Protecting, Maintaining and Improving the Health of Minnesotans

March 24, 2015

Mr. Andrew Burnside, Administrator
Minnesota Veterans Home Hastings
1200 East 18th Street
Hastings, Minnesota 55033

Re: Enclosed Reinspection Results - Project Number SL00788024

Dear Mr. Burnside:

On March 19, 2015 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 January 28, 2015. 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.

Please feel free to call me with any questions.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure
cc: Original - Facility
Licensing and Certification File

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00788	A. Building B. Wing	3/19/2015

Name of Facility	Street Address, City, State, Zip Code
MN VETERANS HOME HASTINGS	1200 EAST 18TH STREET HASTINGS, MN 55033

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix 30601 Reg. # MN St. Statute 144.56 Sub LSC	03/19/2015	ID Prefix 30945 Reg. # MN Rule 4655.6400 Subp. LSC	03/19/2015	ID Prefix 31880 Reg. # MN Rule 144.651 Subd. 20 LSC	03/19/2015
ID Prefix 31995 Reg. # MN Rule 626.557 Subd. 4A LSC	03/19/2015	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 1/28/2015

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

00788-BCH
file
23

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8044 5728

February 9, 2015

Mr. Andrew Burnside, Administrator
Minnesota Veterans Home Hastings
1200 East 18th Street
Hastings, Minnesota 55033

Re: Enclosed State Boarding Care Home Licensing Orders - Project Number SL00788024

Dear Mr. Burnside:

The above facility survey was completed on January 28, 2015 for the purpose of assessing compliance with Minnesota Department of Health Boarding Care 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.

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 Boarding Care 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 is 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:

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email: susanne.reuss@state.mn.us
Telephone: (651) 201-3793
Fax: (651) 201-3790

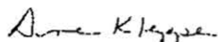
We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

Feel free to contact me with any questions related to this letter.

Sincerely,



Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulations Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosures

cc: Original - Facility
Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00788	A. BUILDING: ____ B. WING ____	01/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME HASTINGS	**1200 EAST 18TH STREET HASTINGS, MN 55033**

(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
3 000	INITIAL COMMENTS *****ATTENTION****** BOARDING CARE HOME 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 1/26/15 to 1/28/15, Surveyors from the Department of Health visited the above provider and the following correction orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health,	3 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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

Minnesota Department of Health

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3 000	Continued From page 1. Division of Compliance Monitoring, Licensing and Certification Program PO BOX 64900 St. Paul MN 55164-0900.	3 000	The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	
3 601	MN St. Statute 144.56 Subp. 2c Tuberculosis Prevention And Control (a) A boarding care home 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	3 601		

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3 601	Continued From page 2 CDC's Morbidity and Mortality Weekly Report (MMWR). 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 boarding care home. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure six of six employees (E1, E4, E6, E7, E8 and E9) were screened for tuberculosis (TB), according to guidelines set by the Centers for Disease Control and Prevention (CDC), during an annual serial TB screening. Findings include: Review of the E1's employee medical file revealed E1 had a one step tuberculin skin test (TST) completed on 10/2/14 with negative results. No symptom screening was included in the record. Review of the E4's employee medical file revealed E4 had a one step TST completed on 9/26/14 with negative results. No symptom screening was included in the record.	3 601		

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3 601	Continued From page 3 Review of the E6's employee medical file revealed E4 had a one step TST completed on 10/16/14 with negative results. No symptom screening was included in the record. Review of the E7's employee medical file revealed E4 had a one step TST completed on 4/4/14 with negative results. No symptom screening was included in the record. Review of the E8's employee medical file revealed E4 had a one step TST completed on 10/2/14 with negative results. No symptom screening was included in the record. Review of the E9's employee medical file revealed E4 had a one step TST completed on 10/2/14 with negative results. No symptom screening was included in the record. On 1/28/15 at 1:00 p.m. the human resource specialist confirmed findings. Review of the facility's TB risk assessment, dated 5/7/2014, revealed the facility was at a medium level of TB risk and baseline and annual screening was required. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review and revise, as needed, policies related to screening staff for TB. The director of nursing or designee could educate staff on procedures related to screening staff for TB. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	3 601		

