CB

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00233	A. Building B. Wing	4/12/2007

Name of Facility	Street Address, City, State, Zip Code
MN VETERANS HOME MINNEAPOLIS	5101 MINNEHAHA AVENUE SOUTH MINNEAPOLIS, MN 55417

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix 20830	04/10/2007	ID Prefix 21620	04/10/2007	ID Prefix	
Reg. # MN Rule 4658.0520 Subp.		Reg. # MN Rule 4658.1345		Reg. #	
LSC		LSC		LSC	
ID Prefix		ID Prefix		ID Prefix	
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix		ID Prefix		ID Prefix	
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix		ID Prefix		ID Prefix	
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix		ID Prefix		ID Prefix	
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By State Agency	Reviewed By EL/Reg	Date: 4/20/07	Signature of Surveyor: 19692	Date: 4/20/07
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 11/17/2006

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

Minnesota Department Of Health
Division of Compliance Monitoring
Licensing and Certification Program

INFORMATIONAL MEMORANDUM

PROVIDER: Mn Veterans Home Minneapolis
5101 Minnehaha Avenue South
Minneapolis, MN 55417

DATE OF SURVEY: April 12, 2007

BEDS LICENSED:

HOSP: _____ NH: 341 BCH: 77 SLFA: _____ SLFB: _____

CENSUS:
HOSP: _____ NH: 301 BCH: 57 SLF: _____

BEDS CERTIFIED:
SNF/18: _____ SNF 18/19: _____ NFI: _____ NFII: _____ ICF/MR: _____ OTHER: _____

NAME(S) AND TITLE(S) OF PERSONS INTERVIEWED:
Interim Administrator- Carol Gilbertson
Assistant Administrator - Jim Ingersol
Director of Nursing- Margaret Sookraj
RN Consultant- Randy Hanson
Registered Nurses- Kim Davidson, Laurie Fitzloff, Trina Iliff
Licensed Practical Nurses- Judy Tranby, Roseline Jaafaru
HST's- Terry Johnson, Vernon Ibewke

SUBJECT: Licensing Revisit

ITEMS NOTED AND DISCUSSED:

An onsite re-visit was made to follow up penalty assessments issued as a result of a licensing revisit completed on April 2, 2007. The results of this visit were delineated during an exit conference which was tape recorded.. Refer to Exit Conference Attendance Sheet (HR116) for the names of individuals attending the exit conference. Refer to the State-2567L and/or State-2567B for the status of state licensing deficiencies.

UNITED STATES POSTAL SERVICE

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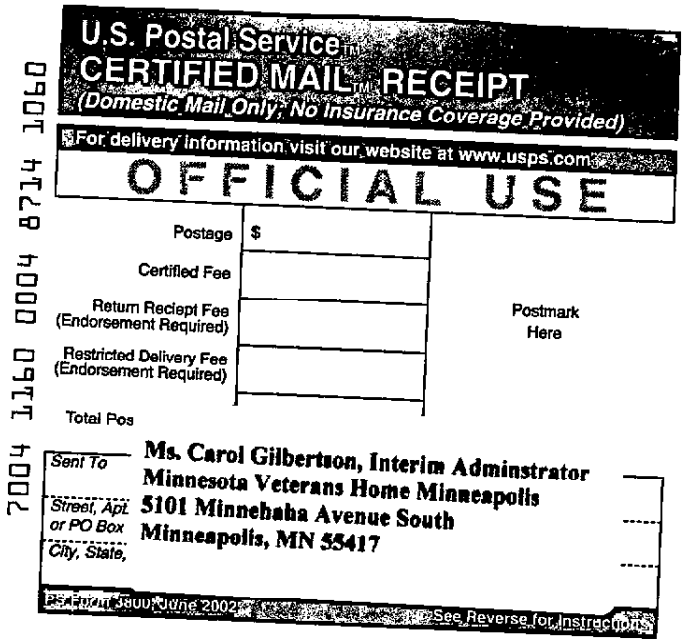

AH Form Approved
4/3/2007
CG

State Form: Revisit Report

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00233	A. Building B. Wing	4/2/2007

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(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix 20565 Reg. # MN Rule 4658.0405 Subp. LSC	Correction Completed 03/27/2007	ID Prefix 20895 Reg. # MN Rule 4658.0525 Subp. LSC	Correction Completed 03/27/2007	ID Prefix 20900 Reg. # MN Rule 4658.0525 Subp. LSC	Correction Completed 03/27/2007
ID Prefix 21545 Reg. # MN Rule 4658.1320 A.B.C LSC	Correction Completed 03/27/2007	ID Prefix 21805 Reg. # MN St. Statute 144.651 Sul LSC	Correction Completed 03/27/2007	ID Prefix 21990 Reg. # MN St. Statute 626.557 Sul LSC	Correction Completed 03/27/2007
ID Prefix 22000 Reg. # MN St. Statute 626.557 Su LSC	Correction Completed 03/27/2007	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	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By 03015	Date: 4/3/07	Signature of Surveyor: 03015	Date: 4/2/07
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 11/17/2006

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00233	A. BUILDING _____ B. WING _____	R 04/02/2007

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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
{2 000}	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 March 28, 29 and April 2, 2007surveyors 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 is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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{2 000}	Continued From page 1 Certification Program; 1645 Energy Park Drive, Suite 300, St. Paul, Minnesota 55108-2970.	{2 000}	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
{2 830}	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	{2 830}		

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{2 830}	Continued From page 2 resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Uncorrected based on the following findings: "The original licensing order issued on March 7, 2007 will remain in effect. Penalty assessment issued. " Based on observation, interview and record review the facility failed to assure 5 of 13 residents in the sample received adequate interventions, and appropriate equipment to reduce/eliminate the risk of falls (#s 112, 100, 101, 84, & 85) and failed to assure that aspiration precautions were in place and being followed for 2 of 7 residents in the sample with swallowing precautions (#s 100 & 66) . Findings include: FALLS PREVENTION The facility failed to ensure fall precautions were in place including securing chair alarms by bracket or adhesive to provide the resistance necessary to set the alarms off when a resident at risk for falls would attempt to stand from a wheelchair or recliner. Resident # 112 had diagnoses which included diabetes mellitus, Alzheimer's disease and a bipolar disorder. The quarterly Minimum Data Set (MDS), dated 2/12/07, identified the resident as moderately cognitively impaired with short and long term memory problems and no memory recall. The MDS also indicated the resident required extensive assistance of two staff to transfer, was unable to maintain balance while	{2 830}		

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{2 830}	Continued From page 3 standing without physical assistance and had fallen within the past 31-180 days. A "Risk for Falls Assessment" form, dated 2/8/07, indicated the resident had fallen within the past 30 days and 31-180 days. The assessment indicated the resident was at high risk for falling with a score of nineteen (a score above nine indicated a resident was at risk of falls). The care plan, last updated 11/14/06, identified the resident at risk for falls due to a history of falls. Staff were directed to ensure the resident had an alarm in use while in bed and in the wheelchair. Review of an "Agency Resident Incident Report", dated 3/18/07, indicated the resident had been observed by staff lying along side of his wheelchair in his room. The report indicated the personal alarm was intact but had not alarmed. The resident had stated, "I slipped out of my chair". "Progress Notes", dated 3/18/07 at 12:29 PM, indicated the resident had been observed by staff lying next to his wheelchair at 12:05 PM. The resident had attended church and had been wheeled to his room by a volunteer. Staff reported that the personal alarm was attached to the resident's shirt but had not sounded. The resident was observed in the dining room on 3/28/07 at 7:40 AM seated in a wheelchair with a personal alarm clipped to the back of his shirt. The alarm monitor was not securely attached to the wheelchair but was lying loose in a large cloth bag attached to the back of the resident's wheelchair. After the surveyor discussed the problem with staff, this resident was observed in the dining room on 3/29/07 at 1:06 PM and with a new personal alarm was attached to the seat of his wheelchair. When interviewed on 3/29/07 at 1:10 PM, a	{2 830}		

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{2 830}	Continued From page 4 Registered Nurse stated that the resident had recently had a history of sliding down in his wheelchair. She stated that the resident's fall had occurred after a volunteer had returned the resident to his room following a church service. She stated that staff had not been alerted that the resident had returned and had found the resident lying on the floor next to his wheelchair. She stated that the personal alarm had not sounded which could have alerted staff that the resident was attempting to stand up from his wheelchair. Resident #100 was placed in a recliner with an alarm that was not secured and he was given the control to his recliner that he should not have had. Resident #100 had diagnoses which included vascular dementia, dysphagia, and diabetes mellitus. A significant change MDS, dated 2/19/07, identified the resident as moderately cognitively impaired with short and long term memory problems. The resident required extensive assistance of two staff and a mechanical lift to transfer and had a history of falling within the past 31-180 days. Resident Assessment Protocol Summary (RAPS), dated 2/14/07, indicated the resident had fallen on 1/2/07 during a diabetic hypoglycemic event (low blood sugar). The RAPS also indicated the resident utilized an alarm to alert staff of attempts at unsafe self transfers. The care plan, dated 2/19/07, identified the resident at risk for falls and indicated the resident was to have a wheelchair and a bed alarm. The care plan also indicated the resident had a history of a fall in 4/06 after the resident inappropriately used the control for his electric recliner. Staff were directed to keep the controls for the recliner away from the resident.	{2 830}		

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{2 830}	Continued From page 5 A "Risk for Falls Assessment" record, dated 2/13/07, indicated the resident had a falls risk score of twenty-three (a score of 9 or more indicated at risk for falls). The resident was observed on 3/28/07 at 9:15 AM as he was transferred with the assistance of staff and a mechanical stand lift from his wheelchair to his electric recliner. The Human Service Technician (HST) then clipped his personal alarm to his shirt and placed the alarm under a lightweight quilt, draped over the back of the recliner. The resident was again observed on 3/28/07 at 2:35 PM sleeping in his electric recliner in his room. The personal alarm was clipped to his shirt but the alarm monitor was not secured to the recliner but was resting on top of the back of the recliner. The resident was again observed seated in his electric recliner in his room on 3/28/07 at 4:55 PM. Although his personal alarm was clipped to his shirt, it was not secured to the back of the recliner but was resting on the top of the back of the recliner. The controls for the electric recliner were resting near his hand on the right arm rest of the recliner. The surveyor alerted the interim nurse manager who then placed the recliner controls on the floor next to the recliner out of the reach of the resident. Resident #101 did not have his alarm secured either in his wheelchair or recliner and staff removed his lap buddy when there was no one around to monitor the resident. Resident # 101 had diagnoses which included glaucoma, dementia, diabetes mellitus, and a history of a cerebrovascular accident (CVA). A significant change MDS, dated 2/13/07 indicated	{2 830}		

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{2 830}	Continued From page 6 the resident was totally dependent upon staff to transfer and ambulate and had a history of falling within the past 31-180 days. Resident Assessment Protocol Summary (RAPS), dated 2/7/07, indicated the resident had a history of falls including a fall prior to admission that resulted in a fractured hip. The care plan, dated 3/17/06, identified the resident at risk for falling and directed staff to apply a personal alarm when the resident was in his wheelchair and while in bed. The care plan also indicated the resident utilized a lap buddy and that the lap buddy could be removed at meal times. The resident was observed as he was wheeled to the dining room on 3/28/07 at 7:10 AM. Two other residents were in the dining room but no staff were present except for the cook who was in the adjacent kitchenette. Staff wheeled the resident to the dining table, removed his lap buddy but did not lock the wheelchair brakes. The resident remained like this for ten minutes until the surveyor requested that a staff lock the brakes of the resident's wheelchair so he could not move away from the table and potentially fall from his wheelchair. The resident had a personal alarm clipped to his shirt but the alarm was not secured by bracket or adhesive to the wheelchair to provide the necessary resistance set the alarm off. The alarm monitor was laying loose in a cloth bag on the back of the resident's wheelchair. The resident was observed on 3/28/07 at 8:40 AM as he was transferred from his wheelchair to a recliner in his room with the use of a mechanical stand lift. There was no way to secure the alarm monitor to the recliner so staff tucked the alarm into a crease in the fabric of the recliner near the top of the recliner. The facility failed to ensure resident #84 received	{2 830}		

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{2 830}	Continued From page 7 adequate interventions and appropriate equipment to reduce/eliminate the risk of falls. Resident #84 had diagnoses that included dementia and Alzheimer's disease. A review of resident #84's MDS (minimum data set) assessment dated 2/9/07, revealed history of a fall in the last 30 days. According to the fall assessment dated 1/27/07, the resident was at risk for falls, and scored an 18 (a score above 9 indicated a risk for falls). The care plan dated 6/1/06, identified the resident at risk for falls. The interventions included a wheelchair and bed alarm to be used at all times, and hip protectors. On 3/28/07 at approximately 9:15 AM, resident #84 was assisted to the toilet, and was not wearing hip protectors as directed on the care plan. Resident #84 had a history of a fall where the alarm failed to sound and the cord for the current alarm was too long to enable the alarm to sound. A review of progress notes dated 2/2/07 at 6:31 PM stated, "...HST (human service technician) found resident lying on the floor...on the right side at 5:30 PM. Resident chair alarm was attached to her clothes when she was found on the floor, and the alarm did not go off." The progress notes dated 2/6/07 at 2:24 PM stated, "HST reports a new bruise to left under arm, and also noted to have yellow bruising to left rib area." The incident report dated 2/2/07, stated the resident was found lying on the floor, but did not mention the alarm failed to sound or any assessment as to why the alarm failed to work. On 3/29/07 the nurse was asked if there was any investigation of the equipment failure after the fall and no further information was provided.	{2 830}		

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{2 830}	Continued From page 8 On the afternoon of 3/28/07 the nurse and surveyor checked resident #84's alarm . The alarm cord was long, and touched the floor. The nurse sat in the resident's wheelchair, and was able to stand before the alarm cord was pulled, and alarm sounded. According to the nurse, the resident had one alarm that was used for both the bed and wheelchair, and the cord length had to be long for the resident to turn in bed. According to the manufacturer's instructions, "Once your MAS unit is mounted to the chosen surface, determine your prescribed distance from the resident and adjust the cord length". On the afternoon of 3/29/07 around 4:00 PM the DON (director of nursing) said if a resident could stand, the cord length was too long. Resident #85's care plan interventions to prevent falls were not being carried out; the personal safety alarm was not secured and the Posey grip was not placed correctly. Resident #85 was admitted to the facility in 2004 with diagnoses that included dementia, syncope (fainting). A review of the resident's fall risk assessment dated 3/23/07, stated the resident was at risk for falls, with a score of 21 (a score above 9 indicated a risk for falls). The resident had a fall on 2/20/07 where he was discovered seated on the floor with the alarm not attached to his clothes. The resident sustained a subdural hematoma (bleeding in the brain). According to the notes it was felt the resident probably removed the alarm. A review of the resident's current plan dated 11/13/06 identified the resident at high risk for falls. According to the care plan, "observe for alarm on and in place	{2 830}		

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{2 830}	Continued From page 9 frequently." A progress note dated 3/14/07 at 6:18 PM stated, "Resident slid out of his wheelchair...As he was trying to get up he slid out of wheelchair and sat down on the foot pedals." The resident was not injured, and the care plan was revised on 3/16/07 included a "Posey grip" on the top of the wheelchair cushion to prevent the resident from sliding out of wheelchair. On 3/28/07 from 9:30 AM to 9:55 AM resident #85 was observed without an alarm that was secured. The resident was observed at 9:30 AM in his room, and then escorted to the nurse's desk, where he remained until 9:55 AM. During the twenty-five minute time period staff were not always present, and the resident was left unattended. At 9:55 AM the resident was escorted to his room and assisted to a standing position. When the resident was seated, the alarm was then clipped to his shirt. The alarm was resting inside a "Posey purse" behind the wheelchair and was not secured by bracket or adhesive to enable the alarm to sound. At 1:30 PM, resident #85 was observed in his room, and the alarm was now located on the outside of the "Posey purse" secured with Velcro. Furthermore, the "Posey grip" was placed under the resident's wheelchair cushion, and not on top of the wheelchair cushion as directed on the care plan. According to the nurse at the same time, the Velcro was changed from the inside of the Posey purse to the outside, because the Velcro wasn't sticking on the inside. When questioned when the changed occurred the nurse said, "late in the morning." (3/28/07). On 3/28/07 at 9 AM, the nurse was queried regarding the alarms. The nurse said the alarms didn't always stick on the	{2 830}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00233	A. BUILDING _____ B. WING _____	R 04/02/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME MINNEAPOLIS	5101 MINNEHAHA AVENUE SOUTH MINNEAPOLIS, MN 55417

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{2 830}	Continued From page 10 "Posey purses" either on the outside or inside. When apprised of the surveyor's observations on 3/28/07, (the alarm was placed inside the Posey purse and was not secured with Velcro), the nurse said the Velcro had come off, and wasn't sure how long the Velcro was missing. The nurse said she was not aware of any policy regarding how or where the movement alarms were to be secured. The manufacturer's recommendations for the Cirrus alarm stated the movement alarm system (MAS) should be mounted on surfaces, either with a mounting bracket or "loop material" (Velcro). According to an interview with purchasing staff on 3/29/07 around 4:00 PM, the facility no longer used the mounting brackets because they were not available. A mesh material was then used to hold the alarms, but the bags were, "wearing out," and being replaced with "Posey purses" and Velcro. A review of a purchasing order stated 10 string alarms were shipped on 3/13/07, and 30 pull cord alarms (blue bumper) were shipped on 3/28/07. SWALLOWING PRECAUTIONS Resident #105's diagnoses includes dementia, Alzheimer's , history of cerebrovascular accident, esophageal reflux and dysphagia. A significant change Minimum Data Set dated 3/02/07 identified the resident as moderately cognitively impaired and requiring assistance with eating. Resident #105 ' s care plan last revised 3/02/07 Under "Chewing/Swallowing Impairment/Meal Safety" "Aspiration Swallowing problems" the care plan indicated the resident should be in an	{2 830}		

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{2 830}	Continued From page 11	{2 830}		

upright position while eating and remain upright for 35 minutes after meals. It also directed staff to keep HOB (head of bed) up 35 degrees at all times. Under "Aspiration precautions" in indicated liquids were to be given by spoon. The nutrition plan included the need for honey thickened liquids that were to be given by spoon and referenced the swallowing guide.

A speech pathology evaluation dated 11/24/06 indicated during the fluoroscopy that "aspiration was present less than 10%". The impression was "moderate oropharyngeal dysphagia characterized by silent aspiration of thin liquids (secondary to reduced laryngeal closure) and delayed oral transit." The report also indicated under Gastroesophageal reflux precautions: Eat smaller , more frequent meals, and avoid eating within 3 hours of bedtime. Keep head of bed elevated at least 35 degrees at all times".

Review of the " Nursing Assistant Assignment Sheets " provided by the Registered Nurse (RN) manager directed staff to elevate the head of the bed 35 degrees and give all liquids by spoon.

Resident #105 was first observed on 3/28/07 at 6:50 AM in bed in his room. The resident's head of bed was flat. A sign was noted above the resident's bed that stated the head of the bed should be elevated to 35 degrees at all times. Resident #105 remained in a flat position until 7:15 AM when staff assisted the resident out of bed and into the dining room. Resident #105 received his tray which contained thicken fluids at 8:15 AM. Staff was observed to totally assist the resident with drinking the thickened fluids via a glass, not a spoon. At 8:47 AM staff was observed to lay the resident down. The resident's head of the bed was flat. Resident #105 was

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{2 830}	Continued From page 12 continuously observed in this position until 9:50 AM. At 9:55 AM on 3/28/07 a Registered Nurse was asked to observe resident #105 while the resident lay in bed. When asked if the resident ' s head of bed was elevated at a 35 degree angle the RN stated " Absolutely not. " The RN then elevated the resident ' s head. At approximately 1:45 PM on 3/28/07 the RN Manager of the unit was interviewed. The RN verified that resident #105 should have the head of his bed elevated at all times and that liquids should be given via spoon. The RN stated that the HST providing cares for resident #105 was new and had " Just got off orientation " . However the RN also verified that a sign was posted above the resident ' s head of the bed. Nursing assistants were not aware of swallowing precautions for resident #100 and the information was not readily accessible to them. The morning of 3/29/07 at 8:12 AM resident #100 was observed in the dinning room with his breakfast tray. A Health Service Technician (HST) (A) was sitting next to him feeding another resident. The resident was eating slowly only taking a bite of food or sip of a drink every now and then. Staff were observed to encourage him to eat. At times the resident would cough after taking a bite of the scrambled eggs. At no time did the staff remind him to take a drink between bites or check for pocketing of food. The HST left the table after the resident he was feeding was done eating. The charge nurse was still present in the dinning room and monitoring the amount of food the resident was eating.	{2 830}		

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{2 830}	Continued From page 13 The resident's tray card indicated the resident received a ground diet but did not contain any information about swallowing precautions. The HST assignment sheet directions for eating for resident #100 indicated: Feeds self after setup, Assist to feed when sleepy. See Swallow Guide. The swallow guide was located behind a counter in the kitchen. The resident's plan of care in the record also directed staff to the swallowing guide. Two HSTs did not know what the swallowing precautions were for resident #100. HST (A) who sat next to the resident at breakfast on 3/29/07 was interviewed around 8:45 AM about the supervision he provided during the meal to resident #100. He responded that he provides encouragement and social interaction. When asked specifically about swallowing precautions he indicated that whenever they feed any resident they check for pocketing and would tell the nurse right away if he noticed it. When asked if he knew what the specific swallowing precautions were for resident #100 he indicated he did not. This HST had only worked in the facility 4 weeks. A second HST (B) was interviewed about the same time. This HST has assisted resident #100 many times. When asked what supervision he provided to the resident at mealtimes he also indicated some help feed but added that the client liked to be independent. When asked if he did any other monitoring or knew what the swallowing precautions were for this resident he indicated that he did not. A Registered Nurse was interviewed on 3/29/2007 at 9:10 AM. She stated that individual residents' swallowing precautions were in a binder which was located in the kitchenette adjacent to the dining room. When a resident	{2 830}		

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{2 830}	Continued From page 14 had been identified with a swallowing difficulty and specific swallowing recommendations had been developed, the care plan and Health Service Technicians' (HST) worksheets were updated to "Follow the swallow guide". The HST was then to review the resident's individual swallowing recommendation which were located in the binder in the kitchen. There were 14 other residents who ate in this dinning room with individual swallowing precautions.	{2 830}		
{21620}	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Uncorrected based on the following findings: "The original licensing order issued on March 7, 2007 will remain in effect. Penalty assessment issued. " Based on observation, interview, and record review, the facility failed to ensure insulin labels were correct for 2 of 3 residents (#'s 37 & 66) in the sample with changed orders for insulin observed during the medication pass. The findings include: Although the residents #s 37 & 66 received the correct medication dosages the facility failed to follow the procedure to change outdated labels on insulin vials after a physician ordered changes for the medications. Incorrect labels could result in medication errors.	{21620}		

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{21620}	Continued From page 15 On 3/28/07 at approximately 7:45 AM a medication pass was observed on resident # 66. As the nurse checked the order with the vial of regular insulin she noted that the label did not match the order. The label was observed to read "give 20 units of regular insulin" when the order on the MAR (medication administration record) read to give 24 units of regular insulin. There was no additional label on the vial that would indicate that the directions had changed and should be referred to the chart. During a record review of resident #66 on 3/28/06 it was noted that the insulin orders were changed to increase the AM and PM regular insulin dose from 20 units to 24 units on 3/15/07. The insulin was administered 24 times since the order had changed. When asked what the procedure was when an incorrect label was found for a medication, the nurse stated that the medication was to be sent back to the pharmacy for correct labeling. According to facility policy titled "Pharmaceutical Policy & Procedures" dated 12/23/97 and revised 03/07, "when a physician order changes or there is an error on the label, the medication shall be returned to the Pharmacy for re-labeling during business hours. In addition, an auxiliary label may be applied over the medication label indication "Directions changed; refer to chart." During an interview with the Pharmacy Director on 3/29/07 at approximately 10:00 AM, it was noted that the the pharmacy staff relies on the nurses on the floor to follow the above procedure, and they usually do not audit the floor charts. An interview with the Director of Nurses and the Nurse Consultant on 3/29/07 at approximately 4:00 PM confirmed that it is the responsibility of the nurse who takes the order	{21620}		

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{21620}	Continued From page 16 for a change in medication dosage to initiate the change in label procedure. A medication pass was observed at 7:10 AM on 3/28/200 for resident # 37. The nurse drew up twenty units of regular insulin in a syringe. The label on the insulin vial indicated the resident was to receive twenty units of regular insulin before the morning and the evening meal and twenty-five units of regular insulin at the noon meal. A review of the physician's order, dated 3/26/2007, indicated the dosage of the regular insulin given before the evening meal had been changed from twenty units of insulin to twenty-four units of insulin. A review of the medication record indicated the dosage of the insulin had been changed to twenty-four units of insulin before the evening meal on 3/26/2007. The label on the insulin had not been changed to indicate the new dosage nor was there any indication on the vial of insulin to alert staff of the the change in dosage of the insulin. The RN looked in the medication refrigerator but there was not another vial of insulin there which had the correct label on it. When interviewed on 3/28/2007 following the medication pass, a Registered Nurse (RN) stated that staff were to send the new physician's order to the pharmacy with the medication and pharmacy staff were responsible to change the medication label to correspond with the new physician order. She stated that nursing staff were also responsible to place a "sticker" on the medication to alert staff of a medication dosage change. The RN stated that she was unsure why the label on the insulin had not been changed or why there was not a "sticker" on the label to alert staff of a dosage change.	{21620}		

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file

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Hand Delivered on March 7, 2007.

