interview on 8/27/15, at 12:30 p.m. the director of nursing (DON) confirmed R13 goes to dialysis on Monday, Wednesday, and Fridays. The DON also verified R13 current care plan and verified that staff were not documenting or monitoring R13 access site to his right arm and stated "we should be doing this and following the care plan." The DON also verified staff should be monitoring the access site for infection, redness, swelling, pain at site, drainage, bleeding, thrill, bruit and notify nurse practitioner or medical doctor.

Review of facility policy titled, Dialysis Patient, Care of revised 5/25/15 indicated staff would monitor residents who require dialysis treatment, will be monitored according to physician orders and facility standards for activity, diet, fluid

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2 565	Continued From page 4 restrictions, site, weight, and vitals signs. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure the facility followed care plans according to the residents individualized needs. 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 with providing cares as directed by the care plan.. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 875	MN Rule 4658.0520 Subp. 2 I Adequate and Proper Nursing Care; Monitor TPR Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: I. Monitoring resident temperature, pulse, respiration, and blood pressure as often as indicated by the resident's condition but at least weekly. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the medical record contained weekly documentation of temperature, pulse, respiration and blood pressures for 3 of 3 residents (R1, R2, R15) reviewed who had a diagnosis of hypertension (high blood pressure). Findings include:	2 875		

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2 875	Continued From page 5	2 875		

R1's current diagnoses according to the Medical Diagnosis Report dated 12/1/10, included hypertension (HTN) and unspecified cardiovascular disease. R1's physician's orders dated 8/21/15, contained orders for furosemide 40 milligrams(mg) once each day for HTN, Lisinopril 2.5 mg once each day for HTN and Clonidine HCL 0.1 mg three times daily for HTN.

R1's Vitals Summary Report revealed temperature, pulse, respiration and blood pressure results were assessed and documented, but lacked 21 weekly assessments identified on the following dates: 7/16/14, 8/6/14, 8/27/14, 10/8/14, 10/22/14, 10/29/14, 11/5/15, 11/12/14, 11/19/14, 12/3/14, 12/17/14, 12/24/14, 1/7/15, 1/21/15, 1/28/15, 2/12/15, 2/14/15, 2/18/15, 3/4/15, 3/11/15, 3/23/15, 3/24/15, 3/25/15, 4/1/15, 4/8/15, 4/15/15, 4/21/15, 4/22/15, 4/29/15, 5/6/15, 5/13/15, 5/20/15, 5/27/15, 6/3/15, 6/17/15, 6/24/15, 7/1/15, 7/8/15, 7/15/15, 7/22/15, 7/29/15, 8/5/15, 8/12/15, 8/19/15, 8/26/15.

R2's current diagnoses according to the Medical Diagnosis Report dated 2/14/13, included HTN, and atrial fibrillation (irregular heartbeat). R2's physician's orders dated 7/10/15, contained orders for Jantoven 2.5 mg once each day for atrial fibrillation.

R2's Vitals Summary Report revealed temperature, pulse, respiration and blood pressure results were assessed and documented, but lacked 17 weekly assessments identified on the following dates: 7/14/14, 7/28/14, 8/4/14, 8/25/14, 9/8/14, 9/15/14, 9/22/14, 9/29/14, 10/6/14, 10/13/14, 10/20/14, 10/27/14, 11/3/14, 11/10/14, 11/17/14, 11/24/14, 12/1/14,