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3 945	Continued From page 4	3 945		
3 945	MN Rule 4655.6400 Subp. 1 Adequate Care; Care in General Subpart 1. Care in general. Each patient or resident shall receive nursing care or personal and custodial care and supervision based on individual needs. Patients and residents shall be encouraged to be active, to develop techniques for self-help, and to develop hobbies and interests. Nursing home patients shall be up and out of bed as much as possible unless the attending physician states in writing on the patient ' s medical record that the patient must remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 1 resident (R24) reviewed for decline in physical and mental condition, that required hospitalization, was provided the proper nursing care and supervision to prevent or minimize the risk of physical and mental decline experienced. Findings include: Review of R24's care plan, last revised on 9/17/14 revealed "I have end stage COPD [Chronic Obstructive Pulmonary Disease] and experience shortness of breath." R24's goals were "I will display optimal breathing pattern daily through review date" and "I will be free of s/sx [signs and symptoms] of respiratory infections through review date." Interventions included "Monitor for s/sx of respiratory insufficiency:	3 945		

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3 945	Continued From page 5	3 945		

Anxiety, Confusion, Restlessness, SOB [shortness of breath] at rest, Cyanosis, Somnolence" The care plan did not include a history of refusal of care.

Review of R24's annual review and physical exam, dated 11/6/14, revealed R24 had diagnoses including COPD, asthma and reactive airway disease, smoked cigarettes and was treated with multiple inhalers, nebulizer treatments, oral medications and occasional oxygen.

Review of the progress notes revealed a note by a registered nurse (RN)-B , effective date 1/6/15 at 7:00 p.m., read "Res [Resident] was called in his room by Writer as he had not been seen. Res stated he had a cough, but was doing fine. Writer asked if she should come down to see him and do an assessment. Res stated "no". Writer then asked if Res thought he felt sick enough to go to the ER [emergency room] and be checked out, Res stated "no I'm fine". Writer reminded Res if he needed anything to contact nursing." The note was created on 1/7/15 at 2:52 p.m. A review of progress notes revealed no further contact with R24 on 1/6/15 or the morning of 1/7/15 by facility staff, no face to face nursing assessment and no explanation of the risks and benefits of declining a nursing assessment. A review of R24's vital signs log for the month of January revealed no vital signs were assessed for R24 on 1/6/15. A review of the evening shift Report at Shift Change report revealed no new clinical concerns were passed along to the night shift nursing staff. No information regarding R24's cough was communicated via the Report at Shift Change. A review of the Clinical Alerts listing printout for 1/6/15 evening shift and 1/7/15 day shift revealed no indication R24's information regarding a cough

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3 945	Continued From page 6	3 945		

was implemented as an alert. The first alert regarding R24 was noted in a handwritten note on the evening shift of 1/7/15 indicating he was at the hospital. The 1/6/15 evening shift listing noted four residents were on antibiotics for upper respiratory infections and two residents were diagnosed with influenza-type A. This information revealed R24 was at an increased risk of infection due to potential exposure to infected residents and his medical history.