March 7, 2007

Mr. Bob Wikan, Administrator
Minnesota Veterans Home Minneapolis
5101 Minnehaha Avenue South
Minneapolis, Minnesota 55417

Re: Project # SL00233015

Dear Mr. Wikan:

On February 27, 2007, 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 November 17, 2006 with orders received by you on December 7, 2006.

State licensing orders issued pursuant to the last survey completed on November 17, 2006 and found corrected at the time of this February 27, 2007 revisit, are listed on the attached Revisit Report Form.

State licensing orders issued pursuant to the last survey completed on November 17, 2006, found not corrected at the time of this February 27, 2007 revisit and at the time of the Office of Health Facility Complaint (OHFC) complaint investigation visit on January 25 and 26, 2007, and subject to penalty assessment are as follows:

Comprehensive Plan Of Care; Use - Mn Rule 4658.0405 Subp. 3	**$300**
Rehab - Range Of Motion - Mn Rule 4658.0525 Subp. 2.B	**$350**
Rehab - Pressure Ulcers - Mn Rule 4658.0525 Subp. 3	**$350**
Medication Errors - Mn Rule 4658.1320 A.B.C	**$500**
Patients & Residents Of Health Facilities Bill Of Rights - Mn St. Statute 144.651 Subd. 5	**$250**
Reporting - Maltreatment Of Vulnerable Adults - Mn St. Statute 626.557 Subd. 4	**$100**

The details of the violations noted at the time of this revisit completed on February 27, 2007 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minnesota Statutes, section 144A.10, you will be assessed an amount of $1,850.00 per day beginning on the day you receive this notice.

The fines shall accumulate daily until written notification from the nursing home is received by the Department stating that the orders have been corrected. This written notification shall be mailed, faxed, or delivered to the Department at the address below or to Ellie Laumark, Minnesota Department of Health, Licensing and Certification Program, Division of Compliance Monitoring, 1645 Energy Park Drive, St. Paul, Minnesota 55108.

When the Department receives notification that the orders are corrected, a reinspection will be conducted to verify that acceptable corrections have been made. If it is determined that acceptable corrections have not been made, the daily accumulation of the fines shall resume and the amount of the fines which otherwise would have accrued during the period prior to resumption shall be added to the total assessment. The resumption of the fine can be challenged by requesting a hearing within 15 days of the receipt of the notice of the resumption of the fine.

If the accumulation of the fine is resumed, the fines will continue to accrue in the manner described above until a written notification stating that the orders have been corrected is verified by the Department.

The costs of all reinspections required to verify whether acceptable corrections have been made will be added to the total amount of the assessment.

You may request a hearing of any of the above noted penalty assessments provided that a written request is made within 15 days of the receipt of this Notice. Any request for a hearing shall be sent to Ellie Laumark, Minnesota Department of Health, Licensing and Certification Program, Division of Compliance Monitoring, 1645 Energy Park Drive, St. Paul, Minnesota 55108.

Once the penalty assessments have been verified as corrected the facility will receive a notice of the total amount of the penalty assessment including the costs of any reinspections.

Also, at the time of this reinspection completed on February 27, 2007 additional violations were cited as follows:

Adequate And Proper Nursing Care; General - Mn Rule 4658.0520 Subp. 1
Labeling Of Drugs - Mn Rule 4658.1345
Reporting - Maltreatment Of Vulnerable Adults - Mn St. Statute 626.557 Subd. 14 (a)-(c)

They are delineated on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Only the ID Prefix Tag in the left hand column without brackets will identify these licensing orders.

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.

Sincerely,

E M Laumark

Ellie Laumark, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 643-2566 Fax: (651) 643-2538

Enclosure

cc: Jocelyn Olson, Assistant Attorney General
Licensing and Certification File
Ellie Laumark, Metro Team D Survey and Review Unit
Mary Henderson, Licensing and Certification Program

L00233r107.let

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00233	A. Building B. Wing	2/27/2007

Name of Facility	Street Address, City, State, Zip Code
MN VETERANS HOME MINNEAPOLIS	5101 MINNEHAHA AVENUE SOUTH MINNEAPOLIS, MN 55417

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).

NH

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix 20490 Reg. # MN Rule 4658.0270 LSC	Correction Completed 02/27/2007	ID Prefix 20540 Reg. # MN Rule 4658.0400 Subp. LSC	Correction Completed 02/27/2007	ID Prefix 20560 Reg. # MN Rule 4658.0405 Subp. LSC	Correction Completed 02/27/2007
ID Prefix 20860 Reg. # MN Rule 4658.0520 Subp. LSC	Correction Completed 02/27/2007	ID Prefix 20870 Reg. # MN Rule 4658.0520 Subp. LSC	Correction Completed 02/27/2007	ID Prefix 20890 Reg. # MN Rule 4658.0525 Subp. LSC	Correction Completed 02/27/2007
ID Prefix 20910 Reg. # MN Rule 4658.0525 Subp. LSC	Correction Completed 02/27/2007	ID Prefix 20915 Reg. # MN Rule 4658.0525 Subp. LSC	Correction Completed 02/27/2007	ID Prefix 20945 Reg. # MN Rule 4658.0530 Subp. LSC	Correction Completed 02/27/2007
ID Prefix 20955 Reg. # MN Rule 4658.0530 Subp. LSC	Correction Completed 02/27/2007	ID Prefix 20965 Reg. # MN Rule 4658.0600 Subp. LSC	Correction Completed 02/27/2007	ID Prefix 21055 Reg. # MN Rule 4658.0625 Subp. LSC	Correction Completed 02/27/2007
ID Prefix 21375 Reg. # MN Rule 4658.0800 Subp. LSC	Correction Completed 02/27/2007	ID Prefix 21435 Reg. # MN Rule 4658.0900 Subp. LSC	Correction Completed 02/27/2007	ID Prefix 21665 Reg. # MN Rule 4658.1400 LSC	Correction Completed 02/27/2007

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	0305	3/7/07	0305	2/28/07
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00233	A. Building B. Wing	2/27/2007

Name of Facility	Street Address, City, State, Zip Code
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(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix 21670 Reg. # MN Rule 4658.1405 A.B.C.I LSC	Correction Completed 02/27/2007	ID Prefix 21685 Reg. # MN Rule 4658.1415 Subp. LSC	Correction Completed 02/27/2007	ID Prefix 21855 Reg. # MN St. Statute 144.651 Sul LSC	Correction Completed 02/27/2007
ID Prefix 21880 Reg. # MN St. Statute 144.651 Sul LSC	Correction Completed 02/27/2007	ID Prefix 21920 Reg. # MN St. Statute 144.651 Sul LSC	Correction Completed 02/27/2007		

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: 11/17/2006		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

AH Form Approved
3/8/2007

CG

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00233	A. Building B. Wing	2/27/2007

Name of Facility	Street Address, City, State, Zip Code
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BCH

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix 30750 Reg. # MN Rule 4655.4160 LSC	Correction Completed 02/27/2007	ID Prefix 30945 Reg. # MN Rule 4655.6400 Subp. LSC	Correction Completed 02/27/2007	ID Prefix 31010 Reg. # MN Rule 4655.7000 Subp. LSC	Correction Completed 02/27/2007
ID Prefix 31285 Reg. # MN Rule 4655.8630 Subp. LSC	Correction Completed 02/27/2007	ID Prefix 31460 Reg. # MN Rule 4655.9000 Subp. LSC	Correction Completed 02/27/2007	ID Prefix 31810 Reg. # MN Rule 144.651 Subd. 6 LSC	Correction Completed 02/27/2007
ID Prefix 31875 Reg. # MN Rule 144.651 Subd. 19 LSC	Correction Completed 02/27/2007	ID Prefix 31880 Reg. # MN Rule 144.651 Subd. 20 LSC	Correction Completed 02/27/2007	ID Prefix 31920 Reg. # MN Rule 144.651 Subd. 28 LSC	Correction Completed 02/27/2007
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:
	0305	3/7/07	0305	2/27/07
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
11/17/2006			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00233	A. BUILDING _____ B. WING _____	R 02/27/2007

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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 February 20, 21, 22, 23, 26 & 27, 2007 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	{2 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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{2 000}	Continued From page 1 Compliance Monitoring, Licensing and Certification Program; 1645 Energy Park Drive, Suite 300, St. Paul, Minnesota 55108-2970.	{2 000}	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
{2 565}	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: "Uncorrected based on the following findings.	{2 565}		

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{2 565}	Continued From page 2 The original licensing order issued on 12/07/06 will remain in effect. Penalty assessment issued." Based on observation, interview, and record review, the facility failed to ensure care plans were followed for 5 of 19 residents in the sample (#'s 27, 8, 86, 69, & 65). Findings include: Pressure Ulcer Treatment/Prevention Resident #27 was not repositioned as directed by his care plan. Resident #27's care plan (revised 12/7/06) directed staff to reposition him every two hours when in bed and the wheelchair. On 2/21/07 at 9:00 AM, the nurse manager said resident #27 staff should be repositioned using a Hoyer lift. Resident #27 had diagnoses that included a stage II pressure ulcer (partial thickness loss of skin layers presenting clinically as an abrasion, blister, or shallow crater) on his left foot, and history of previous pressure ulcers. According to the comprehensive assessment dated 10/3/06, the resident was non-ambulatory, requiring a full body lift and two staff members. On 2/20/07 resident #27 was not adequately repositioned from 4:30 PM to 8:20 PM (3 hours, 50 minutes). At 4:30 PM with the use of a lift, resident #27 was transferred from his bed to wheelchair. At 6:45 PM, two human service technicians (HSTs) assisted the resident with repositioning by lifting the resident up under his arms and attempting to stand the resident. The HSTs lifted the resident for approximately 15 seconds before lowering him back into his wheelchair. During the lift, the resident's knees remained in a flexed position and the resident	{2 565}		

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{2 565}	Continued From page 3 said, "ow" several times. At 8:00 PM, the HST was queried regarding the repositioning. The HST said the resident was unable to bear weight, therefore, two people were needed to help the resident to stand. The HST explained that residents were to be off-loaded (pressure relieved to an area) for a full minute. He did not realize the resident was off-loaded for 15 seconds. The HST then said the resident would be assisted to bed and repositioned when another staff person was available to help with the transfer. At 8:20 PM, the resident was assisted to bed. The resident's left buttock was noted to have a 5-8 centimeter area of redness. On 2/21/07 at 7:20 AM, the redness had resolved. Resident #8 did not have a physician-ordered dressing to a pressure ulcer on two separate observations. The resident's care plan dated 2/12/07 also indicated a Comfeel dressing was to be applied to the open area. On 2/12/07 the resident developed a small open area on his right buttock. It was described as a stage II pressure ulcer, that was healing. The physician ordered the area be cleansed with normal saline and a Comfeel dressing applied. The dressing was to be changed every three days and as needed. Nurses were to check for adherence every shift. During observations of evening cares on 2/20/07, there was no dressing covering the open area. On 2/21/07 at 9:45 AM, there was again no dressing applied to the open area. The treatment sheet did not indicate the nurse checked the area for dressing adherence on the evening shift 2/20/07, however, the night shift signed off that the site had been checked on 2/21/07. When interviewed on 2/21/07 at 9:45 AM, the RN verified there should have been a dressing on the open area.	{2 565}		

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{2 565}	Continued From page 4 Assistance to Maintain Continence Resident #86 failed to receive toileting interventions in accordance with her care plan, and lacked a consistent and accurate bladder assessment. The resident's care plan indicated she was in incontinent of bowel and bladder, and directed staff to toilet as needed and check and change every two hours. During observations the resident was not toileted for 3 hours, 10 minutes. Resident #86's comprehensive assessment dated 1/2/07 described the resident as incontinent of urine, requiring extensive assistance of one staff person with toileting. Although dependent in transferring to the toilet, the 3-day voiding assessment reveled the resident toileted independently twice on 1/10/07 and four times on 1/11/07. According to the 3-day voiding assessment, the resident was toileted by staff eight times, but did not indicate whether the resident voided. The bladder assessment dated 1/13/07 described the resident as incontinent most or all of the time and at times communicated the need to toilet. During the afternoon of 2/22/07, the nurse manager verified the 3-day voiding information was inaccurate. Resident #86's care plan dated 7/17/06 identified incontinence as a problem, and directed the following: "Staff assist resident to the toilet as needed (per request) and check and change resident's incontinent products every 2 hours." The resident also had diagnoses including dementia, and her care plan identified both short and long term memory loss. The facility's "Bowel and Bladder History and Assessment" directed staff to review the bowel	{2 565}		

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{2 565}	Continued From page 5 and bladder assessment and 3-day voiding pattern observation. The plan of care directed staff to describe the findings, as well as interventions to be attempted. On 2/20/07 resident #86 was observed from 4:15 PM until 7:25 PM (3 hours, 10 minutes) without being toileted or checked and changed. The resident was in her room from 4:15 PM until 5:30 PM, at which point she was assisted to the dining room via wheelchair. At 6:30 PM when the resident was assisted back to her room she said, " I'm tired," and requested to go to bed. The human services technician (HST) replied, "I'll be back." At 7:25 PM, the surveyor alerted the HST resident #86 had not been toileted. The HST said he asked the resident if she wanted to use the toilet after dinner but she said "no." The HST re-approached the resident who then said, " I don't need to go," but after encouragement agreed to use the toilet. When transferred onto the toilet the resident's incontinent pad was wet. Although she said she didn't need the toilet, she voided when placed on the toilet. Refusal of assistance was not noted as a concern on resident #86's care plan, nor if she did refuse, how staff were to proceed. Resident #69 did not have his personal alarm attached appropriately. On 2/20/07 at 2:30 PM, the resident was observed lying in bed. A personal alarm was clipped to the resident's clothing, but the box was placed beside him on the bed. The alarm was not secured to a stationary object, such as the head of the bed per the manufacturers' instructions. The care plan (updated 2/07) identified the resident at risk of falls. Interventions included the use of a personal alarm when in bed and wheelchair. The most recent documented fall was 12/28/06, when	{2 565}		

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{2 565}	Continued From page 6 resident #69 was found with the alarm sounding. When interviewed on 2/20/07 at 3:10 PM, a registered nurse verified the alarm should have been secured to the bed. Assistance to Maintain Range of Motion Resident #'s 8, 27, 65 did not received range of motion (ROM) services in accordance with their care plans. Resident #8's care plan dated 12/20/06 indicated he had limited ROM and an addition to the care plan on 1/11/07 indicated he was to receive nursing rehab ROM to upper extremities and lower extremities twice a day with cares and as needed. The resident was to have both active and passive ROM, which was also added to the HST assignment sheet. During the evening cares on 2/12/07 between 7:10 and 7:30 PM no ROM was observed. The treatment sheet for 2/20/07 did not indicate that ROM had been performed. Interviews on 2/21/07 with two HSTs and and the RN revealed confusion as to who was responsible for performing the ROM for resident #8. Each discipline assumed the other was performing the ROM for residents. Resident #27's care plan (revised 1/10/07) said, "ROM--res (resident) discharged from PT. NSG (nursing) to use pillow between knees and behind knees in bed. While res is sleeping, gently draw heels to foot of bed as able per PT recommendation of 1/4/07." A hand-written notation (undated) said, " (i.e. passive stretching every shift)." On 2/21/07 at 2:00 PM, the nurse reported the HSTs completed ROM exercises, and the nurse assisted with #27's ROM 1-2 times a week when	{2 565}		

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{2 565}	Continued From page 7 the HSTs were not trained. On 2/21/07 the HST regularly assigned to resident #27 said she had never completed ROM exercises on resident #27, nor had she received training. Resident #65's care plan dated 2/7/07 indicated limited ROM to upper extremities and lower extremities. The plan was to perform passive ROM and active ROM to upper extremities and lower extremities twice a day with cares. On 2/20/07 at 8:00 PM, the registered nurse (RN) said resident #65 did not have a formal ROM program other than "dressing and undressing." She confirmed she had not been performing ROM for the resident. When the treatment record was reviewed, there was no documentation that ROM had been performed on 2/20/07.	{2 565}		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure 3 of 4 residents whose falls were	2 830		

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2 830	Continued From page 8 investigated (#'s 85, 62, and 80) received adequate nursing care related to minimizing the risk of falls and/or status-post fall care. Findings include: The facility failed to evaluate resident #85's risk for falls, and implement effective interventions to minimize the risk of falls. Resident #85 was admitted to the facility in 2004 with diagnoses including dementia without behavioral disturbances, syncope (fainting) and traumatic subarachnoid hemorrhage (bleeding in the brain). Review of resident #85's minimum data set (MDS) dated 11/13/06 indicated the resident required extensive assistance of one person to transfer between surfaces and to ambulate. The MDS indicated the resident had fallen within the past 30 days. The resident assessment profile (RAP) indicated the resident had an altercation with another resident that led to a fall on 10/24/07. This resulted in hospitalization with a cerebral hemorrhage. The RAP went on to state the resident risked further falls with injury, which would be addressed on the resident's care plan. The resident's care plan dated 11/13/06 indicated the resident had a risk for falls as evidenced by having fallen within the past 30 days. The care plan listed physical therapy, orthostatic blood pressure monitoring and the placement of a Tabs alarm (personal alarm designed to sound if the resident moves a sufficient distance) in the wheelchair and in the bed. A review of the progress notes indicated the Tabs alarm was placed on the resident on 10/31/07 following his return from the hospital. The facility failed to re-evaluate the effectiveness of the Tabs alarm for resident #85 as an	2 830		

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2 830	Continued From page 9 intervention when the resident repeatedly removed the alarm and even when attached failed to prevent additional falls. A review of the progress notes indicated on 11/01/06 the resident was sitting up on the side of the bed and the Tabs alarm was not intact. The progress note stated "Personal alarm not intact. Appeared clip came off, or resident removed it which he is unreliable to tell." On 11/25/06 the progress notes indicated resident #85 was, "sitting at the nurses station, suddenly the alarm sounded. Resident found laying on his back on the floor." Resident #85 re-opened an old scar on his left elbow, measuring 1 centimeter by 1 centimeter. On 12/05/06 at 2:30 AM and again at 6:00 AM the Tabs alarm was found in the wheelchair, not attached to the resident. Progress notes on 12/23/06 at 3:09 PM showed the resident "often chooses to remove alarm." Progress notes for 01/04/07 at 11:30 PM indicated resident # 85, "removed his alarm by removing his gown." Notes for 01/05/07 at 3:04 AM indicated, "Resident kept removing his tabs alarm by removing his pajamas. Informed of the danger of taking off bed alarms, told to use the call light for assistance." On 01/08/07 at 6:00 AM, "Heard bed alarm, resident found in the bathroom. Alarm on floor by resident's feet." The progress notes for 01/25/07 indicated the resident again removed the Tabs alarm by removing his shirt. The note went on to state, "Unable to redirect to request assist related to dementia. unable to teach. Is high fall risk, staff	2 830		

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2 830	Continued From page 10 to continue to redirect and continue to monitor and assist and anticipate needs in hopes to prevent falls." Progress notes for 02/03/07 at 1:21 PM indicated resident again removed his Tabs alarm. No new interventions were implemented, and no comprehensive assessment of his risk for falls was documented. Review of the progress notes for 02/20/07 included a late entry for 02/18/07 at 7:30 AM. The note said, "He was discovered with gown on, seated on the floor. His bed alarm had been unfastened from the gown, likely done by the resident, and was still attached to the head of the bed therefore had not rung at his getting out of bed." Resident was found to have a 5 centimeter laceration to the top of his head and two skin tears to his left hand." The resident was transferred to a hospital where he was admitted for five days for the treatment of an acute subdural hematoma (bleeding in the brain). The facility failed to reassess resident #62's poor balance, continuing falls and implement timely effective interventions that might have protected the resident from repeated falls with injuries. Resident #62 was a 76-year old man who was over six feet tall. The resident had dementia. The resident was observed during the morning of 2/21/07 starting at 7:25 AM. The resident was assisted with a transfer of one male assistant. The resident was observed to have a shuffling gait and reach out for the wall to steady his gait. Although there was documentation of falls for this resident with a head injury in 2004 and numerous falls in 2005, the surveyor reviewed only incident and accident reports, interdisciplinary notes and orders for the past 12 months. Although the facility implemented a number of interventions	2 830		