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2 875	Continued From page 6 12/8/14, 12/15/14, 12/22/14, 1/5/15, 1/12/15, 1/19/15, 1/26/15, 2/2/15, 2/10/15, 2/16/15, 2/23/15, 3/2/15, 3/9/15, 3/16/15, 3/23/15, 3/30/15, 4/6/15, 4/27/15, 5/4/15, 5/11/15, 5/18/15, 6/1/15, 6/8/15, 6/15/15, 6/22/15, 7/6/15, 7/13/15, 7/21/15, 7/21/15, 7/27/15, 8/3/15, 8/10/15, 8/17/15, 8/24/15. R15's current diagnoses according to the Medical Diagnosis Report dated 3/13/2003, included HTN and cognitive deficits due to cerebrovascular disease. R15's physician's orders dated 7/8/15, contained orders for aspirin 81 mg once each day for cerebrovascular disease. R15's Vitals Summary Report revealed temperature, pulse, respiration and blood pressure results were assessed and documented but lacked 11 weekly assessments identified on the following dates: 7/10/14, 7/17/14, 7/24/14, 7/31/14, 8/7/14, 8/14/14, 8/16/14, 8/17/14, 8/19/14, 8/21/14, 8/25/14, 8/28/14, 9/4/14, 9/11/14, 9/18/14, 9/25/14, 10/2/14, 10/9/14, 10/16/14, 10/23/14, 10/30/14, 11/6/14, 11/13/14, 11/20/4, 11/27/14, 12/4/14, 12/25/14, 1/1/15, 1/6/15, 1/7/15, 1/8/15, 1/15/15, 1/22/15, 1/29/15, 2/5/15, 2/12/15, 2/19/15, 2/26/15, 3/5/15, 3/12/15, 3/19/15, 3/26/15, 4/1/15, 4/2/15, 4/9/15, 4/16/15, 5/7/15, 5/14/15, 5/22/15, 5/28/15, 6/4/15, 6/11/15, 6/18/15, 6/25/15, 7/16/15, 7/23/15, 7/31/15, 8/20/15. When interviewed on 8/27/15, at 1:10 p.m. the director of nursing (DON) confirmed the vitals signs including the temperature, pulse, respiration and blood pressure was expected be recorded weekly on bath day in the Vitals report when each resident had their bath. The DON stated the assessment possibly would possibly be documented in the nurses progress note and/or	2 875		

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2 875	Continued From page 7 the bath note. The DON reviewed and confirmed that no other documentation existed in the medical record for R1, R2 and R15. The DON also confirmed R1, R2 and R15 had a diagnosis of HTN, currently received daily medication for high blood pressure and would expect staff to record weekly blood pressures. The facility's Vital Signs Standard of Practice policy dated 5/5/15, indicated staff would record a full set of vital signs including blood pressure, pulse, respiration and temperature on all residents on a weekly basis. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and revise policies and procedures related to documentation of weekly vital signs and could provide staff education related to these policies and procedures. The director of nursing or designee could develop an audit tool to ensure appropriate monitoring is provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 875		
2 960	MN Rule 4658.0600 Subp. 1 Dietary Service - Food Quality Subpart 1. Food quality. Food must have taste, aroma, and appearance that encourages resident consumption of food. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to serve milk and orange juice at palatable temperatures for 2 of 2	2 960		

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2 960	Continued From page 8	2 960		

residents (R19, R6) who ate in the main dining area. This had the potential to affect other residents who dislike warm juice and milk.

Findings include:

On 8/27/15, at 8:46 a.m. R19 entered the main dining room and had a glass of milk and orange juice sitting on the dining room table in front of him. At 8:48 a.m. R19 was asked whether his orange juice was cold and he stated "no, and the milk is warm too, you want to try it."

At 8:58 a.m. R6 entered the main dining room and at 9:00 a.m. started to drink his orange juice, stating "the juice is warm, I suppose it's been here awhile." Subsequently, R6 asked nursing assistant (NA)-B if the juice should be cold and NA-B responded by stating "if you drink it I bet it will be cold." R6 proceeded to taste the milk as well, stating "the milk is warm as well."

At 9:06 a.m. dietary aid (DA)-B was asked to check the temperature of the milk and the orange juice in R6's glasses. The temperature of the milk was 63.8 degrees Fahrenheit (F) and the orange juice was 68.3 degrees (F). DA-B also check the temperature of the milk and juice at the table next to R6's table. The milk in glass was 64.8 degrees (F) and the orange juice was 67.9 degrees (F). The milk and orange juice continued to sit out on the tables while residents continued to enter the main dining room for the breakfast meal.

During interview on 8/27/15, at 9:06 a.m. DA-B stated "we usually put them (meaning glasses of milk and orange juice) out in the morning, usually around 7:20 a.m." (1 1/2 hour ago). DA-B also verified the milk and orange juice needed to be under 40 degrees (F).