A progress note for 1/7/15 at 1:52 p.m. read "Veteran to [local hospital] ER via ambulance for assessment: Writer to resident's room for health and welfare check. Dietary reported to staff that resident had not been seen for a day and was concerned. Writer called into resident room at 1220 [p.m.]. Writer asked resident if he was ok, answer was unintelligible. Writer to room with nurse TR, resident found on floor, on left side, nude from waist down, eyes open, writer unable to understand resident and veteran unable to move self-off floor. 911 called EMS [emergency medical service] on site at 1240 [p.m.]. Per EMS vitals 116/60, pulse 96, 92% on room air respiration rate 32, temperature not taken." Review of progress note for 1/7/15 at 8:50 p.m. revealed R24 was admitted to the hospital at 8:40 a.m. with a diagnosis of pneumonia (lung infection) and was being treated with intravenous therapy (IV) antibiotics. Review of progress notes for 1/8/15 at 10:28 a.m. revealed R24 was being treated for rhabdomyolysis, tested positive for influenza type A and had a stage I pressure ulcer located on his coccyx and hip. (A stage I pressure ulcer is intact skin with non-blanchable redness of a localized area usually over a bony prominence. Rhabdomyolysis is a serious syndrome due to a direct or indirect muscle injury. It results from the death of muscle fibers and release of their

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3 945	Continued From page 7	3 945		

contents into the bloodstream. These substances are harmful to the kidney and often cause kidney damage.)

Review of the hospital history and physical note dated 1/7/15 revealed R24 was "a 69 y.o [year old] male with a history of COPD with ongoing tob [tobacco] use, degenerative disk [sic] disease, gastritis [an inflammation, irritation, or erosion of the lining of the stomach]. , diverticulosis [pouches in wall of colon] who was found down in his room, covered in feces and confused. The staff hadn't seen him in a few days. The patient is confused and not answering questions except he admits he smokes "you bet" and said he had the flu." The 1/7/15 note also indicated R24's rhabdomyolysis was "from laying on the floor for hours". A hospital discharge note, dated 1/14/15 revealed R24 was discharged to a transitional care unit for rehabilitation. The principal problem treated was encephalopathy acute due to pneumonia and influenza. (Encephalopathy is a general term that means brain disease, damage, or malfunction.) Other diagnoses included: community acquired pneumonia, influenza A, rhabdomyolysis, anemia, leukopenia (decrease in the number of white blood cells) and abnormal liver function tests.

On 1/18/15 at 10:00 a.m. a registered nurse senior (RN)-C reported RN-A should have completed an assessment and vitals on R24, due to his symptom of cough and history of respiratory issues. RN-C confirmed it was RN-A's duty to make professional decision whether R24 needed a nursing assessment or hospitalization. RN-C further confirmed R24 should not have been expected to make that decision without RN-A's professional guidance. RN-C reported no further education had yet been provided to any

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3 945	Continued From page 8 staff regarding follow up on this issue, and it was still under review. RN-C was not aware the progress note regarding contact RN-A had with R24 at 7:00 p.m. on 1/6/15 was not created until 2:52 p.m. on 1/7/15. RN-C reported the information should have been documented on 1/6/15 during the evening shift. At 1:00 p.m. RN-C reported the information regarding R24's cough and declining a nursing assessment was not passed along in change of shift report and not implemented as alert charting. RN-C reported she would expect R24's cough symptoms to be implemented under the alert charting procedure and for the information regarding his cough to be communicated to the next shift. During telephone interview on 1/30/15 at 3:00 p.m., RN-A reported she had called R24 that evening as he had not been seen that day. RN-A reported R24 reported he had a cough, but was doing fine and said he did not want a nursing assessment or to be assessed at the hospital. RN-A reported she did not re-approach R24 to offer an assessment and did not explain the risks and benefits of refusal for nursing assessment. RN-A reported she could have been more "forceful" in assessing R24. RN-A explained R24 had previous history of behaviors when pushed to accept care he did not want. RN-A reported she felt her role was to provide the care residents requested because the facility was their home. RN-A reported she documented the interaction with R24 in the progress notes on the evening of 1/6/15 and passed it along verbally in shift report. RN-A believed R24's concerns was implemented as an alert charting because of the progress note she wrote. On 1/30/15 at 3:23 p.m. RN-A called surveyor again and said she thought about it more and reviewed documentation and had not documented the contact she had with R24 until	3 945		