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2 830	Continued From page 11 after falls, they failed to reassess their effectiveness and take additional steps to protect the resident. The resident ' s history of incidents and interventions was as follows: March: 3/5/06 Found with small skin tear. 3/17/06 Found lying in hallway, laceration head, bump on forehead. Intervention: Monitor whereabouts May: 5/6/06 Found on floor. 5/8/06 Found sitting on floor. June: 6/28/06 While being assisted to undress to use the toilet, the resident pushed away, hit head on door frame and fell forward hitting left face on corner of sink. Admitted to the hospital for surgical repair for a ruptured left eye. This resulted in blindness in the left eye. Intervention on return from hospital: bed alarm and escort to and from meals. July: On 7/8/06 he was found sitting on floor next to bed. Sent to the hospital to rule out intracranial pressure. Intervention: Change hip protectors to be worn at all times. The resident ' s comprehensive Minimum Data Set (MDS) functional assessment completed 7/21/06 identified the resident with history of falls, and indicated the resident required limited assistance of one to walk in his room or the corridor and extensive assistance with locomotion on the unit. The resident required partial support for balance. The falls protocol indicated staff was to ambulate the resident and assist with ambulation. 7/21/06 Physical therapy ordered to	2 830		

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2 830	Continued From page 12 evaluate gait for safety, and on 7/24/06 no therapy was recommended. 7/28/06 Wheelchair assessment was completed and one was provided for his use when he was weak. August: On 8/13/06, the resident was ambulating near nursing station, lost balance and staff heard a thud. Intervention: 8/17/06 reduction in quetiapine (antipsychotic medication) to 25 mg every day, 37.5 mg at noon, and 25 mg in the PM. September: On 9/6/06, the resident "Toppled to floor" after rising from a wheelchair. Staff stood nearby. A nursing summary of the resident's falls on 2/11/07 noted the resident had an increase in falls that began on 9/12/06 with a total of eight that month. Interventions: On 9/13/06 a perimeter mattress was ordered to reduce falls out of bed. On 9/21/06 the use of the Fitness Gym was ordered 2 to 3 times a week to increase endurance for walking. October: Risk for Falls Assessment dated 10/06/06 identified the resident with a risk score of 15. Any one with a score above 9 was identified as at risk for falls. The Quarterly MDS reference date 10/12/06 indicated the resident required no supervision in room or corridor for ambulation and only supervision for locomotion between areas. The assessment indicated the resident still required support to maintain his balance. The assessment did not identify any falls in the past 30 days. On 10/14/06 the physician discontinued the need for staff to walk the resident to and from meals or assist with ambulation.	2 830		

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2 830	Continued From page 13 November: The resident's care plan was updated 11/2/06 as, "At risk for falls: Monitor gait and w/c (wheelchair) prn (as needed). Hip protectors all times." 11/12/06 The resident lost footing ambulating with staff, fell against wall and lacerated his head and left wrist. Incident Report "Immediate Plan to ensure resident safety: Monitor Gait." There was no reassessment of the interventions in place to prevent falls even though the fall was with staff assistance. On 11/20/06 the resident was found with a bruised hip. An 11/20/06 progress note stated "Resident with hematoma, unknown origin, is ambulatory with some visual deficit. May have bumped rails or unwitnessed fall." The resident fell againl on 11/22/06, no injuries. December: On 12/04/06 the resident, while coming out of the dinning room fell down onto his knees and banged his head on the door jamb a couple of times. He was seen in an emergency room and there were gashes to the top of his head and above his left eyebrow. 12/04/06 Order for nursing to provide standby assistance at all times when up ambulating. On 12/04/06 felodipine (for blood pressure) was held then discontinued on 12/5/06. 12/05/06 OT (occupational therapy) to evaluate for helmet to be worn when walking. On 12/8/06 there was a progress note indicating the resident refused the rubber helmet and nursing was attempting to find a different style helmet. The current Nursing Assistant Assignment Sheet indicated that he was to wear a helmet, yet refused. The charge nurse indicated on interview on 2/21/07 that he refused the helmet from the start. She ordered a	2 830		

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2 830	Continued From page 14 soft helmet that she hoped the resident would wear. It arrived during the survey. There was an order on 12/7/06 for physical therapy (PT) to evaluate for gait strengthening secondary to recent falls. On 12/12/06 the resident was found with skin tears and hematoma of right elbow. The resident continued to fall with injuries. On 12/27/06 the resident was found with abdominal bruises, stated, "I had a fall." On 12/28/06 the care plan was updated that resident refused to wear helmet when walking. The progress note of 2/11/07 reviewing the resident's fall history indicated the resident had six falls in 12/06. There were no new interventions. A 12/29/06 Risk for Falls Assessment continued to identify the resident at risk for falls. He scored 14. Scores above 9 identified the resident at risk for falls. The quarterly MDS assessment, dated 1/9/07 identified the resident with a fall history and requiring partial support for balance. The same assessment indicated the resident only needed supervision for ambulation. January: The Interdisciplinary Care Plan updated 1/07 indicated the resident was independent with ambulation but assist varied. Staff was to supervise whereabouts and direct the resident to specific destinations. On 1/11/07 quetiapine reduced again to 12.5 mg, 10:00 AM, 12.5 mg noon, and 25 mg at 1800. February: The progress note of 2/11/07 indicated the resident had loose stools for a couple of days and the fall pattern began to occur almost daily starting on 1/13/07. On 1/22/07 there was an order to change the resident from a check and	2 830		

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2 830	Continued From page 15 change program to toileting upon rising, after meals and at hour of sleep. On 1/25/07, Change HCTZ (for regulating blood pressure) 12.5 mg to 8:00 AM. On 2/1/07 the frequency for toileting was increased to every two hours. The progress note of 2/11/07 stated that at the end of the month (1/06), the resident had a fall that resulted in two fractured ribs. The resident continued to fall. A progress note from 2/11/07 indicated that there were three falls so far that month. Although the facility was aware the resident had poor balance and refused to wear a helmet, the care plan only directed staff to supervise the resident's whereabouts. On 2/7/07 the resident was found in another room when staff heard a loud sound. He was found face down by bedside in pool of blood and a hematoma on his head. He was admitted to the hospital for six days with intracranial bleed. The discharge instructions, 2/13/07 indicated there needed to be a plan for fall prevention. On the morning of 2/21/07 at 7:25 AM the surveyor observed the resident in a Broada chair with thigh belts on that restricted the resident's ability to rise out of the chair. A soft helmet was ordered to see if the resident would wear that, and it arrived late the afternoon of 2/21/07. The charge nurse was interviewed on 2/21/07 starting around 11:00 AM. The nurse indicated the only reason the resident had a restraint, was because the wife wanted him tied down. The nurse indicated they were a restraint-free unit. When asked how a bed alarm and noting the resident ' s whereabouts would protect the resident from falls when ambulating she responded, "No" they wouldn't.	2 830		

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2 830	Continued From page 16 The physical therapist was on the unit to evaluate the resident on 2/21/07. The therapist indicated the goal was to get the resident walking again and the restraints off. A progress note entry from 2/13/07 at 3:24 PM reported, "Spouse met with writer, ADON (assistant director of nursing) & RNM (registered nurse manager) discussed fall prevention when res (resident) returns to unit. Decision made to move resident closer to nursing station room (number), however, it was explained to spouse that unit was restraint-free and guarantee cannot be made that res will not fall." The resident's wife was interviewed on 2/22/07 at 5:54 PM. The wife reported her husband had Parkinson-like symptoms, with a shuffling gait and upper body shaking. She reported he was now blind in one eye. She indicated staff made attempts to be more watchful and had put an alarm on his bed, but there wasn't a lot of help on the floor. The wife did not feel the facility staff was very creative on ways to prevent repeat falls, and as a family member she could only push so far. When she indicated they should try a geriatric chair or a Posey (restraint), she said she was told they couldn't do that because the resident could slide down and choke himself. The wife responded that he could kill himself falling. The wife indicated that she was told that the unit was restraint-free and that if restrained her husband would have to move off the unit. She expressed concern that she would not be able to keep her husband in the facility, and he would lose the veteran's benefits for care. The wife stated that she was frustrated because they (staff) knew he would fall again, and wouldn't implement interventions to prevent falls. She exclaimed, "Is	2 830		

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2 830	Continued From page 17 this all I can expect for serving your country?" The wife indicated that the only reason her husband was moved closer to the nursing station and a restraint applied to prevent falls was because she insisted on it. On 2/14/07 the physician ordered physical therapy to evaluate the resident for a restraint sitting device and PT evaluation for ambulation. On 02/15/07 PT was discontinued because the goal was met. A sensor alarm was placed on the bed. The Director of Nurses interviewed the afternoon of 2/22/07 indicated that the facility was not "restraint-free," but a "restraint-appropriate". Resident #80 fell and lacerated his head sometime between 11:00 and 11:45 AM on 2/13/07. The facility failed to perform neurological checks in accordance with their policy for head injuries, failed to arrange for prompt treatment of resident #80's head laceration and failed to document the incident and events surrounding the incident as soon as possible. Ann incident report dated 2/13/07 at 2:45 PM revealed resident #80 "Res (resident) came up to desk, stated he had just fallen and hit his head. Had a Y shaped cut on back of head with the V part one cm (centimeter) in length and the I part two cms in [length]. Pressure applied and site cleaned. Called VA (Veteran's Administration) to have him seen for stitches, but was told he would have to go to HCMC for stitches. Res's sisters here to take him out for lunch, and we decided that the cut was not wide enough to warrant the trip. Neurologically at baseline VS's (vital signs)	2 830		

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2 830	Continued From page 18 stable." The report indicated the resident's physician and the nurse manager were notified the day of the fall, and the nurse practitioner the following day. Resident #80's nursing notes were reviewed. The first note regarding the resident's head injury was documented on 2/13/07 at 10:01 PM by a licensed practical nurse (LPN), not present during the time of the fall. The note indicated the evening officer of the day (OD) assessed the resident's head laceration at 4:45 PM, and requested the resident be seen for sutures. The injury was described as, "'Y'-shaped laceration is noted to be gaping at 2.0 cm vertical portion of laceration. Call was placed to VAMC-UC (Veteran's Administration Medical Center-Urgent Care). RN (registered nurse) at UC stated it is their facility policy that anyone with a head injury is to go to HCMC-ER (Emergency Room)." That hospital informed the nurse they were deferring all patients to other hospitals. The triage nurse at Abbott Northwestern Hospital (ABNW) ER said they could see the resident. The family was then notified of the need to transport the resident. An ambulance arrived at 6:10 PM and the resident left via a stretcher and two attendants. A call was then received from ABNW that a head CT (imaging-type scan) was negative. The laceration was "glued," and the resident returned at 9:30 PM with no new orders. Neurological checks for head injury were then performed and were negative. A second note by the same LPN was written at 10:19 PM containing essentially the same information. A nursing note regarding resident #80's injury was written the following day by an RN on 2/14/07 at 3:11 PM. The note indicated, "Late entry from 2/13/07 day shift, resident had a fall in	2 830		

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2 830	Continued From page 19 his bathroom and hit his head causing a laceration of a 'Y' shape on back of head, staff RN assessed and cleaned area and applied pressure to area until bleeding stopped, call placed to VAMC and they would not take him at ER/urgent care for cracking his head open and stated he would need to go to HCMC ER for evaluation of laceration, resident refused to go to HCMC for eval (evaluation) of laceration and both his sisters were here when he fell and hit his head and when he refused to go to HCMC ER for eval of laceration and they were in agreement with resident that he did not have to go to HCMC ER if he did not want to and they took him out to lunch as they planned, upon return staff RN applied bacitracin (ointment) to laceration and a non-stick drsg (dressing) after cleansing area. Placed call to (doctor's name) by staff RN and updated on fall, laceration, refusal to go to HCMC ER for evaluation of laceration, neurological assessments. Neurological assessments initiated r/t (related to) fall with head be hit." The nurse present at the time of the fall made a late entry on 2/15/07 at 1:38 PM, two days after the incident. "Res (resident) came to the desk and stated that he had fallen in his bathroom and hit his head. Y shaped wound at the back of head, the V part 1 cm in length and the I part 2 cms. Wound was [bleeding] pressure applied and site cleaned. Res sisters were here to take him out for lunch, as the wound was not deep, but continued to seep, a call was made to VAMC but they said that as he hit his head he had to go to HCMC. It was felt that as the bleeding had by now stopped, the sisters took him out. Res later in the evening went to Abbott for glue to the site. Currently the site is dry and intact." A summary of the resident's care conference held	2 830		

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2 830	Continued From page 20 on 2/13/07 was documented by an RN on 2/16/07. Included in the summary were additional notes regarding the injury of 2/13/07. The RN wrote, "MMSE (mini-mental status assessment) completed on 1/9/07 score 22/30 (indicating moderate impairment) with no noted changes per SW (social worker)...Had fall today and caused a laceration to back of head, VAMC would not take resident and stated he should go to HCMC and resident refused to go there and both sisters agreed he would be just fine and decided to take him out to lunch instead, resident continues to deny pain for discomfort of head or any body part at conference...." A physician's note of 2/16/07 at 7:44 PM documented a call made to one of resident #80's sisters at her request. Concerns expressed by the sister were related to the resident's worsening tremors, overall decline in mental status, and uncontrolled diabetes. There was no mention of the resident' fall. A sister of resident #80 was interviewed by telephone on 2/22/07 at 2:30 PM. She was asked to describe what happened on 2/13/07. She said the staff reported the resident fell in the bathroom about 15 minutes before their arrival to take the resident out for lunch. She stated, "He just hit his head really good." She explained that she and her sister told resident #80 that because of his fall, they didn't need to proceed with their plans to go to lunch and would come back another day. She said the resident, however, "really wanted to go out for lunch." The sister said his head was bleeding quite a bit at first, but the nurse was able to get the bleeding under control. The resident reported the area "didn't really hurt." She said they did watch the area when out for lunch, and she didn't feel it was	2 830		

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2 830	Continued From page 21 "gaping or anything." They attended the care conference held that day for the resident. (According to the licensed social worker, the resident and sisters attended a care conference at the facility that day at approximately 2:10 PM). The sister reported that later that evening, one of the nurses called the sister to inform her they would feel better if he had "a couple of stitches," and he was sent in about 5:00 PM. During the afternoon of 2/23/07, an assistant director of nursing (ADON) was interviewed. She said the evening supervisor examined the resident's wound before or after supper and made arrangements to get transportation for stitches. She said he was not sent to the hospital 9-1-1, and it took awhile to arrange for transportation. She described the area as "Y"-shaped and "split." She said it was "oozing a bit and saturating the dressing on the top of his head." The nurse did not feel he was unstable and the wound "wasn't bleeding that much." She said the incident occurred around 11:00 to 11:45 AM. They also checked his blood sugar and it was normal. The family, she said, had just been there for a care conference, at which time the nurse manager talked to them and the resident. She said, "It was up to them and (resident name)'s decision." When asked whether the nurse informed the family of the possible risks of not following up to neurologically assess the resident after a head injury, the ADON replied, "I think they did--explain." The director of nursing (DON) was also present at the interview. When asked why several of the nursing notes were documented as late entries she replied, "I have no idea why. We'd have to ask (nurse manager's name)." When asked how neurological (neuro) testing could be performed when the resident was out of the building, she verified we wouldn't	2 830		

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2 830	Continued From page 22 see the checks during the time the resident was out of the building. In a discussion related to resident #80's history of poor decision making, the DON indicated the "family supports those decisions." This indeed was documented in the resident's medical record. There was no documentation, however, to support the family made an informed decision weighing the risks of leaving the building after a head injury. In addition, documentation on the "Determination of Ability to Make Health Care Decisions" dated 4/7/05 indicated resident #80 was no longer able to make health care decisions because of "severe neurological disease." The document was signed by the resident's physician, and indicated the resident's sisters were his health care agents. On 2/26/07 at 10:00 AM, the RN who initially cared for the resident, as well as the RN manager were interviewed. The RN said resident #80 came to him stating he had fallen in the bathroom. He explained the resident was looking forward to his sisters visit. The sisters, he said, came within minutes of the fall. The resident had a "'Y'-shaped gash to the head," but he had almost stopped the bleeding when his sisters arrived. The RN stated, "Had I had my druthers, I would have sent him to the VA and had a stitch." He said he asked the sisters if they wanted to take him downtown to get it stitched and they said "they didn't want to." He said it was a judgment call as to whether he needed to go in for treatment and they went for lunch and returned. The RN explained that the resident was in his 50's and he felt he could treat him like a child, "or take our risks and let him have a life." He said he completed two neuro checks prior to the outing that were negative, and resumed the checks when he returned. He described the width of the	2 830		

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2 830	Continued From page 23 wound as barely a millimeter or 2, not 2 cm. The nurses verified the resident was gradually losing cognitive functioning, and that was why his sisters assisted him in making decisions. The RN manager said she looked at the wound and determined the resident "needed sutures and to be seen." She said the family felt comfortable taking him out for lunch, and they had a cell phone if they had any problems. They did not know HCMC was diverting patients when the family took the resident out for lunch. She confirmed they had not discussed the importance or policy for performing neuro checks with the family prior to the outing. The RN said he did tell them if the resident had any changes in his cognitive level to call, and that the sisters were bright people. The RN said the family "didn't insist," rather "they wanted" to take the resident out. "Had I explained to them, 'Look, he needs it stitched,' it would have been done." The most recent facility policy and procedure (2/5/88) regarding falls with a head injury indicated the following was to be documented in the resident's record: 1) notification of physician including physician comments and/or orders (no comments were documented), 2) notify family and document call, 3) complete an incident report, 4) document the incident in the interdisciplinary notes. In addition, procedural guidance for neuro checks included "residents with head lacerations." The procedure directed the staff as follows: "Neuro checks are to be done and recorded every 15 minutes for the first hour, then every hour for 3 hours, and then every 4 hours for 24 hours. If the neuro checks are unchanged, they may be discontinued after the 24 hour period." There were approximately two hours after the fall where neuro checks were	2 830		

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2 830	Continued From page 24 lacking, as the resident was out of the facility. SUGGESTED METHOD OF CORRECTION: The Director of Nursing could schedule an in-service for the nursing staff who complete assessments of falls and injuries and facility policies. The quality assurance committee could randomly audit resident records to ensure compliance. TIME PERIOD FOR CORRECTION: Seven (7) days.	2 830		
{2 895}	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: "Uncorrected based on the following findings. The original licensing order issued on 12/07/06 will remain in effect. Penalty assessment issued." Based on observation, interview, and record	{2 895}		

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{2 895}	Continued From page 25 review, the facility failed to ensure range of motion (ROM) was provided for 5 of 13 residents in the sample (#'s8, 27, 79, 10, 65) who required ROM services, and to ensure consistent approaches were implemented related to ROM programs in general. Findings include: Although ROM programs were initiated for residents determined to require those services, the delineation of the specific programs to be carried out and the responsibility for delivery of the treatment was inconsistent. Resident #8's care plan dated 12/20/06 indicated he had limited ROM and physical therapy was to evaluate him for a ROM program. On 1/11/07 an addition for ROM was added to the care plan. It indicated the resident was to have nursing rehab ROM to upper extremities and lower extremities twice a day with cares and as needed. The resident was to have both active and passive ROM, which was also added to the HST assignment sheet. During the evening cares on 2/12/07 between 7:10 and 7:30 PM no ROM was observed. The treatment sheet for 2/20/07 did not indicate that ROM had been done. Two HSTs were interviewed on 2/21/07 at 9:45 AM and 2:00 PM about ROM on the residents. Both HSTs stated they were taught to do ROM, however, one of the HSTs stated, "My understanding is that the nurses are to do the ROM. I was told the HSTs were responsible but then the nurses on the floor told me they were doing the ROM." The RN when interviewed on 2/21/07 at 1:45 PM stated not all HSTs had been trained. She assumed all HSTs knew how to perform ROM, since they were taught in nursing assistant training. She further stated she didn't specifically watch to ensure ROM was performed,	{2 895}		

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{2 895}	Continued From page 26 and assumed the nurses were performing it since they signed off on the treatment sheets. The facility failed to ensure a clear, concise ROM (range of motion) program was developed and implemented for resident #27, and staff were trained and aware of their responsibilities. Resident #27 had diagnoses that included arthritis, osteoporosis, and a four month hospitalization (2006) related to osteomyelitis (bone infection). The comprehensive assessment dated 10/13/06, showed the resident required total assistance with all activities of daily living. The assessment said, "...it was noted he has marked bilateral flexion contractures of his hips, hamstrings and ankles." The PT discharge notes dated 1/10/07 said the resident was discharged after six weeks of therapy, to help with leg stretch and develop a ROM plan for nursing. According to the PT notes the resident was, "poorly tolerant of stretch, particularly when awake," and "If asleep may permit more extensive slow stretch to legs...When alert he is likely to fight furiously with staff during stretch ...This kind of active stretch is not advised." The PT referral/communication dated 1/4/07 directed the following: "Position for knee separation and hip/knee extension when in chair/bed. Use pillow or bath blanket in chair. Use pillow between knees and behind knees in bed. While sleeping gently draw heels to foot of bed as able." Resident #27's care plan (revised 1/10/07) said, "ROM--res (resident) discharged from PT. NSG (nursing) to use pillow between knees and behind knees in bed. While res is sleeping, gently draw heels to foot of bed as able per PT recommendation of 1/4/07." A hand-written notation (undated) said, " (i.e. passive stretching every shift)." The HST assignment sheet	{2 895}		

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{2 895}	Continued From page 27 directed, "Legs extended--gently draw heels to foot of bed. Easier to reposition/do stretching when resident is sleeping," however, did not specify the frequency of stretches. On 2/21/07 at 2:00 PM, the nurse reported the HSTs completed ROM exercises, and the nurse assisted with #27's ROM 1-2 times a week when the HSTs were not trained. The nurse reviewed resident #27's ROM and verified the frequency of leg stretching for resident #27 was not specified. The nurse said resident #27's ROM was not on the treatment record, but should have been. On 2/21/07 the HST regularly assigned to resident #27 said she had never completed ROM exercises on resident #27, nor had she received training. On 2/21/07 at 3:00 PM the nurse manager said the HSTs completed ROM. On 2/22/07 at 9:00 AM the nurse manger said contrary to what she said the previous day, the nurses were to perform ROM. On 2/21/07 at approximately 2:30 PM, two PT staff were interviewed. One staff said nurses completed ROM exercises unless the HSTs were instructed. The second PT said he did not specify the frequency of stretches for resident #27, and it was up to the nurse manager to determine. The RN managers received the referral/communication from PT, and it was their responsibility to determine how the ROM was implemented and assigned. A review of the HST assignment sheets (updated 2/16/07) indicated resident #79 was to have ROM to his right ankle twice a day. An interview with the HST on 2/21/07 at approximately 1:50 PM revealed ROM consisted of putting on the resident's Sensi-socks in the morning. The HST informed the surveyor that education related to	{2 895}		