Minnesota Department of Health

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2 960	Continued From page 9 On 8/27/15, at 9:26 a.m. DA-C stated "the milk and orange juice gets put out in the morning around 7:20 a.m." During interview on 8/27/15, at 9:45 a.m. the registered dietician (RD) verified the temperatures recorded for the orange juice and milk did not promote food palatability and stated :"these temperature are well out of range for palatability." DM verified the facility policy and stated " I would expect staff to have the milk and the orange juice below 41 degrees (F)." Review of facility policy titled, Food Storage undated, indicated sufficient storage facilities are provided to keep foods safe, wholesome, and appetizing. SUGGESTED METHOD OF CORRECTION: The RD or designee could develop policies and procedures to ensure foods are served at the proper temperature to ensure palatability. The RD or designee could educate all appropriate staff on these policies and procedures and could develop a monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Forty (40) days.	2 960		
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.	21015		

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21015	Continued From page 10 This MN Requirement is not met as evidenced by: Based on observation, interview and document interview the facility failed to maintain the cleanliness of the steam table which served 81 residents who ate in the main dining room. Findings include: During a kitchen tour on 8/26/15 at 2:00 p.m., the metal steam table utilized in the resident's main dining room had 2 shelves located underneath the steam table with doors, concealing the shelves. The 2 shelves were noted to have dust and dirt particles covering them. There were small and large silver metal deep dish containers, which fit into the steam table stored on the shelves. Silver metal lids used to cover these containers were also located on these shelves. When interviewed on 8/26/15, at 2:00 p.m. the dietary service manager (DSM) stated the steam cart was scheduled to be cleaned every Tuesday. DSM verified the shelves were dusty and dirty and indicated that staff had failed to clean the steam table cart for the past 2 weeks. During an interview on 8/26/15, at 2:20 p.m. dietary aide (DA)-D stated they use the shelves in the steam table for storage; they will place plates and bowls on it and also indicated the shelf on the right side of the steam table is not used. DA-D stated they use the covers to cover the food, use the pans, cover the pans with saran wrap and then it is covered with the lid. On 8/27/15 at 11:50 am, registered dietitian (RD) verified there were dust and dirt particles on the shelves in the steam table. RD stated the steam	21015		

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21015	Continued From page 11 table pans could come in contact with the food and that is not good. RD stated she didn't want any clean pans that come in contact with food be in dust debris Review of the dietary department cleaning schedule, code B with no date on it, indicated on Tuesdays the steam table storage area were to be cleaned. Review of the cleaning log under cleaning schedule B revealed the steam table had not been cleaned on Tuesday 8/11/15, 8/18/15 nor 8/25/15 (3 weeks). Review of the policy and procedure titled Cleaning and Sanitation of Dining and Food Areas with no date on it, indicated the food service staff will maintain cleanliness and sanitation of the dining and food service areas through compliance with a written, comprehensive cleaning schedule. SUGGESTED METHOD OF CORRECTION: The dining director (DD) or designee could develop, review and/or revise policies and procedures to ensure kitchen equipment is cleaned. The DD or designee could educate all appropriate staff on the policies/procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days.	21015		
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control.	21385		

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21385	Continued From page 12 Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure appropriate infection control measures were implemented for 1 of 1 resident (R14) observed who had soiled linens placed next to dietary items on the over bed table. Findings include: During an observation on 8/27/15 at 7:50 am, nursing assistant (NA)-A was in R14's room. NA-E had performed personal cares to R14's perineal area. NA-E placed the soiled wash cloth in the towel, rolled the towel up and placed it on R14's overbed table. The soiled linen was placed on the table next to the resident's food items: a blue covered mug, a cleared plastic container with a lid on it which contained donuts and a stack of white paper napkins. During an interview on 8/27/15, at 8:15 a.m. NA-E verified that soiled linen shouldn't be placed on the overbed table. During an interview on 8/27/15, at 1:15 p.m. registered nurse (RN)-A verified it was not appropriate to place soiled linen on the residents bedside table. RN-A indicated it should be placed in a white bag and then put in the soiled utility room. During an interview on 8/27/15, at 2:30 p.m. RN-A an infection control nurse stated dirty linen needed to be placed in a white bag and brought to the soiled utility room. RN-A verified it was not acceptable to put soiled linen on the over the bed	21385		

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21385	Continued From page 13 table, which included the towel and wash cloth after cleansing the perineal area. When interviewed on 8/28/15, at 9:10 a.m. the director of nursing (DON) stated soiled linen is to be placed in a bag and brought to the soiled utility room. DON verified the practice identified was not appropriate (placing soiled linens on a residents overbed table). The facilities policy titled" Infection Control policy and procedures" with a revision date of 5/1/15, indicated soiled linen is to be placed in white plastic bag in the resident's room and then will be taken to soiled utility room. The soiled linen is placed directly into the soiled bin in the soiled utility room. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review and/or revise policies and procedures to ensure infection control procedures and standards are maintained by all staff as appropriate. The DON or designee could educate all appropriate staff on the policies/procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days.	21385		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR).	21426		