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3 945	Continued From page 9 1/7/15 because she thought R24's behavior was normal for him. RN-A reported she passed along R24's cough verbally during shift report. The Alert Charting procedure, effective 10/22/14 directed staff "2. The alert charting will provide explanation to other nurses as to the situation/condition each nurse is to be documented on." "4. Alert charting will be implemented when one or more of the following resident situations/conditions occur: ...b. Acute illness" SUGGESTED METHOD OF CORRECTION: The administrator and director of nursing or designee could review and revise policies regarding supervision of residents and monitoring resident health status. The administrator and director of nursing could ensure procedures include face to face contact between residents and staff and providing clinical assessments as indicated. The administrator and director of nursing could provide education to staff on resident supervision, health monitoring and clinical assessments. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	3 945		
31880	MN Rule 144.651 Subd. 20 Patients & Residents of HCF Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend	31880		

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31880	Continued From page 10 changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every non-acute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure that prompt efforts were made by the facility to resolve	31880		

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	00788	A. BUILDING: ____ B. WING ____	01/28/2015

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resident grievances for 8 of 17 residents (R14, R7, R12, R21, R13, R23, R22, and R11) reviewed who expressed a grievance to facility staff.

Findings include:

During an observation on 1/26/15 at 1:30 p.m., at the first floor resident activity computer area, there were three computers and one resident using computer number two for games, and several residents milling about the area complaining the other two computers have not worked for a very long time. When questioned, the residents expressed administration was aware these computers did not work.

When interviewed on 1/26/15, at 3:00 p.m. R14 explained computer number one, one of the gaming computers, has been down for as long as two years. They used to have 4 computers, computer number one needed a new fan, computer number two worked ok but computer number three had not had a tower for a year. R14 further expressed administration had been informed numerous times by numerous people. This information was validated during interviews with R7, R12 and R21 who expressed frustration that the activity computers were broken without a resolution for a very long time.

During an interview with the therapeutic recreation director (TRD) on 1/27/15, at 2:00 p.m. the TRD verified there had been issues with the computers but the person responsible to get them running was no longer at the facility. The TRD verified there were no grievance forms completed regarding the broken computers.

During an interview with R12 on 1/26/15, at 3:30 p.m. concern was expressed regarding another

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resident at the facility. R12 elaborated on telling staff the concern but did not feel being listened to, and did not know what he should do if there was an incident. R12 still had not heard from the "higher ups" at the home. R12 reported he could not understand why the social worker or the administration had not checked in with him about the concern. R12 was not aware of the facility grievance policy and procedure.

When interviewed on 1/27/15, at 11:30 a.m. the director of nursing was not aware of the resident concern and did not have any resident grievance concern forms from 2014 or 2015.

When interviewed on 1/27/15 at 1:30 p.m. the social service supervisor did not know anything about R12's concerns and agreed the system of using the grievance policy and procedure was not in place.

When interviewed on 1/26/15, at 3:40 p.m. R13 expressed concern about seeing residents washing their hands in the drinking fountain, concern about frequent cancellations of the activities scheduled, and no venue for follow up when a concern was expressed. R13 said that the facility staff were informed of the concerns. R13 was not aware of a facility grievance policy and procedure.

When interviewed on 1/27/15, at 11:20 a.m. the infection control registered nurse RN-A was not informed of the resident complaint of clients washing their hands in the drinking fountain, but verified there would need to be further education on infection control for the residents.

When interviewed on 1/28/15, at 11:00 a.m. R23 expressed concern about how he had been

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treated when going to the hospital and did not know about the grievance process at the facility for a resolution to respectful treatment. R23 says he had expressed his concerns to the facility staff but doesn't feel he was listened to and would like a resolution to the concerns expressed he would like to have coaching skills in dealing with the proper response. R23 said he had mentioned the concern with the facility staff after the last visit to the hospital but doesn't feel it was resolved.

During an interview with R22 on 1/27/15, at 3:00 p.m. concerns were expressed about the lack of follow through and interventions when concerns were expressed. An example would be how to get things taken care of at the facility especially follow through. An example would be the time taken to fix the pool sticks which needed new tips. R22 was not aware of the facility grievance policy and procedure for the facility.