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{2 895}	Continued From page 28 ROM exercises for resident #79 had not been provided. In an interview with an RN on 2/21/07 at 1:50 PM, she said each HST responsible for residents who require ROM was expected to complete the ROM exercises. She said it was delineated on their assignment sheets, which she explained, were signed by the HST and co-signed by the nurse. If the signatures were present, it was presumed all tasks/care needs on the sheet were completed for that group of residents by the assigned HST. The RN also said there had not been a program to instruct or review ROM with the HSTs but one HST had been trained on ROM for one particular resident, and the future plan was for the HST to train the others on the unit. A review of physiotherapy progress notes for resident #10 dated 2/6/07 indicated the writer met with an HST on 2/1/07, and instructed the staff person in some basic passive range of motion (PROM) exercises of resident #10's left foot and ankle. "It is my understanding that...the HST would follow-up with the other nursing staff (HST's and nurses) in carrying out this PROM ex. (exercise) on a daily basis." Resident #65 was observed in his room on 2/20/07 at 7:30 PM sitting in his wheelchair. The resident's care plan dated 2/7/07 indicated limited ROM to upper extremities and lower extremities. The plan was to perform passive ROM and active ROM to upper extremities and lower extremities twice a day with cares. The ROM plan did not specify which joints of the upper and lower extremities should be included or how many repetitions were required. When resident #65 was asked whether staff had performed any exercises with him that day he responded, "I don't	{2 895}		

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{2 895}	Continued From page 29 think I had any exercise today. They always say they're going to do it and they never do." At 7:40 PM, the RN and the LPN came into the room to assist the resident to use the bathroom and to assist him with evening cares. When queried at 8:00 PM, the RN stated resident #65 did not have a formal ROM program other than "dressing and undressing." She confirmed she had not been performing ROM for the resident. When the treatment record was reviewed, there was no documentation that ROM had been performed on 2/20/07. On 2/21/07, interviews were conducted with floor staff as to who had responsibility for performing ROM services for residents. The first HST was interviewed at 9:25 AM. She said she learned in nursing assistant registry training, and the HSTs performed ROM based on what and when their assignment sheet directed. A second NA interviewed at 9:30 AM said the "other day" a nurse asked him to perform ROM on a resident, however, he told the nurse he had not been instructed, and didn't feel comfortable performing ROM until he received training. He did perform a stretching program for one resident, who was to stand in the standing lift to attempt to increase his endurance. A third HST interviewed at 9:35 AM said the "nurses are supposed to" perform ROM. She said the therapy department trained one of the HSTs on the floor to perform ROM on her group, and once she was trained, she would be performing ROM, as well. She added that the responsibility of ROM shifting from the nurses to the HSTs was new, "just handed down in the last month." A licensed practical nurse was interviewed at 9:45 AM. He said, "I do the ROM on people on this unit." A registered nurse was	{2 895}		

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{2 895}	Continued From page 30 interviewed at 1:45 PM. She said the "HSTs are responsible." She explained that the physical therapists (PT) assessed the residents and gave recommendations. She said the PT staff usually showed the nurse or HST how to perform the ROM, however, the persons on that floor were not very complicated, such as standing in the standing lift, or flexing ankles. She said as of 1/18/07, the nurses were to instruct the HSTs and they were to perform the ROM with cares. The following day on 2/22/07 at 8:45 AM, the director of nursing (DON) was interviewed. She said since the survey, the nurses were performing the ROM. If the physical therapists had assessed the residents, then the HSTs could perform it. She would expect the HSTs to let the nurse know, however, if it wasn't performed, and the nurse should have been monitoring the completion of the task and signing off on the treatment sheets. At 1:35 PM, the DON verified the information given to surveyors on a monitoring visit, indicating that nurses were responsible for performing ROM, and in the future, HSTs would be trained. She said that hadn't changed. It was her understanding the ROM was noted on the treatment sheets and was being signed off by the nurses, as the HSTs hadn't been trained. However, after meeting with the RN managers, she found eight different people told her "about eight different things." She explained she didn't want the HSTs to perform the ROM until they were trained, and if they had been trained, then it wasn't documented. The DON explained they were finding lots of teaching "went by the wayside." The facility policy and procedure for ROM dated 1/07 indicated the frequency for ROM was to be twice daily and was to be delineated on the	{2 895}		

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{2 895}	Continued From page 31 resident's care plan, as well as on the HST assignment sheet. Problems, deterioration, or the development of new problems were to be "reported to the licensed nurse." It did not specify the nurse as the person responsible for performing ROM, nor did the policy specify completion of the task be recorded on the nursing treatment sheets.	{2 895}		
{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: "Uncorrected based on the following findings. The original licensing order issued on 12/07/06 will remain in effect. Penalty assessment issued." Based on observation, interview, and record review, the facility failed to ensure 2 of 6 residents in the sample (#'s 27 and 8) who with	{2 900}		

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{2 900}	Continued From page 32 pressure sores, received appropriate care to minimize the risk of further development or worsening of pressure ulcers. Findings include: Resident #27 was not repositioned as directed by his care plan. Although unable to bear weight, staff also attempted to assist him to a standing position. Resident #27 had diagnoses that included a stage II pressure ulcer (partial thickness loss of skin layers presenting clinically as an abrasion, blister, or shallow crater) on his left foot, and history of previous pressure ulcers. According to the comprehensive assessment dated 10/3/06, the resident was non-ambulatory, requiring a full body lift and two staff members. The comprehensive assessment described the resident as totally dependent on staff for all activities of daily living, including repositioning. On 2/20/07 resident #27 was not adequately repositioned from 4:30 PM to 8:20 PM (3 hours, 50 minutes). At 4:30 PM with the use of a lift, resident #27 was transferred from his bed to wheelchair. At 6:45 PM, two human service technicians (HSTs) assisted the resident with repositioning by lifting the resident up under his arms and attempting to stand the resident. The HSTs lifted the resident for approximately 15 seconds before lowering him back into his wheelchair. During the lift, the resident's knees remained in a flexed position and the resident said, "ow" several times. At 8:00 PM, the HST was queried regarding the repositioning. The HST said the resident was unable to bear weight, therefore, two people were needed to help the resident to stand. The HST explained that residents were to be off-loaded (pressure relieved to an area) for a full minute. He did not realize	{2 900}		

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{2 900}	Continued From page 33 the resident was off-loaded for 15 seconds. The HST then said the resident would be assisted to bed and repositioned when another staff person was available to help with the transfer. At 8:20 PM, the resident was assisted to bed. The resident's left buttock was noted to have a 5-8 centimeter area of redness. On 2/21/07 at 7:20 AM, the redness had resolved. Resident #27's care plan (revised 12/7/06) directed staff to reposition him every two hours when in bed and the wheelchair. On 2/21/07 at 2:30 PM, the physical therapist said the resident had bilateral knee contractures (the resident was unable to extend his knees, and they remained in a flexed position at negative 45-50 degrees). On 2/21/07 at 9:00 AM, the nurse manager said resident #27 staff should not have attempted to stand the resident, and repositioning should have been performed using a Hoyer lift. Resident #8 did not have a physician-ordered dressing to a pressure ulcer on two separate observations. On 2/12/07 the resident developed a small open area on his right buttock. It was described as a stage II pressure ulcer, that was healing. The physician ordered the area be cleansed with normal saline and a Comfeel dressing applied. The dressing was to be changed every three days and as needed. Nurses were to check for adherence every shift. The resident's care plan dated 2/12/07 also indicated a Comfeel dressing was to be applied to the open area. During observations of evening cares on 2/20/07, there was no dressing covering the open area. On 2/21/07 at 9:45 AM, there was again no dressing applied to the open area. The treatment sheet did not indicate the nurse	{2 900}		

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{2 900}	Continued From page 34 checked the area for dressing adherence on the evening shift 2/20/07, however, the night shift signed off that the site had been checked on 2/21/07. When interviewed on 2/21/07 at 9:45 AM, the RN verified there should have been a dressing on the open area.	{2 900}		
{21545}	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or	{21545}		

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{21545}	Continued From page 35 designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: "Uncorrected based on the following findings. The original licensing order issued on 12/07/06 will remain in effect. Penalty assessment issued." Based on observation, interview, and record review, the facility failed to ensure medications were administered with an error rate less than five percent for 2 of 40 medication opportunities (#'s 66 and 70). Findings include: The facility failed to follow physician's orders for resident #'s 66 and 70, resulting in two insulin (for diabetic control) medication administration errors. Resident #66, who had a diagnoses including diabetes, was administered the incorrect dosage of insulin. The resident had physician's orders for human NPH insulin 14 units with human regular insulin 20 units every evening. In addition to this dose, the resident was to receive additional units of human regular insulin in a dosage determined by the results of a blood sugar check (sliding scale).	{21545}		

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{21545}	Continued From page 36 On 2/20/07 at approximately 5:15 PM, resident #66's medication administration pass was observed. The licensed practical nurse (LPN) was observed completing a blood sugar test. The results of the test indicated the resident should have received 6 units of regular human insulin, in addition to the set dose of insulin. The LPN proceeded to prepare to draw insulin out the vials. After uncapping the empty syringe and with the bare needle exposed, the LPN reached over to turn her medication book around to double check the prescribed dosage. In the process of doing so, the exposed needle made contact with the paper in the medication book and the front plastic cover of the medication book. The LPN began to draw the insulin into the syringe from the vial. When the surveyor informed her she had contaminated the needle she replied, "Really? When did I do that?" The LPN then discarded the contaminated syringe and opened a new sterile syringe. The LPN was then observed to draw up 14 units of human NPH insulin, then in the same syringe, drew up 6 units of regular human insulin, as indicated by the results of the blood sugar check. The LPN then proceeded from the hallway outside the resident's room with the uncovered syringe to the resident's room. She administered the insulin into resident #66's abdomen. After the insulin was administered and the LPN left the bedside, the surveyor prompted the LPN to re-check the physician's orders to verify the dosage. The LPN then verified she failed to administer the 20 units of regular human insulin ordered to be given in addition to the amount as a result of the blood sugar testing results.	{21545}		

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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
{21545}	Continued From page 37 The LPN then drew up an additional 20 units of regular human insulin. She explained to the resident she had not given her the full dose because the order had recently changed and she needed to administer a second injection. The resident did not comment, and allowed the second injection. Resident #70's medication pass by a LPN was observed on 2/20/07 at 5:00 PM. The resident received 18 units of insulin human regular. The physician's order dated 3/21/06 indicated the resident was to receive insulin human regular 29 units 15 minutes before breakfast, 18 units, 15 minutes before dinner, and 10 units for blood sugars 400, daytime only. An interview with the LPN after administration of the insulin revealed dinner was served on the unit at approximately 5:15 PM to 5:30 PM. When questioned about the time of administration of the insulin, the LPN said the insulin was to be given according to the time on the medication administration record (MAR) versus fifteen minutes before the meal as indicated on the order. Observations were conducted of the resident while seated in the dining room. Although the resident was served coffee while waiting for the dinner meal, the resident was not served dinner until 6:04 PM, approximately one hour after receiving the insulin injection. The resident left the dining room at approximately 6:45 PM and went to his room. He sat on the edge of the bed and told the surveyor, "I feel a little woozy." The LPN was summoned, and she re-checked his blood sugar which was at 197. A review of the MAR for 1/07 and 2/07 indicated	{21545}		

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{21545}	Continued From page 38 that resident #70's blood sugars at 5:00 PM ranged from 111 to 428. A physician progress note on 2/2/07 indicated, the resident had type II (adult onset) diabetes milltus and fasting blood sugars were ordered to be completed four times daily. The physician noted the following: "AM range is 88-173; noon range is 156-410; supper range is 129-341; HS (bedtime) range is 138-333." An interview with the registered nurse manager on 2/21/07 at 8:40 AM verified the order for insulin human regular needed to be changed related to the "fifteen minutes" before meals and/or the nurses needed to be aware as to when the insulin was given in order to ensure the resident was served his meal more timely. The facility hypoglycemia treatment reference guide indicated, "Regular insulin (Give no more than 30 minutes before meal)."	{21545}		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure medication labels were correct for observations of 3 of 40 medications administered (#'s 80, 63 and 81). Findings include: On 2/20/07 at 5:15 PM resident #80 was observed receiving insulin (for diabetic control). A sliding scale (varying amounts) dose of regular insulin was to be given based on the resident's	21620		

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21620	Continued From page 39 blood sugar testing. The resident was to receive 2 units of insulin for a blood sugar 200 and above, 4 units for a blood sugar of 300 and above, and 4 units at bedtime if the blood sugar was above 300. These changes in orders for insulin were received 2/16/07, however, the label did not match the directions as above and there was no label change on the bottle. The licensed practical nurse (LPN) stated there should have been a label change on the bottle. She further stated the pharmacy was to send the label with the new directions and nurses were responsible to we put the new label on the bottle. On 2/21/07 at approximately 8:00 AM, a medication pass was observed for resident #63. The nurse drew up 8 units of glargine insulin into a syringe. The label on the bottle directed staff to administer 12 units of glargine insulin twice a day. When questioned regarding the discrepancy, the nurse said the order was changed, and the resident was to receive 8 units twice a day instead of 12 units. The nurse verified a label change should have been placed on the bottle when the dose was changed. The resident's medical record revealed the glargine insulin dose was changed on 1/28/07. Furthermore, the nurse practitioner and nurse manager said on 2/22/07 at approximately 10:00 AM, the resident's insulin schedule was very "complicated" and confusing. The resident received both glargine and novolog insulin, as well as two different sliding scales one based on meal consumption, and another based on blood sugar testing. During observation of medication pass on 2/22/07 at 11:50 AM, resident #81 was given the nebulae treatment Ipratropium BR .02% (to improve breathing). The medication administration record and the label on the box both indicated the	21620		

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21620	Continued From page 40 Ipratropium was to be given along with Albuterol four times a day. The LPN informed the surveyor that the Albuterol was discontinued by the physician on 2/16/07. Neither the medication administration record nor the label on the box had been changed to reflect the new physician's order. The LPN was unable to verify whether staff continued to administer the two drugs together in error, or whether they had been administered correctly according to the new order during the previous week. She was able to verify, however, that the label on the box should have been changed, a new entry made on the medication sheet, and a new label obtained from the pharmacy. She stated the pharmacy was located in the building which made it more convenient. She further stated nurses were responsible for placing the new labels, writing the new order on the medication record, and notifying the pharmacy. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) could schedule an in service for all nursing staff to review the policy regarding medication label changes. The DON could delegate nursing staff to monitor compliance and report to the quality assurance committee. TIME PERIOD FOR CORRECTION: Seven (7) days.	21620		
{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	{21805}		

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{21805}	Continued From page 41 employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: "Uncorrected based on the following findings. The original licensing order issued on 12/07/06 will remain in effect. Penalty assessment issued." Based on random observation, interview, and record review, the facility failed to ensure 7 randomly observed residents (#'s 84, 82, 71, 60, 83, 65, and 11) had a dignified dining experience. Findings include: During observation of the supper meal 2/20/07 at 5:15 PM on the 4 north dining room, residents were not assisted or fed in a dignified manner. During the observations, a human services technician (HST) began to arrange the residents at their places for the supper meal. Resident #84 was pulled backwards in her wheelchair. The HST did not inform the resident prior to moving her, startling the resident, who appeared frightened by the sudden movement. Resident #82 was also moved in her wheelchair without explanation. An HST and a licensed practical nurse (LPN) were seated at a table with five residents while assisting to feed two of the residents. During the mealtime the two staff did not engage the residents in conversation, except to direct them to eat. Instead, they had a conversation among themselves about work issues including comments such as, "That's why the morale is so bad here." While resident #71 was being assisted to eat by	{21805}		

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{21805}	Continued From page 42 the HST, the resident was being fed heaping spoons of pureed food and pudding. When another resident spilled food, the HST left the table to clean the floor, and resident #71 began to cough for 30 seconds. None of the staff attended to him. He was able to stop coughing but had food dribbling on his chin. The HST returned and began feeding the resident. Resident #71's medical record revealed diagnoses including dysphagia (difficulty swallowing), dementia, and Huntington's disease. The care plan for feeding dated 1/5/07 noted he had an altered nutritional status related to severe dysphagia. It directed staff to feed him slowly with small amounts, allowing 45-60 seconds to swallow. Staff were also to observe for signs of aspiration (food into the lungs). Residents #60, 82, and 83 were not served their meal until 15 minutes after the other residents sat their table. It was observed that the trays were set up at 6:00 PM. At 6:12, a HST entered the dining room and was told by another HST to feed the three residents. The residents were then served their trays and they were assisted to eat. The staff did not ask if their food was warm enough, and the residents would not have been capable of complaining because of cognitive impairments. During an interview with the nurse manager 2/21/07 at 2:00 PM, she verified that staff should not have been discussing work issues, rather should have engaged the residents in conversation to make their meals enjoyable. The nurse manager verified that resident #71 should have been fed small amounts and observed for choking/coughing during the meal. She stated that independent residents were served first, but staff was to assist all residents at mealtime.	{21805}		

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{21805}	Continued From page 43 Resident #65 was taken to breakfast at 8:10 AM on 2/21/07. His breakfast tray was sitting on the kitchen counter ledge with an insulated cover over the plate. The dietary staff had finished distributing breakfast, and the other residents were either eating or being assisted to eat. The plate under the dome was cold and contained two poached eggs and toast. The egg yolks were hard, one having separated from the egg white. Part of the egg white on one egg had congealed. The resident stated, "These don't taste good--they're hard." The HST replied, "I don't know what to do. The kitchen staff has left." The RN stated she would call the dietary staff, who was supposed to have remained in the kitchenette until 9:00AM. When the dietary staff brought him fresh, warm eggs, he ate most of them. Four other residents were being assisted to eat by two HSTs. They were being fed oatmeal. Scrambled eggs were also on uncovered, cold plates. At approximately 8:20 AM, the residents finished their cereal and were offered the eggs. One resident ate half of the eggs, and another wouldn't eat any. The HST explained the resident didn't like eggs. Another resident ate nothing on his tray and another ate the eggs. When asked whether the eggs may have become cold since they had been uncovered for some time, the two HSTs said they didn't think there was anything wrong with eating the cold food. They indicated the residents ate pretty slowly and the food was hot when delivered around 7:30 AM. They further stated they didn't know what to do. When asked about reheating the food the HST responded by asking, "You mean we have to reheat the food during the meal? " They continued to feed the residents cold eggs. When interviewed at 2/21/07 at 8:30 AM, the assistant administrator agreed the food should have been warm when	{21805}		

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{21805}	Continued From page 44 served and the staff should have reheated the food in the microwave if needed. The facility failed to provide timely meal service and assistance to resident #11 during the evening meal on 2/20/07. During observations of the evening meal on 2/20/07 at approximately 5:25 PM resident #11 was wheeled into the dining room and placed at a table by a human service technician (HST). The resident was observed to sit up in a Broda type wheelchair with a lap tray attached. Staff started to serve the evening meal at approximately 5:30 PM. At 5:50 PM approximately 26 resident were sitting at tables in the dining room; 5 residents and 2 tables had been served one of which was another resident sitting at the table with resident #11. Resident #11 was observed squirming in the wheelchair and reaching out over the lap tray. At 5:56 PM resident #11 was observed watching the residents that had been served at his table eat.. At 6:02 PM another resident was placed at the table with resident #11, this resident was served his meal at 6:07 PM. Resident #11 continued to watch others eat at his table and still had not been served his meal; the resident was again observed to reach out over the lap tray. At 6:12 PM resident #11 was served his evening meal and the HST immediately sat down to assist the resident to eat. An interview with the HST to find out why resident #11 had not been served and assisted to eat when his tablemates were served revealed that "Normally the resident would have been served with his tablemates and fed. Usually a senior staff person would set up the meal tickets so that all residents a table would be served together. The feeder's are served and fed last. The resident would reach for his food if served and no one was able to feed him."	{21805}		

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{21805}	Continued From page 45 A review of the HST assignment sheet last updated 2/21/07 indicated, "Total assist with eating." A review of the quarterly minimum data set (MDS) dated 1/9/07 indicated, "Extensive assistance with eating." A review of the resident assessment protocol summary (RAPS) dated 5/8/06 indicated, "Staff to set up and feed during meals." "Cause/Risk factors: Diagnoses - Parkinson's with dementia and affective mood disorder. Risk factors are decreased mobility, contractures, skin breakdown, pain, falls, and injury."	{21805}		
{21990}	MN St. Statute 626.557 Subd. 4 Reporting - Maltreatment of Vulnerable Adults Subd. 4. Reporting. A mandated reporter shall immediately make an oral report to the common entry point. Use of a telecommunications device for the deaf or other similar device shall be considered an oral report. The common entry point may not require written reports. To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment, any evidence of previous maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment. A mandated reporter may disclose not public data, as defined in section 13.02, and medical records under section 144.335, to the extent necessary to comply with this subdivision. This MN Requirement is not met as evidenced by: "Uncorrected based on the following findings.	{21990}		

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{21990}	Continued From page 46 The original licensing order issued on 12/07/06 will remain in effect. Penalty assessment issued." Based on observation, interview, and record review the facility failed to immediately report an allegation of physical abuse for 1 of 1 (#85) residents in the sample who alleged physical abuse. Findings include: Resident # 85 alleged that he was cut by a staff person with a knife. The facility failed to report the allegation to the common entry point (Minnesota agency designated to take reports of alleged abuse towards nursing home residents). A review of resident #85's medical record indicated that on 01/07/07 at 8:30 PM, the licensed practical nurse (LPN) was informed by the human service technician (HST) that resident #85 "had become combative with cares, and was bleeding." After the HST left the room the resident requested the LPN ensure his door was closed, then stated to the LPN, "I don't know how he was able to cut me with that knife." The LPN "assured resident that the HST didn't have a knife." The LPN documented she "found three skin tears on the resident's right hand and dark purple bruises" after examining resident #85. One measuring three centimeters, the second measuring one centimeter, and the third measuring one-half centimeter." She also noted, "two small skin tears on the left hand, and dark purple bruises. One on the left index finger measuring one-half centimeter. The other on the top of the left hand measuring one centimeter." The LPN then documented she cleaned and dressed the "skin tears," and "helped the resident	{21990}		

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{21990}	Continued From page 47 to bed and assured the resident he was safe from any harm." The note said the LPN "informed HST to stay out of resident's room, and another HST would care for the resident the remainder of the night. On 01/08/07 at 10:05 AM, the registered nurse (RN) documented in the progress notes, "When asked what happened, states 'someone got him with a knife last night.' Unable to give details does not say anything other than that." On 01/11/07 at 4:25 PM an entry in the progress notes indicated resident #85 was seen by a psychology intern at request of the "team." The note indicated, "met briefly with the resident regarding incident last weekend that left cuts and bruises on his hands. Resident's account of the incident coincides with what he told the RNM (registered nurse manager); that someone cut him with a knife." Review of the form titled, "Vulnerable Adult Maltreatment Report" (date on form illegible) described the incident, "Resident aggressive behavior kicking and hitting out at HST. Unable to redirect obtained bruising with skin tears on hands. ID (interdisciplinary) team discussed. No staff maltreatment." The form also said, "Results of facility investigation: Behavior of resident caused self-injury to hands. Attempted to hit HST, missed hitting bed and surroundings, causing bruising and skin tears. Mental health to work with resident history of teasing and difficult to redirect behavior secondary to diagnosis of dementia." The form in resident #85's chart titled, "Mental Health Services Referral Request" submitted by the licensed social worker (LSW) on 01/16/07	{21990}		