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21426	Continued From page 14 This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure all health care workers (HCW's) received baseline tuberculosis (TB) screening for signs and symptoms of TB for 1 of 5 newly hired employees, licensed practical nurse, (LPN)-A reviewed in the sample. Finding include: The facility lacked all components required for HCW's TB screening. A review of personnel records for five newly hired employees revealed the following: Review of LPN-A's personnel record revealed LPN-A was hired on 6/22/15, and a baseline TB screening was not completed prior to her employment at the facility. During interview on 8/25/15, at 8:35 a.m. the director of nursing (DON) confirmed the facility policy and verified TB screening was not completed and stated "this should be done before	21426		

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21426	Continued From page 15 hire and they should be following the policy." Review of facility policy titled, Tuberculosis Screening, Evaluation and Management: Employees, revised on 5/1/15, indicates all employees are properly screened for tuberculosis, according to current state and federal regulation and guidelines. Record then repeat the TST if not read before 72 hours. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop a system to ensure the facility is maintaining an accurate system for recording tuberculin skin testing for resident and staff in order to provide appropriate care and services. The Director of Nursing could develop and implement a random audit tool to ensure compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21426		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide a dignified dining experience for 9 of 9 residents (R1, R2, R7, R12, R15, R17, R21, R24, R25) eating their	21805		

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21805	Continued From page 16 meal while staff cleaned dirty plates in the vicinity. This had the potential to affect the 25 other residents eating in the dining room. Findings include: It was observed on 8/27/15, at 8:55 a.m. that a staff member pushed a stainless steel, three tiered cart utilized for busing dishes into the center of the main dining room. The top tier of the busing cart consisted of two large bins used for soiled dish storage and two uncovered white pails used for "liquid and solid waste"; the second and third tier consisted of additional bins half full of scraped, dirty dishes, glasses, cups and bowls. One uncovered, attached garbage can to the side of the busing cart was noted. During continuous observation on 8/27/15, from 8:55 a.m. to 9:15 a.m. staff pushed the busing cart and plastic garbage can through the center of the dining room and cleared the following tables: #3, #4, #5, #6, #9, #11, #12, and #13 of dirty dishes, silverware, glasses and napkins. During that time frame, residents were still eating their breakfast, sipping coffee and/or visiting. It was observed that staff used a large handled spatula to scrape remaining food from the plates into the uncovered pail located on the top tier of the busing cart and then stacked the soiled plates in another bin. It was also noted that staff "dumped" leftover coffee, milk and juice from the glasses into another uncovered pail located on the top tier of the busing cart. While stacking the glasses/dishes into the bins, clanking and clattering noise was evident. During this entire process, the busing cart was located in the center of the dining room with resident tables located on each side of the cart, within a few feet.	21805		

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Continued From page 17

On 8/27/15, at 9:15 a.m. interviewed dietary aide (DA)-A confirmed staff pick up dirty dishes and clean the area when a resident is finished eating and leave the table. DA-A stated the staff do not wait until the entire table of resident's have finished eating and further verified this was the usual practice and routine implemented for all three meals.

On 8/27/15, at 12:40 p.m. interviewed the dietary manager (DM) stated that staff at times, do clear the tables of dirty dishes prior to all the residents located at the same table have finished their meal. The DM clarified the busing cart should be placed at the edge of the dining room against the wall and done in a manner not to disrupt/disturb the dining experience for the remaining residents. The DM confirmed placing the busing cart in the center of the dining room, scraping food off plates in front of other residents and clanking dishes which produced noise was not a dignified dining experience for residents who were eating their meal nor for those residents just entering the dining room. The DM reported the facility is working towards many new changes with culture change surrounding dining.

On 8/27/15, at 1:25 p.m., the director of nursing (DON) verified clearing plates from tables, scraping food from plates and stacking dishes into a busing cart next to tables while other residents are still eating was not a dignified dining experience.

The facility's Following the Meal Service policy dated 2013, indicated staff will initiate cleaning of the dining area after all individuals have been served and have left the dining area. Individuals will not be rushed through the meal.

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21805	Continued From page 18 SUGGESTED METHOD OF CORRECTION: The director of nursing service could monitor the dining room to ensure that staff is available to assist with the meal. A reassignment of duties could be implemented based on the results of the audit. She could inservice staff regarding a dignified meal service. Dining room audits could be conducted to ensure all residents are provided a dignified dining experience and the results could be reported to the quality assurance committee for review and recommendation. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		