During an interview with R11 on 1/28/15, at 9:00 a.m. concerns were expressed to surveyor about the food. R11 did not know what to do about a resolution to the issues. R11 did not know about the facility grievance process or where to obtain a form to express concern despite discussing food concerns with staff on multiple occasions with various staff members, and at resident council.

When interviewed on 1/27/14, at 11:20 a.m. the administrative assistant (AA) did not have any grievance concern forms. The administrator did not have any grievance concern forms for 2014 or 2015. The director of social services did not have any concern grievance forms. The administrator verified an effective system for resolving grievances was not currently in place.

A review of the facility policy dated April 15,1998,

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31880	Continued From page 14 titled, Resident Grievance Procedure, directed staff a verbal complaint from residents should be addressed by the staff person who received the complaint. If the verbal complaint did not get resolved it should be referred to the responsible supervisor for resolution within 3 business days. The policy indicated the social worker would present a written resolution to the grievant within seven days. The expected practice was that the responder would meet with the grievant when presenting the written response. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review and revise policies related resident grievance procedures. The administrator or designee could provide education to all staff on resident grievance procedures. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	31880		
31995	MN Rule 626.557 Subd. 4A Reporting Maltreatment of Vulnerable Adults Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section.	31995		

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31995	Continued From page 15 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the internal reporting system resulted in immediate reporting to the common entry point for 1 of 4 residents (R24) reviewed for reporting of signs of potential maltreatment. Findings include: Review of the Vulnerable Adult Acts policy, last revised December 2012, directed staff "A. Any facility employee, volunteer, consultant, or other person providing services in this facility is required by law, and by this policy, to report any situation of maltreatment (abuse, neglect, financial exploitation) of residents if they have witnessed, been informed of or believe that there is or has been maltreatment of a resident. B. Staff Responsibilities 1. For witnessed/suspected incident of maltreatment, intercede immediately (if necessary) to protect the resident, and if indicated, remove the perpetrator. 2. If indicated, provide first aid and/or obtain qualified medical care. 3. Immediately notify supervisory staff, preferably in this order: immediate supervisor, Officer of the Day, Clinical Manager, RN Administrative Supervisor or Administrator." The policy directed supervisory staff "Reports the incident verbally, following these guidelines: During off hours, the Administrator/Designee is notified by phone of the vulnerable adult incident. During working hours, the Administrator/Designee is notified verbally and by the written Incident Report. 2. The Administrator/Designee will direct/delegate the follow-up through the nursing supervisor/designee. 3. The Administrator/Designee will initiate the internal	31995		

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and external reporting procedure." "External Reporting Procedures 1. Social Services/Mental Health Director (M-F Days) [Monday through Friday] or the O.D [Officer of the Day] (weekends, holidays, evenings and nights) will: a. After determining that a VA [vulnerable adult] incident occurred or may have occurred, telephone the Vulnerable Adult incident to the Common Entry Point (CEP) at [contact information] immediately of initial knowledge of the incident and complete the "Notification of VA Report to the CEP".

Review of R24's care plan, last revised on 9/17/14 revealed "I have end stage COPD [Chronic Obstructive Pulmonary Disease] and experience shortness of breath." R24's goals were "I will display optimal breathing pattern daily through review date" and "I will be free of s/sx [signs and symptoms] of respiratory infections through review date." Interventions included "Monitor for s/sx of respiratory insufficiency: Anxiety, Confusion, Restlessness, SOB [shortness of breath] at rest, Cyanosis, Somnolence"

Review of R24's annual review and physical exam, dated 11/6/14, revealed R24 had diagnoses including COPD, asthma and reactive airway disease, smoked cigarettes and was treated with multiple inhalers, nebulizer treatments, oral medications and occasional oxygen.