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{21990}	Continued From page 48 requested that the resident be referred for mental health services for the following reason: "Resident #85 sustained injuries in an altercation with an HST...He stated the HST had a knife which is how he got cut. The team would like an assessment on (resident #85's) ability to accurately report. Does he have a history of delusions? Or is he accurate in his perceptions?" The requested psychological assessment was completed on 01/30/07 by the psychology intern and included the following information: The resident reported on three separate occasions he was cut by the HST with a knife (at the time to the incident to the LPN, on the day following the incident 1/08/07 to the nurse manager, and on 1/11/07 to the psychology intern). The assessment concluded with the following statement, "Whether or not (resident #85) is accurate about staff cutting him with a knife is difficult to determine. He has memory impairments, but that does not rule out the possibility of what he claims. His reports would require collateral support for verification. His belief is that he was cut by staff and he has held on to that belief in a consistent manner. Without a professional medical/forensic opinion it is difficult to know if the cuts were caused by a knife or were self-inflicted...." In an interview with the director of nursing (DON) and an administrative nurse on 2/23/07 at 5:30 PM, the DON said the assistant director of nursing (ADON) would have called it in, but they were unable to produce evidence the allegation by the resident had been reported to the common entry point. The "Operating Policy and Procedures" titled, "Vulnerable Adults Act" dated 10/96 said it was	{21990}		

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{21990}	Continued From page 49 the policy of the home to require the investigation of vulnerable adult reports. The policy also said, "Any known abuse must be reported; in addition, any suspicion of abuse must also be reported. Facility staff would have reason to suspect abuse may have occurred if a resident, staff, family member, or other individual reports an incident of abuse. All suspicious situations will be reported and allegations of maltreatment will usually be accepted at face value."	{21990}		
22000	MN St. Statute 626.557 Subd. 14 (a)-(c) Reporting - Maltreatment of Vulnerable Adults Subd. 14. Abuse prevention plans. (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency. (b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse.	22000		

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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
22000	Continued From page 50 (c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to follow it's policies to conduct a thorough investigation and protect residents while the investigation was being conducted for an allegation of staff abuse for 1 of 1 residents (#85) who alleged abuse. Findings include: Resident # 85 alleged that he was cut by a staff person with a knife. The facility failed to ensure the protection of other residents during the investigation of the allegations and to thoroughly investigate the allegations of physical abuse made by a resident. Resident #85 was admitted to the facility in 2004	22000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00233	A. BUILDING _____ B. WING _____	R 02/27/2007

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22000	Continued From page 51 and had diagnoses including traumatic subarachnoid hemorrhage, dementia without behavioral disturbances, and chronic airway obstruction. A review of resident #85's medical record indicated that on 01/07/07 at 8:30 PM, the licensed practical nurse (LPN) was informed by the human service technician (HST) that resident #85 "had become combative with cares, and was bleeding." The LPN's documentation in the progress notes indicated she entered the resident's room and "found the resident standing in the middle of the floor, dressed from the waist up and furious." The resident then stated to the LPN, "'Get him the hell out of here before I kill him,"' (referring to the HST who had returned to the room with the LPN). The LPN then requested the HST leave the room so she could calm the resident and provide treatment to his wounds. After the HST left the room the resident requested the LPN ensure his door was closed, then stated to the LPN, "I don't know how he was able to cut me with that knife." The LPN "assured resident that the HST didn't have a knife," and explained the HST was there to help the resident get ready for bed. The LPN went on to document that the resident's roommate was also agitated, as evidenced by yelling racial slurs, hitting the wall with his fists, and kicking the foot of his bed. The roommate calmed down when the LPN explained she was there to help resident #85. The LPN documented she "found three skin tears on the resident's right hand and dark purple bruises" after examining resident #85. One measuring three centimeters, the second measuring one centimeter, and the third measuring one-half centimeter." She also noted, "two small skin tears on the left hand, and dark	22000		

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22000	Continued From page 52 purple bruises. One on the left index finger measuring one-half centimeter. The other on the top of the left hand measuring one centimeter." The LPN then documented she cleaned and dressed the "skin tears," and "helped the resident to bed and assured the resident he was safe from any harm." The note said the LPN "informed HST to stay out of resident's room, and another HST would care for the resident the remainder of the night. The LPN then proceeded to notify the officer of the day (OD) of the incident and documented on the "call log" to alert the resident's nurse practitioner. She then notified resident #85's son of the "skin tears" which resulted when his father became combative with an HST during cares. There was no documentation in the record the resident's son was informed that resident #85 alleged the wounds were caused by a knife. There was no documentation in the record that the OD assessed the wounds or interviewed the HST involved. A detailed description was lacking as to the appearance of the wounds (i.e. even or jagged edges) to aid in an explanation as to the cause of the wounds, or evidence of an investigation of the resident's allegation that the HST caused the wounds with a knife. On 01/08/07 at 10:05 AM, the registered nurse (RN) documented in the progress notes the dressing was removed from the right arm, and resident had Steri-strips (wound dressing) intact over the "skin tears." Also noted were bruises, described as dark purple bruise on the right hand measured 20 centimeters by 16 centimeters, and the bruise on the left hand measured 10 centimeters by 13 centimeters. The RN documented, "When asked what happened, states 'someone got him with a knife last night.'	22000		

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22000	Continued From page 53 Unable to give details does not say anything other than that." On 01/11/07 at 4:25 PM an entry in the progress notes indicated resident #85 was seen by a psychology intern at request of the "team." The note indicated, "met briefly with the resident regarding incident last weekend that left cuts and bruises on his hands. Resident's account of the incident coincides with what he told the RNM (registered nurse manager); that someone cut him with a knife." Review of the form titled, "Vulnerable Adult Maltreatment Report" (date on form illegible) described the incident, "Resident aggressive behavior kicking and hitting out at HST. Unable to redirect obtained bruising with skin tears on hands. ID (interdisciplinary) team discussed. No staff maltreatment." The form also said, "Results of facility investigation: Behavior of resident caused self injury to hands. Attempted to hit HST, missed hitting bed and surroundings, causing bruising and skin tears. Mental health to work with resident history of teasing and difficult to redirect behavior secondary to diagnosis of dementia." The report did not explain how the ID team determined the injuries resulted from resident #85 hitting the bed without a witnessed account, nor does the form explain the determination the resident was not credible in his allegation that he was cut by a knife. Attached to the "Vulnerable Adult Maltreatment Report" was an account of a phone interview conducted with the HST (alleged perpetrator) on 01/08/07 at 10:10 AM by the RN manager. The interview stated, "Asked if he would go to the bathroom to be washed, refused to go at this time so was starting to remove shoes while he was in	22000		

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22000	Continued From page 54 bed. When started to remove pants that were half down close to his knees, started to kick with hard force but missed almost hitting his (HST's) chest. HST explained he was only trying to help and the resident calmed down for a very short time then started kicking again. Explained he could be washed and get ready for bed later then attempted to hit. Explained he would leave but (resident #85) continued with trying to hit (HST). (HST) states there was no physical contact with him, then noted blood on (resident #85"s) hand. Asked (resident #85) what happened and (resident #85) said he cut him with a knife. HST states he did not have a knife and is unable to determine what brought on behavior. He did not grab his hands at anytime. Unable to determine how bruising occurred, as there was not any contact." The interview did not state how the ID team came to the conclusion that the resident acquired the "bruises and skin tears" by "hitting the bed and surroundings." There was no evidence the resident's roommate or other staff or residents were interviewed regarding the details of the incident. The form in resident #85's chart titled, "Mental Health Services Referral Request" submitted by the licensed social worker (LSW) on 01/16/07 requested that the resident be referred for mental health services for the following reason: "Resident #85 sustained injuries in an altercation with an HST. He apparently became combative--LPN stepped in to calm (resident #85) down. He had cuts and bruises to both hands. LPN was able to de-escalate by talking. HST was reassigned. (Resident #85) stated the HST had a knife which is how he got cut. The team would like an assessment on (resident #85's) ability to accurately report. Does he have a history of delusions? Or is he accurate in his perceptions?"	22000		

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22000	Continued From page 55 The requested psychological assessment was completed on 01/30/07 by the psychology intern and included the following information: The resident reported on three separate occasions he was cut by the HST with a knife (at the time to the incident to the LPN, on the day following the incident 1/08/07 to the nurse manager, and on 1/11/07 to the psychology intern). The report noted resident #85 had a history of combative behavior, but had not ever received any injuries during cares in the past. The assessment stated there was no record of delusions or hallucinations in the resident's charted history and the resident "did not make any unbelievable or odd comments/statements that would be considered delusional" during the assessment. The assessor noted that the resident had a significant decline in his cognitive ability since suffering a head injury in 10/06, but was capable of answering questions during the assessment. The assessment concluded with the following statement, "Whether or not (resident #85) is accurate about staff cutting him with a knife is difficult to determine. He has memory impairments, but that does not rule out the possibility of what he claims. His reports would require collateral support for verification. His belief is that he was cut by staff and he has held on to that belief in a consistent manner. Without a professional medical/forensic opinion it is difficult to know if the cuts were caused by a knife or were self-inflicted. There is a possibility that if he was sleeping when approached by staff, he may have lashed out because of fear, causing the cuts and bruises to self." During an interview with the RN manager and the director of nursing (DON) on 2/26/07 at approximately 10:00 AM and 2:30 PM, they	22000		

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22000	Continued From page 56 indicated they were unaware of the results of the mental health assessment, and were not aware of any further investigation into the incident as a result of the assessment. The "Operating Policy and Procedures" titled, "Vulnerable Adults Act" dated 10/96 said it was the policy of the home to: To protect adults who, because of physical or mental disability or dependance on institutional services, are particularly vulnerable to maltreatment. To require the reporting of suspected/know maltreatment of residents. To require the investigation of vulnerable adult reports. The policy also said, "Any known abuse must be reported; in addition, any suspicion of abuse must also be reported. Facility staff would have reason to suspect abuse may have occurred if a resident, staff, family member, or other individual reports an incident of abuse. All suspicious situations will be reported and allegations of maltreatment will usually be accepted at face value." The policy indicated it was the supervisor's responsibility in possible maltreatment events to assess the situation to: "Ensure the resident's immediate needs are met, provide for the safety of the resident(s). This may include such actions as placing the involved employee on investigatory suspension and or removing the perpetrator from the area, gather the facts, and compile/protect the evidence." SUGGESTED METHOD OF CORRECTION:	22000		

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22000	Continued From page 57 The Administrator and Director of Nursing could review and revise policies and procedures for investigating reports of suspected maltreatment and provide additional training to involved staff on how to conduct a through investigation and protect residents during that investigation. A designated staff could monitor the system to assure compliance. TIME PERIOD FOR CORRECTION: Seven (7) days.	22000		

Minnesota Department of Health

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{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 February 20, 21, 22, 23, 26, & 27, 2007 surveyors of this Department's staff, visited the above provider . NO VIOLATIONS NOTED	{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 Boarding Care Homes.	

Minnesota Department of Health

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Minnesota Department of Health

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{3 000}	Continued From page 1	{3 000}	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings is 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.	

PA mn

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Hand delivered on December 7, 2006

December 7, 2006

Mr. Bob Wikan, Administrator
Minnesota Veterans Home Minneapolis
5101 Minnehaha Avenue South
Minneapolis, Minnesota 55417

Re: Enclosed State Nursing Home Licensing Orders - Project Number SL00233015

Dear Mr. Wikan:

The above facility was surveyed on November 17, 2006 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 you 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.

The order form should be signed and returned to this office when all orders are corrected. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

Please feel free to call me with any questions.

Sincerely,

Ellie Laumark, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651)643-2566 Fax: (651)643-2538

Enclosure(s)

cc: Original - Facility
Licensing and Certification File
Program Assurance Unit
Mary Lou Heider, Stratis Health

00233s07nh.rtf

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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, November 13, 14, 15, 16 and 17, 2006 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	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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2 000	Continued From page 1 Compliance Monitoring, Licensing and Certification Program; Complaints; 85 East Seventh Place, Suite 220; P.O. Box 64900, St. Paul, Minnesota 55164-0900. 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 which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 490	MN Rule 4658.0270 Withdrawal of Funds from the Account Upon the request of the resident or the resident's	2 490		

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2 490	Continued From page 2 legal guardian, conservator, representative payee, or other person designated in writing by the resident, a nursing home must return all or any part of a resident's funds given to the nursing home for safekeeping, including interest, if any, accrued from deposits. A nursing home must develop a policy specifying the period of time during which funds can be withdrawn. The policy must ensure that the ability to withdraw funds is provided in accordance with the needs of the resident and must specify whether or not the nursing home allows residents to obtain funds to meet unanticipated needs on days when withdrawal periods are not scheduled. A nursing home must notify residents of the policy governing the withdrawal of funds. Funds kept outside of the nursing home must be returned within five business days. This MN Statute is not met as evidenced by: Based on observation, policy review and interview the facility failed to develop policies to ensure residents who had monies held in trust were able to withdrawal funds in accordance with their needs. Findings include: The facility's policy did not address any provision to allow residents to obtain funds to meet unanticipated needs. On 11/15/06 at approximately 1:15 PM during the nursing home resident group interview all nine of the residents in attendance agreed that they were unable to withdraw money from their trust accounts outside of the posted banking hours. The residents reported that the bank is open from 9:30-11:30AM weekdays and from 1-2 PM on Monday, Wednesday, and Fridays. The	2 490		

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	00233	A. BUILDING _____ B. WING _____	11/17/2006

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2 490	Continued From page 3 resident's all agreed that they would be unable to access their funds on the weekends, or in the evening. During the resident group interview for Board and Care residents held on 11/14/06 at 10:30 AM residents reported it was difficult to access their funds (in the nursing home building) when they needed to due to the limited hours the cashier's office was open. One resident reported he wanted to access his funds on Veterans' Day but the office was closed. The " Minnesota Veterans Home Minneapolis Things to Know " from the resident handbook indicated the Cashier Window is open Monday, Wednesday and Friday from 9:30 AM to 11:30 AM and 1:00 PM to 2:30 PM. On Tuesday and Thursday it is only open in the AM. The hours were posted at the Cashier ' s Window. In addition the sign indicated the window was closed weekends and holidays. There was no other method for residents to access their funds during off hours. This was confirmed by interview with the assistant administrator the morning of 11/15/06. SUGGESTED METHOD OF CORRECTION: The Administrator could review and revise existing policies and procedures as necessary to ensure residents have access to their funds for unanticipated needs. The Administrator could inservice all appropriate personnel and establish a monitoring system to ensure adequate access to trust funds. TIME PERIOD FOR CORRECTION: Thirty (30) days.	2 490		

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2 540	Continued From page 4	2 540		
2 540	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care as defined in part 4658.0405. Subp. 2. Information gathered. The comprehensive resident assessment must include at least the following information: A. medically defined conditions and prior medical history; B. medical status measurement; C. physical and mental functional status; D. sensory and physical impairments; E. nutritional status and requirements; F. special treatments or procedures; G. mental and psychosocial status; H. discharge potential; I. dental condition; J. activities potential; K. rehabilitation potential; L. cognitive status; M. drug therapy; and N. resident preferences. This MN Statute is not met as evidenced by: Based on observation, interview, and record review the facility failed to complete comprehensive skin assessments for 11 of 11 residents in the sample reviewed for the risk of	2 540		

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2 540	Continued From page 5 pressure ulcers,(#s 17, 10, 1, 2, 7, 8, 9 , 27 , 28, 22, & 20), and 13 of 30 residents in the sample reviewed with incontinence (#s 11, 8, 17, 16, 1, 2, ,9, 7, 27, 13, 15, 21 & 22). Findings include: Urinary Incontinence Assessments: The facility lacked a system that comprehensively assessed a resident's incontinence that included voiding patterns, perineal assessments, risks and causative factors, treatment approaches and how these factors or causes could be modified, stabilized or removed in order to assist residents to maintain or improve their incontinence. Although the facility had started to perform some assessments of voiding patterns and identified types of incontinence the assessments weren't comprehensive failed identify what could be done to reduce the incontinence. Resident # 11 had diagnoses which included dementia and incontinence. A quarterly Minimum Data Set (MDS), dated 10/24/06, identified the resident as severely cognitively impaired with both long and short term memory problems. The MDS further indicated he was totally dependent on staff for all activities of daily living, including toileting and was frequently incontinent of urine. The Resident Assessment Protocol Summary (RAPS), dated 5/8/06, identified the resident with both urinary and bowel incontinence and wore an incontinence brief. The RAPS further indicated that if staff toileted the resident he could be kept continent during the day. Although the resident was identified with urinary incontinence, there was no indication a comprehensive assessment was completed that included voiding patterns, diagnosis and medication which may affect continence, visual	2 540		

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2 540	Continued From page 6 inspection of the perineal /rectal area; risks/benefits, environmental factors, or mobility/environmental limitations. When interviewed on 11/16/07, at 2:00 PM, a nurse manager said that a 3 day bladder assessment was not located for this resident. The nurse manager further verified that the resident did not have a comprehensive urinary incontinence assessment completed to determine an individualized toileting program. Resident # 8 lacked an individualized assessment of his voiding pattern that comprehensively integrated risks and causative factors, treatment approaches and how these factors or causes could be modified, stabilized or removed in order to accurately evaluate the appropriate time interval for providing assistance with the resident's toileting needs. The resident was admitted in 1/2000 with diagnoses that included organic brain syndrome, uncontrolled diabetes mellitus, and chronic renal failure with dialysis. The Quarterly Minimum Data Set (MDS) dated 9/30/05 and the Annual MDS dated 1/7/06 identified moderate cognitive impairment, multiple daily episodes of bowel and bladder incontinence, and total dependence for transfers, toileting and hygiene. The facility Bowel and Bladder Assessment V02 dated 9/19/06 identified incontinence with inadequate control, frequency of urinary elimination at less frequent than every 8 hours, a lack of awareness of the urge to void and identified urinary incontinence type as Intractable. He was not on a scheduled toilet program, and the intervention and approach selected was to be a greater than 2 hour, but less than 4 hour check and change program. A notation was made on the	2 540		

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2 540	Continued From page 7 assessment the resident was not to be placed on the toilet related to safety and he was at risk of falls while seated on the toilet. A 3 day bladder and bowel record was completed 1/10/06-1/12/06. For the 66 separate opportunities to record hourly checks for incontinence, 54 identified the resident as dry, and only 12 indicated he was wet. A post void residual check was completed on 1/13/06 that yielded 12 ml. No bladder continence interventions were checked on the ADL Assistance V01 form. The Plan of Care identified a check and change program only, but the Human Services Technician (HST) Worksheet dated 11/9/06 directed staff to assist with use of the urinal; however, this was not being done. Although the resident was identified with urinary incontinence, the assessment and summary lacked several components that included evidence of a physical examination/visual inspection, effect of hydration/fluid balance status related to dialysis, determination of appropriate individual voiding intervals from the 3 day record, environmental factors, effects of medications, risk/benefit factors, complete UTI history , specific behaviors, all co-morbid medical conditions, and how all these factors could be modified or influenced to develop an individualized toilet plan. Resident # 17's urinary incontinence had not been comprehensively assessed. Resident #17 had a diagnoses that included dementia . The resident's quarterly Minimum Data Set (MDS) dated 7/11/06, identified the resident as being totally dependent upon staff for all cares which included multiple daily episodes of	2 540		

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2 540	Continued From page 8 urinary incontinence. During continuous observations on 11/13/06 from 4:45 PM to 7:45 PM (a period of 3 hours) the resident was observed sitting in a Broda chair without having been checked for incontinence. This time frame was also verified in an interview with the Human Service Technician (HST) on 11/13/06 at 7:50 PM. The care plan dated 11/9/06, indicated the resident as being incontinent of bowel and bladder with the approach being; "check and change every 2 hours and as needed". The urinary assessment dated 3/9/06, was incomplete as it did not include a visualization of the peri/rectal area, previous interventions used to minimize urinary incontinence, a summary of the resident's voiding pattern, type of incontinence, medications, restraints, unrelieved pain and resident choice. In an interview with the unit nurse manager on 11/16/06 at 3:45 PM she confirmed the record lacked a comprehensive assessment of the resident's urinary incontinence. Resident #16 had a diagnoses which included dementia. The resident's quarterly Minimum Data Set (MDS) dated 9/15/06, identified the resident as being totally dependent upon staff for all cares which included multiple daily episodes of urinary incontinence. The resident's care plan dated 9/6/06 instructed staff to check and change incontinence brief every 2 hours. The urinary assessment dated 9/06/06, was incomplete as it did not include a visualization of the peri/rectal area or a summation of the	2 540		

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2 540	Continued From page 9 assessment which would provide any recommendations for minimizing the resident's incontinence. The facility failed to complete a comprehensive bowel and bladder assessment for resident #1 . Resident #1's most recent minimum data set (MDS) dated 11/03/06 indicated the resident was incontinent of bladder on a daily basis. Review of the resident's "Bowel and Bladder Assessment " dated 10/30/06 reveled that the facility failed to include a visual exam of the resident's perineal area, and did not include a comprehensive summary of the resident's urinary status or a plan to address the resident needs related to his urinary status. The facility failed to complete a comprehensive bowel and bladder assessment for resident #2 . Resident #2's most recent minimum data set (MDS) dated 11/03/06 indicated the resident was incontinent of bladder on a daily basis. Review of the resident's "urinary incontinence assessment" (form was not signed or dated) reveled the facility failed to identify the type of incontinence the resident was experiencing, did not include a visual exam of the resident's perineal area, and did not include a comprehensive summary of the resident's urinary status or a plan to address the resident needs related to his urinary status. Resident # 9 also lacked an individualized assessment of his voiding pattern that comprehensively integrated risks and causative factors, treatment approaches and how these factors or causes could be modified, stabilized or removed in order to accurately evaluate the appropriate time interval for providing assistance with the resident's toileting needs.	2 540		

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2 540	Continued From page 10 Resident # 7 also lacked an individualized assessment of his voiding pattern that comprehensively integrated risks and causative factors, treatment approaches and how these factors or causes could be modified, stabilized or removed in order to accurately evaluate the appropriate time interval for providing assistance with the resident's toileting needs. The facility failed to complete a comprehensive bladder assessment for resident #27, which was consistent with the care plan. Resident #27's bladder assessment dated 9/11/06, was inconsistent with the care plan, and failed to mention the resident's fluid intake pattern, as well as an examination of the perineum. According to the assessment the resident was identified as a good candidate for bladder retraining because the resident was able to sit on the toilet and had periods of continence. According to the assessment, the resident was aware of the urge to void. However, review of the care plan dated 3/14/06 stated,"..Does not have rehab potential regarding incontinence management." According to the care plan, "staff assist resident to toilet per his request. Staff check resident every 2 hours while awake and as needed. Staff assist with changing incontinent products. The facility failed to conduct complete bladder assessments for residents #13 and #15 were cognitively impaired, incontinent of bladder and were assessed for a toilet/check and change program of more than two hours and less than four hours. A review of the annual Minimum Data Set (MDS) dated 5/23/06 indicated that resident #15 was	2 540		

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2 540	Continued From page 11 totally incontinent of bowel and bladder and required total assist of one to use the bathroom. The Resident Assessment Protocol Summary (RAPS) dated 5/24/06 indicated, "He is incontinent of bowel and bladder and wears incontinence briefs. Toilet/change per schedule." The bladder assessment dated 11/16/06 indicated frequency of urination as every 2-4 hours. Although the facility completed a 3-day voiding pattern and concluded the resident had "functional incontinence" there was no assessment the causative factors, treatment approaches and how these factors or causes could be modified, stabilized or removed in order to accurately evaluate the appropriate time interval for providing assistance with the resident's toileting needs. A review of the annual Minimum Data Set (MDS) dated 4/13/06 indicated that resident #13 was totally incontinent of bowel and bladder and required total assist of one to use the bathroom. The Resident Assessment Protocol Summary (RAPS) dated 4/13/06 indicated, "He is incontinent of bladder and wears incontinence briefs. Change every 2 hours and as needed." The bladder assessment dated 2/2/06 indicated check and change program. The most current HST assignment sheet indicated, "Check and Change program - with toileting/changing greater then 2 hours and less than 4 hours." Although the facility completed a 3-day voiding pattern and concluded the resident had "functional incontinence" there was no assessment the causative factors, treatment approaches and how these factors or causes could be modified, stabilized or removed in order to accurately evaluate the appropriate time interval for providing assistance with the resident's toileting needs.	2 540		

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2 540	Continued From page 12 Resident #21 and #22 were incontinent and their comprehensive bowel and bladder assessment did not include visualization of the perineum to assess for abnormality leading to incontinence. Resident #21 had a bowel and bladder assessment dated 10/26/06 that did not include visualization of the perineal area. Resident #22 had a bowel and bladder assessment completed 9/13/06 that did not include visualization of the perineal area. Pressure Ulcer Assessments: Resident #17 did not a have a comprehensive skin assessment. Resident #17 had a diagnoses that included dementia and Parkinson's disease. The quarterly Minimum Data Set (MDS) dated 10/24/06 identified the resident as being totally dependent upon staff for all activities of daily living. The Resident's Assessment Protocol (RAP) dated 2/13/06 indicated the resident was at risk for skin breakdown due to incontinence and dependence in mobility. No further assessment was present in the RAP. Although, the care plan dated 11/9/06, directed the staff to reposition the resident every 2 hours the record lacked a comprehensive assessment for pressure ulcer risk factors which included pressure points, nutrition, hydration, skin assessment, mobility, tissue tolerance (the ability of the resident's skin to tolerate the effects of pressure over time without adverse effects) while lying and sitting, resident's behaviors, medications, pain and the resident's choice. In an interview with the unit nurse manager on	2 540		

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2 540	Continued From page 13 11/16/06 at 9:58 AM, she confirmed the facility had not comprehensively assessed the resident's skin. On 11/13/06 the resident was observed from 4:45 PM until 7:45 PM sitting in a Broda Chair (a type of wheel chair) and was not repositioned for a period of 3 hours. At 8:05 PM after the resident was placed into bed the nurse observed her buttocks and report that the skin was reddened and creased. She further stated that the resident buttocks had a slight slit in the skin near the coccyx. During toileting cares on 11/15/06 at 9:50 AM the resident's buttocks area was observed by a surveyor and at that time the pressure sore had further developed, measuring approximately 1.5 by .5 inches. Resident #10 had diagnoses that included dementia, bilateral knee replacement, and osteoarthritis. A quarterly Minimum Data Set (MDS), dated 10/31/06, identified the resident with moderate cognitive loss, dependent on staff for assistance for all activities of daily living (ADL), and incontinent of bowel all of the time. The resident had a supra pubic catheter placed on 10/12/06 for urinary retention. The Resident's Assessment Protocol Summary (RAPS), dated 8/9/06, indicated the resident was at risk for skin breakdown due to incontinence and dependencies. No further assessment was present in the RAPS. The resident's Braden Scale (tool for predicting risk for developing a pressure ulcer), dated 10/24/06, indicated the resident was chairfast with his ability to walk, severely limited and his skin was very moist at least once a shift. Even though the resident was chairfast the Braden was scored at 15-16 indicating the resident was at	2 540		

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2 540	Continued From page 14 low risk for developing a pressure ulcer. There was no analysis of the results from the Braden Scale and staff verified that no assessment had been completed of the length of time the resident's skin was able tolerate pressure without adverse effects. It was confirmed a comprehensive assessment had not been done. Although resident #10 was identified as at risk of skin breakdown, the facility failed to comprehensively assess the resident for risk factors which included pressure points, nutrition, hydration, skin assessment, mobility, tissue tolerance while lying and sitting, resident behaviors, incontinence (bowel), medications, pain, and resident's choice. During interview on 11/13/06, at 8:00 PM, the nurse manager said the resident should have been repositioned every two hours. She further said that the facility had not completed a tissue tolerance assessment for this resident and a comprehensive skin assessment was not available. The facility failed to complete a comprehensive skin assessment for resident #1. Resident #1's most recent minimum data set (MDS) dated 11/03/06 indicated the resident required extensive assistance of one person with bed mobility, and total assistance of two people to transfer between surfaces. The facility failed to assess the ability of the residents skin to tolerate the effects of pressure without adverse effects. They also failed to identify risk factors which placed the resident at risk for skin breakdown and failed to develop a comprehensive individualized plan to minimize the risk for skin breakdown. The facility failed to complete a comprehensive skin assessment for resident #2. Resident #2's	2 540		

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2 540	Continued From page 15 most recent minimum data set (MDS) dated 11/03/06 indicated the resident required limited assistance of one person with bed mobility, and extensive assistance of one person to transfer between surfaces. The facility failed to assess the ability of the resident's skin to tolerate the effects of pressure without adverse effects. They also failed to develop a comprehensive individualized plan to minimize the risk for skin breakdown. On 11/15/06 at approximately 10:30AM an interview with the 4th floor nurse manager indicated they planned to begin tissue tolerance assessments (ability of the skin to tolerate the effects of pressure without adverse effects) soon, but no residents on the 4th floor have had any tissue tolerance assessments yet. Resident #7 was identified at risk for pressure ulcers, but lacked an individualized plan of interventions developed from the comprehensive resident assessment to develop, review, and revise the resident's comprehensive plan of care in order to prevent the development of pressure ulcers. The resident was admitted in 5/06 with diagnoses that included diabetes mellitus and neuropathy, peripheral vascular disease and was currently being treated for open wounds on foot and incision site of a below the knee amputation. The significant change Minimum Data Set (MDS) dated 8/7/06 identified a moderate cognitive impairment, extensive assistance for transfers, total dependence for toilet use and hygiene and bowel and bladder incontinence. The facility used an assessment tool called a Braden Pressure Sore Risk Assessment (used for predicting pressure ulcer risk). This	2 540		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME MINNEAPOLIS	5101 MINNEHAHA AVENUE SOUTH MINNEAPOLIS, MN 55417

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
2 540	Continued From page 16 assessment dated 11/7/06 identified the resident with a score of 16, or at risk for developing a pressure ulcer. The Plan of Care dated 8/1/06 identified the the skin integrity problem area and directed interventions that included 2 hour repositioning, protective bed and wheelchair surfaces, and vascular clinic recommendations that included use of a wound vacuum pump. The unit nurse manager was interviewed on 11/15/06 at 10:20 AM and asked how the Comprehensive Skin Assessments were completed. She reported the facility had not been doing tissue tolerance assessments and the (Resident Assessment Protocol) RAP summary statements were done by the MDS nurse. The Skin Status Assessment data and Skin ADL Interventions were documented on a checklist format, but there was not a narrative summary review and analysis of the data gathered. Even though the care plan identified the resident at risk for skin integrity and completed a Skin Status Questionnaire, the facility failed to comprehensively assess the resident's risk for pressure ulcers. The assessment record lacked documentation that identified and integrated all pertinent risk factors and potential causes (that included pressure points,nutrition, hydration, skin assessment, mobility, sitting and lying tissue tolerances, resident behaviors, incontinence, medications, pain, and resident's choices) and how these factors or causes could be modified, stabilized or removed in relation to prevention of skin breakdown and individualized protocols to be implemented as related to pressure ulcer prevention. Resident #8 was identified at high risk for pressure ulcers, and lacked an individualized plan	2 540		

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2 540	Continued From page 17 of interventions developed from the comprehensive resident assessment to develop, review, and revise the resident's comprehensive plan of care in order to prevent the development of pressure ulcers. Even though the care plan identified the resident at risk for skin integrity and completed a Skin Status Questionnaire, the facility failed to comprehensively assess the resident's risk for pressure ulcers. The assessment record lacked documentation that identified and integrated all pertinent risk factors and potential causes (that included pressure points,nutrition, hydration, skin assessment, mobility, sitting and lying tissue tolerances, resident behaviors, incontinence, medications, pain, and resident's choices) and how these factors or causes could be modified, stabilized or removed in relation to prevention of skin breakdown and individualized protocols to be implemented as related to pressure ulcer prevention. Resident #9 was also identified at risk for pressure ulcers, and lacked an individualized plan of interventions developed from the comprehensive resident assessment to develop, review, and revise the resident's comprehensive plan of care in order to prevent the development of pressure ulcers. Even though the care plan identified the resident at risk for skin integrity and completed a Skin Status Questionnaire, the facility failed to comprehensively assess the resident's risk for pressure ulcers. The assessment record lacked documentation that identified and integrated all pertinent risk factors and potential causes (that included pressure points,nutrition, hydration, skin assessment, mobility, sitting and lying tissue	2 540		

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2 540	Continued From page 18 tolerances, resident behaviors, incontinence, medications, pain, and resident's choices) and how these factors or causes could be modified, stabilized or removed in relation to prevention of skin breakdown and individualized protocols to be implemented as related to pressure ulcer prevention. The facility failed to complete a comprehensive skin assessment related to pressure ulcer development for resident #27. A review of the client's record revealed a Braden scale (a tool that predicts pressure ulcer risk) was completed on 10/8/06. The Braden scale identified the resident at moderate risk for the development of pressure ulcers. However, the facility failed to identify other risk factors which placed the resident at risk such as; history of pressure ulcers, a review of medications and diagnoses (the resident had congested heart failure with lower extremity edema), cognitive impairment (the resident's cognitive status was described as "moderately impaired") and history of noncompliance or refusing cares. Furthermore, the facility failed to complete a comprehensive assessment of the resident's skin, including the ability of the skin to tolerate the effects of pressure without adverse affects (tissue tolerance). On 11/15/06 at 8:30 AM the nurse manager verified the Braden scale was used to assess pressure ulcer risk and said, "We don't do tissue tolerance." The facility failed to complete a comprehensive skin assessment for resident #28, which included risk factors not identified on the Braden scale, as well as the ability of the skin to tolerate the effects of pressure without adverse affects (tissue tolerance).	2 540		

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2 540	Continued From page 19 The assessment for resident #22 did not include a comprehensive assessment of the resident's skin condition including the ability of his skin to tolerate the effects of pressure without adverse effects (tissue tolerance). Observation on 11/15/06 at 6:40 AM of the skin for resident #22 revealed that the resident had a pressure sore on his right heel with eschar of .5x .5 cm. that was protected with a prafo boot. During an interview with the nurse manager 11/13/06 at 11:30 AM she stated the pressure ulcer developed in early October after the resident had fractured his hip and his mobility had declined. Review of the medical record revealed a skin status questionnaire dated 9/13/06 that the nurse manger identified as the facility's skin assessment. The assessment did not include an observation of the resident's skin after being in the same position to evaluate the effect of pressure. The assessment concluded that the resident should be repositioned every two hours. Interview with the nurse manager 11/16/06 at 8:30 AM verified that the facility was not including tissue tolerance as part of the skin assessment for resident's with limited mobility. Resident #20 was dependent on staff for mobility and repositioning and did not have a comprehensive assessment of the resident's skin condition including the ability of his skin to tolerate the effects of pressure without adverse effects (tissue tolerance). Resident #20 did not have any open areas on the skin at the time of the survey, the medical record contained a minimum data set (MDS) dated 9/1/06 that no pressure ulcers, and pressure relief devices for chair and a turning repositioning	2 540		

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2 540	Continued From page 20 program. The skin status questionnaire completed 11/15/06 did not include a tissue tolerance test. The nurse manager verified 11/16/06 at 8:30 AM at that the facility did not include tissue tolerance as part of the assessment of skin risk. SUGGESTED METHOD OF CORRECTION: The Director of Nurses could review and revise existing policies and procedures as necessary, provide an inservice for all appropriate personnel and establish a monitoring system to ensure resident needs are being met. TIME PERIOD FOR CORRECTION: Thirty-(30) days.	2 540		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Statute is not met as evidenced by: Based on observation, interview and record review the facility failed to develop a comprehensive care plan for 1 of 1 residents in the sample who received renal dialysis (#8) at an outside facility and 1 of 4 residents in the sample with a pressure ulcer, (#4). Findings include:	2 560		

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2 560	Continued From page 21 Resident # 8's comprehensive plan of care did not include necessary components that identified and addressed all care needs of a resident with renal disease who received dialysis. The resident was admitted in 2000 with diagnoses that included organic brain syndrome, uncontrolled diabetes mellitus type II, chronic renal failure, and osteoarthritis. The Quarterly Minimum Data Set (MDS) dated 9/30/05 and the Annual MDS dated 1/7/06 identified moderate cognitive impairment, edema, renal failure, special treatments for dialysis and monitoring acute medical condition. The current Plan of Care dated 9/21/06 identified on the Problem Statement only that the nurse manager spoke with the dialysis team related to cares he needed at dialysis. The Approaches on the Plan of Care included left wrist shunt, check each shift for bruit and thrill, dialysis was 3 days/week, and nursing removed the dialysis dressing the morning after the dialysis run. While there was evidence of some communication between the (End Stage Renal Dialysis) ESRD facility and the nursing facility, the Plan of Care lacked information in the following areas: potential for bleeding and an emergency plan; care of the shunt; potential for infection; labs ordered and clinical monitoring information and precautions; medication hold and coordination with ESRD; provisions for medications/meals that will be missed during dialysis. On 11/14/06 at 3:30 PM, the nurse manager was interviewed. She acknowledged that several items regarding dialysis coordination and care were not on the Plan of Care and they would be	2 560		

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2 560	Continued From page 22 working on adding the components. Resident #4 had a recurrent pressure sore on his left hip toward the buttock area. The area was observed by a surveyor during the survey as a basically healed stage II wound, and as of 11/14/06 was covered with a protective Tegaderm dressing. The resident was able to transfer himself to bed, and did so on 11/13/06 after supper. He remained in bed on his left side with the head of the bed raised when the surveyor left the floor at 9:15 PM. Staff was not observed to encourage the resident to reposition off his side. A registered nurse (RN) was interviewed on 11/15/06 at 8:45 AM. She said the resident was always leaning on his left side, and said his mental health issues got in the way of reasoning. She said he was nearly always on his left side and would not listen if staff encouraged him to turn. They tried rearranging his room and moving his television, but he " yelled and screamed. " She explained there was a pattern of opening, healing, and then reopening wounds to his left side. When asked when resident #4 would have his wound dressing changed, a nurse said she did not think the resident would cooperate, since he was anxious about leaving on an outing in the next hour. When asked if she would ask the resident, she said she had a good relationship with him, and likely could convince him to allow it. The resident agreed to have the dressing changed, which was then observed by a surveyor. The RN verified care plan interventions to manage the resident ' s non-compliance was	2 560		

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2 560	Continued From page 23 lacking on 11/16/06 at 10:30 AM. In addition, documentation that the risks of not repositioning were explained to the resident was not found. Resident #4 ' s Braden Scale for predicting pressure sores dated 9/18/06 revealed he was at moderate risk for skin breakdown. His care plan 9/18/06 indicated he was to have his skin inspected during weekly skin checks. It was noted he had a stage II pressure ulcer that recurrently opened and healed. His care plan lacked interventions aside from pressure relieving devices and encouraging good intake. SUGGESTED METHOD OF CORRECTION: The Director of Nurses could review and revise existing policies and procedures as necessary, provide an inservice for all appropriate personnel and establish a monitoring system to ensure resident needs are being met. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 560		
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 Statute is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure the comprehensive plan of care was being carried out for 5 of 32 residents in the sample (# 5, 12, 9, 16, 41) Findings include:	2 565		

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2 565	Continued From page 24 Resident #5 was not toileted or repositioned every two hours in accordance with his care plan. Observations of resident #5 began on 11/13/06 at 4:50 PM. A Human Services Technician (HST) emerged from the resident ' s room at that time with a bag of garbage. At 5:35 PM the resident was transported to the dining room for supper. At 7:07 PM resident #5 was returned to his room, where he remained the rest of the evening. At 8:15 PM, the HST brought linen into the resident ' s room. At 8:42 PM, the surveyor intervened regarding resident #5. The HST said he needed to assist another staff person, and would then assist resident #5. He looked at his watch and said, " Yeah, it ' s probably time. " At 8:50 PM, the HST went to assist resident #5 to bed. At 9:00 PM, the resident was taken to the bathroom (4 hours, 10 minutes later). Although his incontinent pad was dry, the resident began voiding prior to being seated on the toilet. When asked how often the resident should have been toileted and repositioned the HST said, " Every couple hours. " . When asked the circumstances that evening related to resident #5, he did not comment. The morning of 11/15/06 at 10:55 AM, resident #5 was observed in his room with one clothing protector around his neck and the other on his lap. The HST responsible for the resident was assisting another resident with a bath. She confirmed the resident had not been cared for since before breakfast when another HST got him up, a minimum of three hours earlier. She assisted the resident to the toilet. He was not successful in voiding in the toilet, and the HST confirmed he probably voided once in the incontinent brief.	2 565		

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2 565	Continued From page 25 Resident #5 ' s care plan identified him as at risk for falls, and staff was to utilize a chair alarm. The Minimum Data Set (MDS) assessment of 8/25/06 indicated the resident had fallen in the previous 31-180 days. During observations the evening of 11/13/06 and the mornings of 11/14/06 and 11/15/06, the chair alarm was not used. A registered nurse (RN) verified on 11/16/06 at 2:40 PM that the chair alarm should have been utilized. During three meal observations, resident #5 was not provided meal assistance in accordance with his care plan, as delineated by the speech language pathologist (SLP). Resident #5 ' s swallowing evaluation 11/15/05 indicated he was " Difficult to feed due to advanced dementia. His care plan 3/21/06 indicated he was at risk for swallowing problems. Staff was to give reminders to chew and/or swallow. Sips of liquid were to be given between bites. Each bite was to be chewed and swallowed before offering the next bite. If the resident refused food on a utensil, he was to be offered small chunks of food with a gloved hand when the resident readily opened his mouth. The swallowing guide by the SLP dated 7/26/06 directed staff to watch for holding of liquids in his mouth. Staff was use a plastic coated spoon to protect the resident ' s teeth or offer solids in small chunks by hand. During the meal observation at supper on 11/13/06 the staff person used a regular spoon (versus plastic coated) or a gloved hand to feed the resident. The staff also did not provide sips of liquid between bites. The HST gave approximately three bites of food, followed by liquids. Resident #5 coughed at times during the	2 565		

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2 565	Continued From page 26 meal. During meal observations on 11/14/06 at 8:17 AM, resident #5 was fed using a gloved hand. The HST but did not give the resident liquids between bites. The HST tried to feed the resident a banana and a donut. The resident frequently resisted by pursing his lips or moving his head away. The resident appeared to be holding liquid in his mouth, and the HST encouraged him to swallow. The HST then said he was going to try using a spoon. He returned with a regular spoon (versus plastic coated). He placed the spoon inside the resident ' s mouth and removed food that was pocketed. Few liquids were provided throughout the meal and the resident ate poorly. Attempts were made to give more food, although the resident continued chewing, and some coughing was again noted. A registered nurse (RN) was interviewed on 11/15/06 at 9:15 AM. She said the resident ' s dementia had progressed, and he likely had forgotten to swallow. She said sometimes the resident chewed and chewed a bite of food. Because he was biting on the spoon, the plastic coated spoon was to be used. Resident #12 did not have his right leg elevated or his urinal emptied as directed in his care plan dated 9/29/06. Resident #12 had diagnoses that included chronic venous insufficiency with stasis ulcers, and a left below the knee amputation. An annual Minimum Data Set (MDS), dated 9/29/06, identified the resident as having modified independence with daily decision making. The Resident Assessment Protocol Summary (RAPS), dated 9/29/06, indicated that the resident	2 565		

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2 565	Continued From page 27 was seen at the vascular clinic on 9/14/06, and the physician recommended left leg elevation. The RAPS also said the resident was seen by occupational therapy (OT), on 9/15/06, and therapy "provided him with an articulating leg rest for his electric wheel chair, which the resident was receptive to using, and said the resident was able to tolerate leg elevation to a 45 degree angle." On 9/14/06, at 9:00 AM, a physician order indicated, "Resident to have right elevating leg rest on power wheel chair raised to the highest level that he tolerates. The care plan dated 9/29/06, directed staff to elevate the right leg rest on the resident's wheel chair as high as the resident tolerates. During observations on 11/13/06, at 4:40 PM, the resident was seated in his wheel chair and his right leg and was hanging down at a 90 degree angle with the foot resting on the foot rest. Again at 5:00 PM, the residents right leg was hanging down with his foot resting on the pedal. His right knee was swollen. At 6:50 PM, he was wheeling himself down the hall and his right leg was hanging down with his right foot on the pedal of the wheel chair. Again at 8:00 PM, the resident continued to sit in his wheel chair without his right leg elevated. On 11/16/06, at 2:00 PM, during interview a nurse manager verified that the resident had not been advised of the risks of not elevating his right leg when sitting in his wheel chair. The nurse manager said that the physician had not been notified that the resident was not elevating his right leg as ordered. Resident #12's care plan directed staff to "check and empty his urinal every two hours." The resident was observed on 11/13/06, at 5:00 PM	2 565		

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2 565	Continued From page 28 and a urinal containing approximately 200 cubic centimeters (cc's) of urine was hanging on the end of his bed. The urinal containing the urine was left hanging on the end of the residents bed and had not been emptied at 8:00 PM. On 11/14/06,at 9:35 AM, the urinal was again observed filled with approximately 100 cc's of urine hanging on the end of the resident's bed. At 12:00 PM the urinal containing urine had not been emptied. During interview on 11/14/06, at 10:00 AM, the resident said, "Sometimes it's quite a while before the urinal is emptied, that's why they gave me two, so I can use the second one if the first one is full. They should empty it." On 11/15/06, at 8:50 AM, a human resource technician (HST) said the resident requested two urinals, "We empty it if we see it, it should be put in his record so we are reminded to empty it". On 11/15/06, at 1:40 PM, a nurse said maybe some staff do not empty his urinal, I noticed a few times it wasn't emptied."It should be emptied every two hours." Resident # 9 did not receive necessary care and supervision to prevent falls as identified in the comprehensive resident assessment. He was left unattended in his room with his personal wheelchair alarm not functioning and was observed standing and attempting to transfer without supervision. The resident was admitted to the facility in 8/01 with diagnoses that included dementia, Alzheimer's Disease, paralysis agitans, and hearing loss. The Significant Change of Status Minimum Data Set (MDS) dated 6/8/06 identified moderately impaired cognitive ability, total	2 565		