Review of the progress notes revealed a note by a registered nurse (RN)-B , effective date 1/6/15 at 7:00 p.m. read "Res [Resident] was called in his room by Writer as he had not been seen. Res stated he had a cough, but was doing fine. Writer asked if she should come down to see him and do an assessment. Res stated "no". Writer then

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asked if Res thought he felt sick enough to go to the ER [emergency room] and be checked out, Res stated "no I'm fine". Writer reminded Res if he needed anything to contact nursing." The note was created on 1/7/15 at 2:52 p.m. A review of progress notes revealed no further contact with R24 on 1/6/15 or the morning of 1/7/15 by facility staff, no face to face nursing assessment and no explanation of the risks and benefits of declining a nursing assessment. A review of R24's vital signs log for the month of January revealed no vital signs were assessed for R24 on 1/6/15. A review of the evening shift Report at Shift Change report revealed no new clinical concerns were passed along to the night shift nursing staff. No information regarding R24's cough was communicated via the Report at Shift Change report. A review of the Clinical Alerts listing printout for 1/6/15 revealed no indication R24's information regarding a cough was implemented as an alert. The listing did note four residents were on antibiotics for upper respiratory infections and two residents were diagnosed with influenza-type A. This information revealed R24 was at an increased risk of infection due to potential exposure to infected residents.

A progress note for 1/7/15 at 1:52 p.m. read "Veteran to [local hospital] ER via ambulance for assessment: Writer to resident's room for health and welfare check. Dietary reported to staff that resident had not been seen for a day and was concerned. Writer called into resident room at 1220 [p.m.]. Writer asked resident if he was ok, answer was unintelligible. Writer to room with nurse TR, resident found on floor, on left side, nude from waist down, eyes open, writer unable to understand resident and veteran unable to move self-off floor. 911 called EMS [emergency medical service] on site at 1240 [p.m.]. Per EMS

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vitals 116/60, pulse 96, 92% on room air respiration rate 32, temperature not taken." Review of progress note for 1/7/15 at 8:50 p.m. revealed R24 was admitted to the hospital at 8:40 a.m. with a diagnosis of pneumonia (lung infection) and was being treated with intravenous therapy (IV) antibiotics. Review of progress notes for 1/8/15 at 10:28 a.m. revealed R24 was being treated for rhabdomyolysis, tested positive for influenza type A and had a stage I pressure ulcer located on his coccyx and hip. (A stage I pressure ulcer is intact skin with non-blanchable redness of a localized area usually over a bony prominence. Rhabdomyolysis is a serious syndrome due to a direct or indirect muscle injury. It results from the death of muscle fibers and release of their contents into the bloodstream. These substances are harmful to the kidney and often cause kidney damage.) Review of the progress notes revealed a note dated 1/9/15 revealed "A report of the incident was faxed by writer to CEP [Common Entry Point] 1-9-15 @ 12:55 p.m."

A review of the Vulnerable Adult Report, dated 1/9/15 revealed R24's incident at the facility and condition at the hospital was reported to the Common Entry Point on 1/9/15 at 11:50 a.m.

On 1/28/15 at 10:00 a.m. a registered nurse senior (RN)-C reported she reported her concerns of potential neglect to the Common Entry Point as soon as she was aware of R24's diagnoses from the hospital, which included rhabdomyolysis. RN-C reported she was not aware RN-A did not chart the information regarding R24's cough on 1/6/15 at 7:00 p.m. until 1/7/15 at 2:52 p.m. due to the display functions of the electronic medical record. RN-C reported the facility was aware of R24's physical and mental decline at the facility on 1/7/15 and of

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31995	Continued From page 19 his condition at the hospital on 1/8/15. RN-C verified the concern of potential neglect was not reported to the common entry point until 1/9/15. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review and revise, as needed, policies related to reporting of vulnerable adult maltreatment allegations. The administrator or designee could ensure staff are educated on signs of potential maltreatment and internal and external maltreatment reporting procedures. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	31995		