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2 565	Continued From page 29 dependence on two assistants for transfers, loss of balance standing and a history of falls. He had 13 incidents of falls to date in 2006. Physician's orders dated from 6/6/06 directed the use of a wheelchair alarm to help prevent falls by alerting staff when resident is at risk of falls. The current Plan of Care dated 9/18/06 and Human Services Technician (HST)Worksheet directed use of a wheelchair Sensicare alarm and transfers with assistance of 1-2 with a transfer belt. During evening observations on 11/13/06 at 6:35 PM, the resident was observed standing at his bedside holding on to the bed rails with the alarm not sounding. No staff was in the immediate area. A staff HST was located and he was informed of the resident's standing attempt. At 6:40 PM the HST entered the room and found the resident partially sitting on the edge of the chair, and was nearly slid out on to the floor. The HST reached behind the resident, holding under his arms and slid the resident back. The HST was asked if the alarm was working, and he reached down and turned the unit to the On position; it was set to Off during the resident's attempted standing. He stated " it was supposed to be turned On." The HST asked the resident if he would like his shoes on and stated, "I'll put your shoes on so you would have better footing." He put the resident's shoes on, and the resident remained seated in his room for the next 1 hour and 5 minutes without any activity or contact by staff. Resident # 16 had diagnoses which included dementia and depression. The care plan last updated 9/6/06 indicated the resident was resistive with cares at times, and had a behavior of "digging at fecal material and smears it". The	2 565		

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2 565	Continued From page 30 care plan specified the resident was dependent upon staff for all grooming/hygiene needs and instructed the staff to "wash hands (residents) often". On 11/15/06 at 10:53 AM the surveyor entered into resident room. A Human Service Technician (HST) indicated she was just leaving the room as she was finished providing personal cares to the resident. During the interview with the resident at that time, the resident's fingernails were observed to have a dark brown substance coating the cuticles and embedded under the nails. At 11:00 AM the surveyor asked the RN unit manager to view the resident's dirty fingernails. She agreed the nails should have been cleaned but offer the explanation that the resident does become resistive at times. Resident #41 had a diagnoses which included dementia. A significant change MDS dated 10/24/06 identified the resident as needing assistance of staff for personal hygiene, bathing and dressing. The care plan last updated 11/03/06 indicated the resident "needs assist of one staff daily to complete grooming/hygiene needs". During observations of the resident at the evening meal on 11/13/06 at 5:25 PM, he was noted to have a dark brown substance embedded under all of his fingernails. In another interview with the resident on 11/15/06 at 2:45 PM he was again noted to have a dark brown substance under his fingernails. In an interview with the unit nurse manager on 11/16/06 at 10:30 AM she confirmed that	2 565		

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2 565	Continued From page 31 personal hygiene included fingernail care and that the resident's nails should have been cleaned. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) could review and revise existing policies and procedures, inservice all appropriate personnel and establish a monitoring system to ensure compliance. TIME PERIOD FOR CORRECTION: Thirty -(30) days	2 565		
2 860	MN Rule 4658.0520 Subp. 2 F. Adequate and Proper Nursing Care; Hands-Feet Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: E. per care and attention to hands and feet. Fingernails and toenails must be kept clean and trimmed. This MN Statute is not met as evidenced by: Based on observation, interview and record review the facility failed to assist 1 randomly observed resident with fingernail care.(#16). Findings include: Resident # 16 had diagnoses which included dementia and depression. The quarterly Minimum Data Set (MDS) dated 9/15/06 identified the resident as being dependent upon staff for all activities of daily living and was incontinent of both bowel and bladder. The care plan last updated 9/6/06 indicated the resident was resistive with cares at times, and had a behavior of "digging at fecal material and smears it". In addition, the care plan specified the resident was	2 860		

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2 860	Continued From page 32 dependent upon staff for all grooming/hygiene needs and instructed the staff to "wash hands (residents) often". On 11/15/06 at 10:53 AM the surveyor entered into resident room. A Human Service Technician (HST) indicated she was just leaving the room as she was finished providing personal cares to the resident. During the interview with the resident at that time, the resident's fingernails were observed to have a dark brown substance coating the cuticles and embedded under the nails. At 11:00 AM the surveyor asked the RN unit manager to view the resident's dirty fingernails. She agreed the nails should have been cleaned but offer the explanation that the resident does become resistive at times. Resident #41 had a diagnoses which included dementia. A significant change MDS dated 10/24/06 identified the resident as needing assistance of staff for personal hygiene, bathing and dressing. The care plan last updated 11/03/06 indicated the resident "needs assist of one staff daily to complete grooming/hygiene needs". During observations of the resident at the evening meal on 11/13/06 at 5:25 PM, he was noted to have a dark brown substance embedded under all of his fingernails. In another interview with the resident on 11/15/06 at 2:45 PM he was again noted to have a dark brown substance under his fingernails. In an interview with the unit nurse manager on 11/16/06 at 10:30 AM she confirmed that	2 860		

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2 860	Continued From page 33 personal hygiene included fingernail care and that the resident's nails should have been cleaned. SUGGESTED METHOD OF CORRECTION: The Director of Nurses could review and revise existing policies and procedures as necessary, provide an inservice for all appropriate personnel and establish a monitoring system to ensure resident needs are being met. TIME PERIOD FOR CORRECTION: Seven (7) days.	2 860		
2 870	MN Rule 4658.0520 Subp. 2 H. Adequate & Proper Nursing Care-CleanClothing Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: H. Clean clothing and a neat appearance. Residents must be dressed during the day whenever possible. This MN Statute is not met as evidenced by: Based on observation, and interview, the faciltiy failed to have a routine for cleaning shoes for residents #13, #15, #44, and #45 who reside on the 3rd floor in Building 6. Findings include: During the entrance tour on 11/13/06 at approximately 11:15 AM of the 3rd floor in Building 6, resident #13 was observed to be wearing a pair of black shoes with multiple white colored splatters on the top and outside of the shoes and a thick layer of food debris on the soles of the shoes. During random observations on the 3rd floor of Building 6 on 11/16/06 at approximately 10:00 AM resident #15, 44	2 870		

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2 870	Continued From page 34 and#45's shoes were noted to have white splatters on the tops and sides of their dark colored shoes. During observations of morning cares on 11/14/06 at approximately 7:50 AM the human service technician (HST) was observed getting resident #13 up and dressed and the resident's shoes still had multiple white splatters on the top and sides along with the thick layer of food debris on the soles of the shoes. An interview with the HST at the time revealed that the shoes were filthy and when the HST attempted to cleanse the bottom of the shoes with a washcloth the HST stated, "Ooh, I don't know if I can get that off . Whatever it is it doesn't smell vey good. It's not coming off." An interview with the nurse manager (NM) on 11/15/06 at 10:30 AM revealed that there was no routine for checking the condition of shoes on the unit or cleaning schedule. SUGGESTED METHOD OF CORRECTION: The Director of Nurses could review and revise existing policies and procedures as necessary, provide an inservice for all appropriate personnel and establish a monitoring system to ensure resident needs are being met. TIME PERIOD FOR CORRECTION: Seven (7) days.	2 870		
2 890	MN Rule 4658.0525 Subp. 2 A Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the	2 890		

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2 890	Continued From page 35 development of a nursing care plan which provides that: A. a resident who enters the nursing home without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and This MN Statute is not met as evidenced by: Based on interview and record review, the facility failed to assess, evaluate and implement interventions for 1 of 10 resident's in the sample with a decline in range of motion since admission, (#17) . Fndings include: Resident #17 had limitations in range of motion (ROM) to both arms and did not receive the necessary services to prevent further decline in range of motion. Resident # 17, had diagnoses which included Parkinson's disease and dementia . The resident 's annual Minimum Data Set (MDS) dated 2/13/06 and the quarterly MDS dated 7/28/06 both indicated there wasn't any limitation of ROM of the arms. The quarterly MDS dated 10/24/06, reflected a decline in the limitation of ROM in both arms. All 3 of the MDS's identified the resident was totally dependent upon staff for activities of daily living. During observations throughout the survey of 11/13 -11/16/06 the resident was observed to have held the left arm closely to the chest in a stationary position. In addition, during observations of evening cares on 11/13/06 at 7:45 PM the resident was resistant to having the	2 890		

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2 890	Continued From page 36 arms moved in order for the staff to complete personal cares. A physical therapy screen completed on 10/8/06 identified there was limitation of arms on both sides with a deficit listed in overall muscle tone and coordination. The care plan dated 11/09/06, did not identified any type of rehabilitation nursing program being provided. The current Human Service Technician (HST) worksheet listed that ROM would be provided with the act of getting the resident dressed and undressed, but it did not specify an individualized program for either passive or active ROM. In an interview with the unit manager on 11/16/06 at 10:20 AM she confirmed the resident did not received any ROM other than the functional ROM which was completed while resident was being dressed and undressed. SUGGESTED METHOD OF CORRECTION: The administrator in conjuntion with therapy and nursing staff could review and revise existing policies and procedures as necessary to ensure residents with limitations in range of motion are identified and received services necessary to improve or maintain the current level of funtioning. The administration could review staffing needs in the therpay and nursing department. The administrator or his designee could inservice staff as needed to ensure there is a system in place for identification, assessment and care plan interventions for residents with range of motion limitations and develop a system to monitor the implementation of the system..	2 890		

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2 890	Continued From page 37 TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 890		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Statute is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure that 5 out of 11 residents in the sample with limitations in range of motion (# 28, 27, 5, 21 & 8) received treatment and services to increase range of motion or prevent a further decrease in range of motion. Findings include: Resident #28 experienced a decline in ROM without an assessment, evaluation or interventions to minimize the decline. Resident #28 had diagnoses that included cerebrovascular disease (stroke), hemiplegia, and multiple sclerosis. Review of the comprehensive assessment dated 10/2/06, said the resident required total assistance with all activities of daily living, such as dressing,	2 895		

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2 895	Continued From page 38 grooming and bathing. The assessment stated, "Screened by PT on 9/25/06 and was noted to have a decreased ROM and voluntary movement of his neck, upper and lower extremities." The physical therapy screen for 6/29/06 and 9/25/06 revealed the following; 6/29/06: Neck, no limitation. Hand, including wrist or fingers, limitation on one side. Leg, including hip or knee, partial loss. Foot, including ankle or toes, partial loss. 9/25/06: Neck, limitation on both sides. Hand, including wrist or fingers, limitation both sides. Leg, including hip or knees, full loss. Foot, including ankle or toes, full loss. Review of the care plan dated 10/2/06 revealed a lack of ROM interventions. On 11/15/06 at 10 AM the nurse manager reported that no one residing on the 2N unit received ROM exercises. According to the nurse manager, ROM was provided when residents were assisted with dressing. The nurse manager agreed that if a decline in ROM was noted with an intervention of daily dressing, more aggressive therapy may be indicated. Resident #27 experienced a decline in ROM without an assessment, evaluation or interventions. Resident #27 had diagnoses that included arthritis,osteoporosis, and a 4 month hospitalization from May until September related to osteomyelitis (bone infection). According to the comprehensive assessment dated 10/13/06 the resident required total assistance with all activities of daily living. According to the assessment, "...it was noted he has marked	2 895		

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2 895	Continued From page 39 bilateral flexion contractures of his hips, hamstrings and ankles. Refer to PT screen completed 10/4/06. He was evaluated by orthopedics and they felt there was no good surgical options for correction at this time..." The physical therapy screen for 3/3/06 and 10/4/06 was reviewed as follows; 3/3/06: Leg, including hip or knee, partial loss. Foot, including ankle or toes, partial loss. 10/4/06: Leg, including hip or knee, full loss. Foot, including ankle or toes, full loss. Review of the care plan dated 10/13/06, revealed a lack of ROM interventions. During observations while the resident was in bed on 11/13/06 at approximately 7:70 AM, and the morning of 11/14/06, the resident's legs were observed to be in a flexed position. On 11/16/06 at 11:30 AM the director of physical therapy said the physical therapist's started completing ROM screens approximately a year ago for the MDS (minimum data set). According to the director of physical therapy, the screens were not evaluations, and that it was nursing's responsibility to initiate treatment, or refer if a decline was noted. The director of physical therapy said the facility did not have a strong restorative program. Resident #5 had documented deficits in range of motion (ROM), however, there wasn ' t a plan in place to improve ROM or prevent further decline. Resident #5 ' s physical therapy screening performed by a physical therapist at the time of the Minimum Data Set assessments indicated a decline in ROM. The assessment for the 3/14/06	2 895		

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2 895	Continued From page 40	2 895		

assessment showed partial loss limitation on one side of his neck, full loss limitations on one side for his arm, and partial loss limitations on both sides for his hand, leg, foot, and other. The subsequent assessment for the 8/25/06 assessment revealed partial loss limitations on both sides in all areas.

A registered nurse (RN) was interviewed on 11/15/06 at 9:15 AM. She said the Human Service Technicians (HSTs) could perform ROM on residents if they were trained, however, she did not believe they had such training. She said they did not want the residents injured should ROM be performed improperly. When asked whether nursing staff were performing ROM for residents, she said, " Very seldom. "

Evening cares were observed for resident #5 on 11/13/06 at 9:00 PM. Although the resident stood and had his arms lifted during a standing lift transfer, purposeful ROM services were not provided during the cares.

Two physical therapists (PT) were interviewed on 11/16/06 at 10:30 AM. The PT staff said there were four different staff persons assessing almost 400 residents quarterly. There could be variables in how they were scored, as the same therapist did not necessarily assess the same person each quarter. By doing so, they agreed one of the variables could be omitted. The physical therapist who discharged the resident from PT on 7/12/06 said he had not assessed the resident, however, from the description of the performance of care; it did not sound as if the resident actually experienced a decline in his ROM. At the time of his discharge, the resident was walking and had no contractures requiring stretch. At the time the therapist noted the

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2 895	Continued From page 41 resident had slightly declined.. Resident #21 had a limitation in her neck mobility and was not receiving appropriate services to prevent a further decrease in her neck range of motion (ROM). Resident # 21 was admitted to the facility December 2004 from another nursing facility, the physical therapy assessment dated 12/20/04 notes a partial limit of the neck ROM with hard rigidity. It is noted that the neck rigidity did not meet MDS criteria. The physical therapy screen completed 10/27/06 noted a neck limitation on one side with a partial loss, the deficit was noted to affect the residents overall muscle tone and coordination. Review of the medical record revealed a progress note (dated 4/13/06) in which the nurse practitioner diagnosed the resident to have torticollis, unspecified cause. The DISCUS screen completed 8/9/05 and 8/28/06 by nursing and co-signed by the nurse practitioner, both scored the screen for torticollis as not present. The current care plan (undated) and last reviewed with annual MDS date 10/27/06 did not direct staff to provide range of motion for the resident's neck. The nurse practitioner progress notes reflected on 11/03/05 the resident held her head to the right. A progress note dated 4/13/06 noted the resident had reduced flexion to the right and a new diagnosis of Torticollis (unspecified type) with a plan: "patient leans head to the left and neck is contracted. Husband says patient started posturing with lean more than 18 months ago." During a phone interview with the nurse practitioner 11/15/06 at 1 PM she stated the neck torticollis was not caused by a medication side	2 895		

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2 895	Continued From page 42 effect and is an unavoidable decline due to dementia and her posture. An interview with the nurse on the unit 11/13/06 at 7:30 PM revealed that the resident's neck positioning is worse since admission. Interview with the nurse manager on 11/16/06 at 9 AM revealed the resident has had a neck contracture since her admission and it "seemed about the same". She verified the resident did not receive regular range of motion to her neck or postioning to prevent further contracture to the neck. The resident was noted to have seven falls in the past three months, during an interview with the physical therapist 11/14/06 at 9:40 AM, she stated that a resident should be referred to therapy for assessment for falling, she stated that this resident had not been referred for assessment. After the surveyor's inquiries an assessment was done by physical therapy 11/15/06, and rated the cervical PROM(range of motion): left rotation 50% of normal, right side bending 50% of normal. The recommendations were to use a cervical wedge to hold head at midline and one pillow when lying supine, and 2 pillows when lying on the side. Also to encourage the resident to lie on bed when fatigued and allow cervical muscles to rest. These recommendations were added to the care plan by the nurse manager on 11/16/06. Neuroleptic medication side effects: Resident #8, a resident with a limited range of motion, did not receive appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion; in addition, the facility lacked a system to consistently assess performance of Nursing	2 895		

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2 895	Continued From page 43 Rehabilitation activity, and the provision of individualized services with adequate supervision to maintain function. The resident was admitted in 1/2000 with diagnoses that included organic brain syndrome, depressive disorder, and osteoarthritis. The Quarterly Minimum Data Set (MDS) dated 9/30/05 and the Annual MDS dated 1/7/06 identified limitations in range of motion on both sides for arms and legs and also identified a partial loss of voluntary movement in these areas. Quarterly Range of Motion Data Collection performed by nursing on Form M02-288C also identified these range of motion restrictions on 1/30/05, 4/20/05, 10/8/05, 1/4/06, 4/4/06, 6/27/06 and 9/20/06. The current Plan of Care dated 9/21/06, however, did not identify any problem area related to loss of range of motion, nor did it direct any approaches by nursing staff to maintain or improve this function. The current Human Services Technician (HST) Worksheet dated 11/9/06 did not identify any maintenance or restorative Rehabilitative Nursing approaches for range of motion. During meal observations on 11/13/06 from 5:00PM until 6:10 PM, the resident was observed during attempts to feed himself. He was unable to raise his left upper extremity to reach food items or utensils, and demonstrated pain behaviors and grimacing when using his left upper extremity. The HST Worksheet identified the resident as one that must be fed, and current Plan of Care identified partial to total assistance for feeding. On 11/14/06 at 8:20 PM, the resident was asked by staff to raise his left arm and place his hand to his head; he was unable to perform the movement and could only raise the arm slightly	2 895		

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2 895	Continued From page 44 off the armrest of the chair. On 11/14/06 at 3:30 PM, unit nursing staff was interviewed. They reported the resident was not on a range of motion program and they "should be getting therapy involved." They added "he goes to the fitness gym and imagine he is getting some range there. Range of motion wasn't passed on to us." On 11/15/06 at 9:30 AM, the fitness gym personnel and Physical Therapy staff were interviewed. They reported "It's been many months since we saw him, he should have been discontinued." They reported there was no restorative nursing program for range of motion, and it should be done during dressing and other activities of daily living (ADLs). One Physical Therapist reported they had done a care plan review on the resident on 10/10/06 and did not recommend range of motion and added "how they integrate range of motion into cares I'm not sure." One Physical Therapist (RPT) reported nursing has no formal range of motion program but should do it with ADLs and they (nursing) did not document the task completion, but only verbally reported it had been done. The RPT reported when they get a referral on a resident they are unable to determine if the decline was from not getting range of motion activity or it was from a disease process. The Physical Therapy director reported the nursing staff does get initial training and periodic updates on range of motion procedures. Facility Nursing policies and procedures dated 6/90 for range of motion did not identify range of motion in conjunction with activities of daily living, but rather identified traditional range of motion	2 895		

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2 895	Continued From page 45 exercises that were to be done repetitively, and slowly. In addition, these nursing treatments were to be documented on the care plan and daily care records. SUGGESTED METHOD OF CORRECTION: The administrator in conjunction with therapy and nursing staff could review and revise existing policies and procedures as necessary to ensure residents with limitations in range of motion are identified and received services necessary to improve functioning and prevent further declines. The administration could review staffing needs in the therapy and nursing department. The administrator or his designee could inservice staff as needed to ensure there is a system in place for identification, assessment and care plan interventions for residents with range of motion limitations and develop a system to monitor the implementation of the system.. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 895		
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	2 900		

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2 900	Continued From page 46 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 Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure 9 of 9 residents in the sample with or at risk of developing pressure ulcers (#17, #27, 10, 9, 8, 1, 2, 7, & 4) received interventions necesssary to prevent pressure ulcers, promote healing and prevent further pressure ulcer development. Findings include: Resident #17 who the facility had identified at risk for pressure ulcers did not have a comprehensive skin assessment and developed an open area after not being repositioned off the buttocks for a period of 3 hours on 11/13/06. Resident #17 had a diagnoses that included dementia and Parkinson disease. The quarterly Minimum Data Set (MDS) dated 10/24/06 identified the resident as being totally dependent upon staff for all activities of daily living. The Resident's Assessment Protocol (RAP) dated 2/13/06 indicated the resident was at risk for skin breakdown due to incontinence and dependence in mobility. No further assessment was present in the RAP. Although, the care plan dated 11/9/06, directed the staff to reposition the resident every 2 hours the record lacked a comprehensive assessment for pressure ulcer risk factors which included pressure points, nutrition, hydration, skin assessment, mobility, tissue tolerance (the ability of the resident's skin to tolerate the effects of	2 900		

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2 900	Continued From page 47 pressure over time without adverse effects) while lying and sitting, resident's behaviors, medications, pain and resident's choice. In an interview with the unit nurse manager on 11/16/06 at 9:58 AM, she confirmed the facility had not comprehensively assessed the pressure ulcer. On 11/13/06 the resident was observed from 4:45 PM until 7:45 PM sitting in a Broda Chair (a type of wheel chair) and was not repositioned for a period of 3 hours. At 8:05 PM after the resident was placed into bed the nurse observed her buttocks and reported that the skin was reddened and creased. She further stated that the resident's buttocks had only a slight slit in the skin near the coccyx. During toileting cares on 11/15/06 at 9:50 AM the resident's buttocks area was observed by a surveyor and at that time the pressure sore had increased in size, measuring approximately 1.5 by .5 inches. The care plan dated 11/9/06, directed the staff to reposition the resident every 2 hours. Resident #27 lacked a comprehensive skin assessment, and lacked interventions to promote healing of an existing pressure ulcer, and prevent further pressure ulcer development. Resident #27 had diagnoses that included a stage 2 pressure ulcer (a partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crator) on the left foot, history of MRSA (methicillin resistant staphylococcus aureus) in the wound, and osteomyelitis (bone infection).	2 900		

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2 900	Continued From page 48 The facility failed to complete a comprehensive skin assessment related to pressure ulcer development. A review of the client's record revealed a Braden scale (a tool that predicts pressure ulcer risk) was completed on 10/8/06. The Braden scale identified the resident at moderate risk for the development of pressure ulcers. However, the facility failed to identify other risk factors which placed the resident at risk such as; history of pressure ulcers, a review of medications and diagnoses (the resident had congested heart failure with lower extremity edema), cognitive impairment (the resident's cognitive status was described as "moderately impaired") and history of noncompliance or refusing cares. Furthermore, the facility failed to complete a comprehensive assessment of the resident's skin, including the ability of the skin to tolerate the effects of pressure without adverse affects (tissue tolerance). On 11/15/06 at 8:30 AM the nurse manager verified the Braden scale was used to assess pressure ulcer risk and, "We don't do tissue tolerance." The facility failed to ensure interventions were implemented to promote healing of the pressure ulcer on the left foot. Review of the resident's care plan dated 10/13/06 stated, "Rook boots on in the morning, Prafo boots (boots for pressure relief) on at bedtime. Use ace wraps daily to the LE until the ulcer is healed." During observations on 11/13/06 at 7:50 PM, the resident was assisted to bed. The HST (human service technician) removed the "Rook boots" (a	2 900		

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2 900	Continued From page 49 type of boot lined with a soft material, similar to lambs wool) which were on both lower extremities. According to the HST, the boots were on at all times. The resident's left foot was observed to be wrapped with Kerlix. After the resident was assisted with bedtime cares, the Rook boots were reapplied. During observation on 11/14/06 at approximately 7:50 AM, the resident was assisted with morning cares. The Rook boot's were in place on the lower extremities, removed for cares and reapplied. On 11/15/06 at approximately 10 AM the nurse manager and surveyor verified with the HST that the Prafo boots were not applied the evening of 11/13/06. According to the nurse manager the Rook boots were, "soft boots without pressure relief." The nurse manager and charge nurse said the ace wraps were on hold because of the pressure ulcer, however record review and verification with the nurse practitioner stated they should be on daily and off at bedtime. The documentation on the treatment record for November indicated the ace wraps had not been applied the entire month. The facility failed to ensure interventions were implemented to prevent further pressure ulcer development. During observations on 11/13/06 the resident was observed from 4:45 PM until 7:50 PM (3 hours, 5 minutes) without being repositioned. At 7:30 PM the HST was questioned when the resident was last repositioned and said, "He doesn't like to be moved. We try to avoid it as much as possible." Review of the care plan dated 10/13/06 directed staff to reposition every 2 hours.	2 900		

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2 900	Continued From page 50 During observations on 11/13/06 and 11/14/06 the resident was observed to have a pressure reduction cushion in the wheelchair. However, on 11/13/06 at 7:50 PM, the cushion was wrapped in an Allegra pad, and on the morning of 11/14/06, the cushion was wrapped in a towel. On 11/15/06 at 1:30 PM, the nurse manager verified the cushions should not have anything over them. Resident #10, who the facility had identified at risk for skin breakdown did not have a comprehensive skin assessment and was not provided assistance with repositioning while sitting in a wheel chair on 11/13/06 from 5:00 to 8:10 PM (a period of 3 hours and 10 minutes) . The care plan dated 9/12/06, directed staff to reposition the resident every 2 hours. Resident #10 had diagnoses that included dementia, bilateral knee replacement, and osteoarthritis. A quarterly Minimum Data Set (MDS), dated 10/31/06, identified the resident with moderate cognitive loss, dependent on staff for assistance for all activities of daily living (ADL), and incontinent of bowel all of the time. The resident had a supra pubic catheter placed on 10/12/06 for urinary retention. The Resident's Assessment Protocol Summary (RAPS), dated 8/9/06, indicated the resident was at risk for skin breakdown due to incontinence and dependencies. No further assessment was present in the RAPS. The resident's Braden Scale (tool for predicting risk for developing a pressure ulcer), dated 10/24/06, indicated the resident was chairfast with his ability to walk, severely limited and his skin was very moist at least once a shift. Even though the resident was chairfast the Braden was	2 900		

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2 900	Continued From page 51 scored at 15-16 indicating the resident was at low risk for developing a pressure ulcer. There was no analysis of the results from the Braden Scale and staff verified that no assessment had been completed of the length of time the resident's skin was able tolerate pressure without adverse effects. It was confirmed a comprehensive assessment had not been done. Although resident #10 was identified as at risk of skin breakdown, the facility failed to comprehensively assess the resident for risk factors which included pressure points, nutrition, hydration, skin assessment, mobility, tissue tolerance while lying and sitting, resident behaviors, incontinence (bowel), medications, pain, and resident's choice. During interview on 11/13/06, at 8:00 PM, the nurse manager said the resident should have been repositioned every two hours. She further said that the facility had not completed a tissue tolerance assessment for this resident and a comprehensive skin assessment was not available On 11/13/06, the resident was observed from 5:00 PM until 8:10 PM sitting in a wheel chair and was not repositioned for a period of 3 hours and 10 minutes. At 5:15 PM the resident was wheeled into the dining room where he remained until 6:05 PM. At 6:10 PM a human service technician (HST), wheeled the resident out of the dining room, and left the resident sitting in his wheel chair in the hall. He remained seated in the hall in his wheel chair with his eyes closed until 7:45 PM, when the nurse manager gave the resident a glass of juice. At 8:00 PM, when the surveyor intervened the nurse manager said the HST was on break, and the resident should have been repositioned. At 8:10 PM, 2 HST's transferred the resident from his wheel chair	2 900		

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2 900	Continued From page 52 using a transfer belt. When the incontinence brief was removed the residents buttocks were reddened and creased. When the HST provided peri care the resident had soft stool smearing the brief and wash cloth. On 11/13/06, at 8:05 PM, the HST said the resident had been up since 4:55 PM (not repositioned for a period of 3 hours and 15 minutes), and she said she didn't have time to reposition the resident. During interview on 11/13/06, at 8:00 PM, the nurse manager said the resident should have been repositioned every two hours. Resident #9, who was identified at high risk of development of pressure ulcers by the comprehensive assessment, was not provided with timely changes of position for a period of three hours and 15 minutes during the evening of 11/13/06. The resident was admitted to the facility in 8/01 with diagnoses that included dementia, Alzheimer's Disease, and paralysis agitans. The Significant Change of Status Minimum Data Set (MDS) dated 6/8/06 identified moderately impaired cognitive ability, total dependence on two assistants for transfers, loss of balance while standing and use of pressure relieving devices for chair and bed. The Braden Scale assessment for predicting pressure sore risk was scored at a 22 (not at risk) on 3/29/06; however, the score decreased to 10 on 6/27/06 and placed him at high risk for pressure ulcer development. The resident's Plan of Care dated 9/18/06 directed the resident be repositioned every two hours as did the HST Worksheet dated 11/9/06. Resident #9 was also identified at risk for	2 900		

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2 900	Continued From page 53 pressure ulcers, and lacked an individualized plan of interventions developed from the comprehensive resident assessment to develop, review, and revise the resident's comprehensive plan of care in order to prevent the development of pressure ulcers. Even though the care plan identified the resident at risk for skin integrity and completed a Skin Status Questionnaire, the facility failed to comprehensively assess the resident's risk for pressure ulcers. The assessment record lacked documentation that identified and integrated all pertinent risk factors and potential causes (that included pressure points,nutrition, hydration, skin assessment, mobility, sitting and lying tissue tolerances, resident behaviors, incontinence, medications, pain, and resident's choices) and how these factors or causes could be modified, stabilized or removed in relation to prevention of skin breakdown and individualized protocols to be implemented as related to pressure ulcer prevention. During the evening of 11/13/06 during observations of the resident from 4:45 PM until 8:00 PM the resident remained in his wheelchair and was not transferred out of the chair by staff until requested to do so at 8:00 PM. His skin was checked and he was transferred to the toilet. The skin was noted to be reddened and wrinkled, but no open areas were identified. The HST was interviewed and asked about the repositioning schedule for the resident. He reported the staff stands and repositions the resident when taken to the toilet every 2 to 4 hours. Resident #8 was identified at high risk for pressure ulcers, and lacked an individualized plan	2 900		

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2 900	Continued From page 54 of interventions developed from the comprehensive resident assessment to develop, review, and revise the resident's comprehensive plan of care in order to prevent the development of pressure ulcers. Even though the care plan identified the resident at risk for skin integrity and completed a Skin Status Questionnaire, the facility failed to comprehensively assess the resident's risk for pressure ulcers. The assessment record lacked documentation that identified and integrated all pertinent risk factors and potential causes (that included pressure points,nutrition, hydration, skin assessment, mobility, sitting and lying tissue tolerances, resident behaviors, incontinence, medications, pain, and resident's choices) and how these factors or causes could be modified, stabilized or removed in relation to prevention of skin breakdown and individualized protocols to be implemented as related to pressure ulcer prevention. Resident #8, who was identified at high risk of development of pressure ulcers by the comprehensive assessment, was not provided with timely changes of position for a period of two hours and 34 minutes during the evening of 11/13/06. The resident was admitted in 1/2000 with diagnoses that included organic brain syndrome, uncontrolled diabetes mellitus, and chronic renal failure with dialysis. The Annual Minimum Data Set (MDS) dated 1/7/06 identified moderate cognitive impairment, multiple daily episodes of bowel and bladder incontinence,total dependence for transfers, toileting and hygiene and history of a resolved Stage 2 pressure ulcer during the past 90 days.	2 900		

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2 900	Continued From page 55 The current Plan of Care dated 4/20/06 identified the history of a coccyx pressure ulcer and directed approaches that included repositioning every two hours per 1-2 staff. The Human Services Technician (HST) Worksheet dated 11/9/06 also directed staff to reposition the resident every two hours. On 11/13/06 at 4:40 PM, the HST staff was observed as they transferred the resident out of bed to the wheelchair for dinner. He remained in the wheelchair until 7:14 PM (2 hours and 34 minutes) at which time two HST's again transferred the resident back to bed for change of his brief and for sleep. His skin was observed to be red and wrinkled with creases on the buttocks and lower back. One of the HSTs was interviewed and asked about the resident's repositioning schedule. She stated they reposition the resident every two hours when in the chair or bed and the resident "had open spots but they are better now." She also reported they check and change resident every 2 to 4 hours. The facility failed to complete a comprehensive skin assessment for resident #1. Resident #1's most recent minimum data set (MDS) dated 11/03/06 indicated the resident required extensive assistance of one person with bed mobility, and total assistance of two people to transfer between surfaces. The facility failed to assess the ability of the resident's skin to tolerate the effects of pressure without adverse effects. They also failed to identify risk factors which placed the resident at risk for skin breakdown and failed to develop a comprehensive individualized plan to minimize the risk for skin breakdown.	2 900		

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	00233	A. BUILDING _____ B. WING _____	11/17/2006

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2 900	Continued From page 56 The facility failed to complete a comprehensive skin assessment for resident #2. Resident #2's most recent minimum data set (MDS) dated 11/03/06 indicated the resident required limited assistance of one person with bed mobility, and extensive assistance of one person to transfer between surfaces. The facility failed to assess the ability of the resident's skin to tolerate the effects of pressure without adverse effects. They also failed to develop a comprehensive individualized plan to minimize the risk for skin breakdown. On 11/15/06 at approximately 10:30AM an interview with the 4th floor nurse manager indicated they planned to begin tissue tolerance assessments (ability of the skin to tolerate the effects of pressure without adverse effects) soon, but no residents on the 4th floor have had any tissue tolerance assessments yet. Resident #7 was identified at risk for pressure ulcers, but lacked an individualized plan of interventions developed from the comprehensive resident assessment to develop, review, and revise the resident's comprehensive plan of care in order to prevent the development of pressure ulcers. The resident was admitted in 5/06 with diagnoses that included diabetes mellitus and neuropathy, peripheral vascular disease and was currently being treated for open wounds on foot and incision site of a below the knee amputation. The significant change Minimum Data Set (MDS) dated 8/7/06 identified a moderate cognitive impairment, extensive assistance for transfers, total dependence for toilet use and hygiene and bowel and bladder incontinence.	2 900		

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2 900	Continued From page 57 The facility used an assessment tool called a Braden Pressure Sore Risk Assessment (used for predicting pressure ulcer risk). This assessment dated 11/7/06 identified the resident with a score of 16, or at risk for developing a pressure ulcer. The Plan of Care dated 8/1/06 identified the the skin integrity problem area and directed interventions that included 2 hour repositioning, protective bed and wheelchair surfaces, and vascular clinic recommendations that included use of a wound vacuum pump. The unit nurse manager was interviewed on 11/15/06 at 10:20 AM and asked how the Comprehensive Skin Assessments were completed. She reported the facility had not been doing tissue tolerance assessments and the (Resident Assessment Protocol) RAP summary statements were done by the MDS nurse. The Skin Status Assessment data and Skin ADL Interventions were documented on a checklist format, but there was not a narrative summary review and analysis of the data gathered. Even though the care plan identified the resident at risk for skin integrity and completed a Skin Status Questionnaire, the facility failed to comprehensively assess the resident's risk for pressure ulcers. The assessment record lacked documentation that identified and integrated all pertinent risk factors and potential causes (that included pressure points,nutrition, hydration, skin assessment, mobility, sitting and lying tissue tolerances, resident behaviors, incontinence, medications, pain, and resident's choices) and how these factors or causes could be modified, stabilized or removed in relation to prevention of skin breakdown and individualized protocols to be implemented as related to pressure ulcer prevention.	2 900		

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2 900	Continued From page 58 Resident #4 ' s Braden Scale for predicting pressure sores dated 9/18/06 revealed he was at moderate risk for skin breakdown. His care plan 9/18/06 indicated he was to have his skin inspected during weekly skin checks. It was noted he had a stage II pressure ulcer that recurrently opened and healed. His care plan lacked interventions aside from pressure relieving devices and encouraging good intake. Resident #4 had a recurrent pressure sore on his left hip toward the buttock area. The area was observed by a surveyor during the survey as a basically healed stage II wound, and as of 11/14/06 was covered with a protective Tegaderm dressing. The resident was able to transfer himself to bed, and did so on 11/13/06 after supper. He remained in bed on his left side with the head of the bed raised when the surveyor left the floor at 9:15 PM. Staff was not observed to encourage the resident to reposition off his side. A registered nurse (RN) was interviewed on 11/15/06 at 8:45 AM. She said the resident was always leaning on his left side, and said his mental health issues got in the way of reasoning. She said he was nearly always on his left side and would not listen if staff encouraged him to turn. They tried rearranging his room and moving his television, but he " yelled and screamed. " She explained there was a pattern of opening, healing, and then reopening wounds to his left side. When asked when resident #4 would have his wound dressing changed, a nurse said she did not think the resident would cooperate, since he was anxious about leaving on an outing in the	2 900		

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2 900	Continued From page 59 next hour. When asked if she would ask the resident, she said she had a good relationship with him, and likely could convince him to allow it. The resident agreed to have the dressing changed, which was then observed by a surveyor. The RN verified care plan interventions to manage the resident ' s non-compliance was lacking on 11/16/06 at 10:30 AM. In addition, documentation that the risks of not repositioning were explained to the resident was not found. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) could review and revise existing policies and procedures as necessary to ensure residents have care and services to maintain or improve their incontinence. The DON could inservice all appropriate personnel and establish a monitoring system to ensure compliance. TIME PERIOD FOR CORRECTION: Thirty -(30) days.	2 900		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and	2 910		

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2 910	Continued From page 60 B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Statute is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure that 12 of 30 residents in the sample who were incontinent received appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder functioning as possible. (#11, 17, 5, 27, 8, 16, 1, 2, 9, 7, 13, 15 & 20). Findings include: The facility lacked a system to individually assess residents and utilize the assessment to determine the appropriate time intervals for providing assistance with toileting and/or incontinence care and failed to carry out care plans. Resident # 11 had diagnoses which included dementia and incontinence. A quarterly Minimum Data Set (MDS), dated 10/24/06, identified the resident as severely cognitively impaired with both long and short term memory problems. The MDS further indicated he was totally dependent on staff for all activities of daily living, including toileting and was frequently incontinent of urine. The Resident Assessment Protocol Summary (RAPS), dated 5/8/06, identified the resident with both urinary and bowel incontinence and wore an incontinence brief. The RAPS further indicated that if staff toileted the resident he could be kept continent during the day. Although the resident was identified with urinary	2 910		

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2 910	Continued From page 61 incontinence, there was no indication a comprehensive assessment was completed that included voiding patterns, diagnosis and medication which may affect continence, visual inspection of the perineal /rectal area; risks/benefits, environmental factors, or mobility/environmental limitations. When interviewed on 11/16/07, at 2:00 PM, a nurse manager said that a 3 day bladder assessment was not located for this resident. The nurse manager further verified that the resident did not have a comprehensive urinary incontinence assessment completed to determine an individualized toileting program. Resident # 17's urinary incontinence had not been comprehensively assessed and the care plan was not being carried out. Resident #17 had a diagnoses that included dementia . The resident's quarterly Minimum Data Set (MDS) dated 7/11/06, identified the resident as being totally dependent upon staff for all cares which included multiple daily episodes of urinary incontinence. During continuous observations on 11/13/06 from 4:45 PM to 7:45 PM (a period of 3 hours) the resident was observed sitting in a Broda chair without having been checked for incontinence. This time frame was also verified in an interview with the Human Service Technician (HST) on 11/13/06 at 7:50 PM. The care plan dated 11/9/06, indicated the resident as being incontinent of bowel and bladder with the approach being; "check and change every 2 hours and as needed".	2 910		

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2 910	Continued From page 62 The urinary assessment dated 3/9/06, was incomplete as it did not include a visualization of the peri/rectal area, previous interventions used to minimize urinary incontinence, a summary of the resident's voiding pattern, type of incontinence, medications, restraints, unrelieved pain and resident choice. In an interview with the unit nurse manager on 11/16/06 at 3:45 PM she confirmed the record lacked a comprehensive assessment of the resident's urinary incontinence. Resident #17's care plan dated 11/9/06, indicated the resident as being incontinent of bowel and bladder with the approach being; "check and change every 2 hours and as needed". The resident did not receive timely assistance with incontinence cares for a period of 3 hours during the evening of 11/13/06. Resident # 17 had a diagnoses which included dementia. The quarterly Minimum Data Set (MDS) dated 10/24/06, identified the resident as being totally dependent upon staff for all activities of daily living and had multiple daily episodes of urinary incontinence. During continuous observations on 11/13/06 from 4:45 PM to 7:45 PM (a period of 3 hours) the resident was observed sitting in a Broda chair without having been checked for incontinence. This time frame was also verified in an interview with the Human Service Technician (HST) on 11/13/06 at 7:50 PM. Resident #5 was not toileted every two hours in accordance with his care plan. Observations of resident #5 began on 11/13/06 at 4:50 PM. A Human Services Technician (HST)	2 910		

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2 910	Continued From page 63 emerged from the resident ' s room at that time with a bag of garbage. At 5:35 PM the resident was transported to the dining room for supper. At 7:07 PM resident #5 was returned to his room, where he remained the rest of the evening. At 8:15 PM, the HST brought linen into the resident ' s room. At 8:42 PM, the surveyor intervened regarding resident #5. The HST said he needed to assist another staff person, and would then assist resident #5. He looked at his watch and said, " Yeah, it ' s probably time. " At 8:50 PM, the HST went to assist resident #5 to bed. At 9:00 PM, the resident was taken to the bathroom (4 hours, 10 minutes later). Although his incontinent pad was dry, the resident began voiding prior to being seated on the toilet. When asked how often the resident should have been toileted and repositioned the HST said, " Every couple hours. " When asked the circumstances that evening related to resident #5, he did not comment. The morning of 11/15/06 at 10:55 AM, resident #5 was observed in his room with one clothing protector around his neck and the other on his lap. The HST responsible for the resident was assisting another resident with a bath. She confirmed the resident had not been cared for since before breakfast when another HST got him up, a minimum of three hours earlier. She assisted the resident to the toilet. He was not successful in voiding in the toilet, and the HST confirmed he probably voided once in the incontinent brief. Resident #27 lacked a comprehensive bladder assessment that was consistent with the care plan, and did not receive toileting assistance as directed on the care plan.	2 910		

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2 910	Continued From page 64 Resident #27's bladder assessment dated 9/11/06, was inconsistent with the care plan, and failed to mention the resident's fluid intake pattern, as well as an examination of the perineum. According to the assessment the resident was identified as a good candidate for bladder retraining because the resident was able to sit on the toilet and had periods of continence. According to the assessment, the resident was aware of the urge to void. However, review of the care plan dated 3/14/06 stated,"..Does not have rehab potential regarding incontinence management." According to the care plan, "staff assist resident to toilet per his request. Staff check resident every 2 hours while awake and as needed. Staff assist with changing incontinent products.." Review of the "Nursing Assistant Assignment Sheet" stated, "check and change every 2 hours." On 11/13/06 the resident was observed from approximately 4:45 PM until 7:20 PM without being assisted to the toilet (2 hours, 35 minutes). When the resident was assisted to the bathroom the HST (human services technician) stated he did not know when the resident was last toileted. The resident was assisted to the toilet and a wet incontinent pad was removed, which had a strong urine odor. Resident # 8 lacked an individualized assessment of his voiding pattern that comprehensively integrated risks and causative factors, treatment approaches and how these factors or causes could be modified, stabilized or removed in order to accurately evaluate the appropriate time interval for providing assistance with the resident's toileting needs. The resident was admitted in 1/2000 with	2 910		

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2 910	Continued From page 65 diagnoses that included organic brain syndrome, uncontrolled diabetes mellitus, and chronic renal failure with dialysis. The Quarterly Minimum Data Set (MDS) dated 9/30/05 and the Annual MDS dated 1/7/06 identified moderate cognitive impairment, multiple daily episodes of bowel and bladder incontinence, and total dependence for transfers, toileting and hygiene. The facility Bowel and Bladder Assessment V02 dated 9/19/06 identified incontinence with inadequate control, frequency of urinary elimination at less frequent than every 8 hours, a lack of awareness of the urge to void and identified urinary incontinence type as Intractable. He was not on a scheduled toilet program, and the intervention and approach selected was to be a greater than 2 hour, but less than 4 hour check and change program. A notation was made on the assessment the resident was not to be placed on the toilet related to safety and he was at risk of falls while seated on the toilet. A 3 day bladder and bowel record was completed 1/10/06-1/12/06. For the 66 separate opportunities to record hourly checks for incontinence, 54 identified the resident as dry, and only 12 indicated he was wet. A post void residual check was completed on 1/13/06 that yielded 12 ml. No bladder continence interventions were checked on the ADL Assistance V01 form. The Plan of Care identified a check and change program only, but the Human Services Technician (HST) Worksheet dated 11/9/06 directed staff to assist with use of the urinal; however, this was not being done. Although the resident was identified with urinary incontinence, the assessment and summary lacked several components that included evidence of a physical examination/visual	2 910		

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2 910	Continued From page 66 inspection, effect of hydration/fluid balance status related to dialysis, determination of appropriate individual voiding intervals from the 3 day record, environmental factors, effects of medications, risk/benefit factors, complete UTI history , specific behaviors, all co-morbid medical conditions, and how all these factors could be modified or influenced to develop an individualized toilet plan. Resident #16 had a diagnoses which included dementia. The resident's quarterly Minimum Data Set (MDS) dated 9/15/06, identified the resident as being totally dependent upon staff for all cares which included multiple daily episodes of urinary incontinence. The resident's care plan dated 9/6/06 instructed staff to check and change incontinence brief every 2 hours. The urinary assessment dated 9/06/06, was incomplete as it did not include a visualization of the peri/rectal area or a summation of the assessment which would provide any recommendations for minimizing the resident's incontinence. The facility failed to complete a comprehensive bowel and bladder assessment for resident #1 . Resident #1's most recent minimum data set (MDS) dated 11/03/06 indicated the resident was incontinent of bladder on a daily basis. Review of the resident's "Bowel and Bladder Assessment " dated 10/30/06 reveled that the facility failed to include a visual exam of the residents perineal area, and did not include a comprehensive summary of the resident's urinary status or a plan to address the resident's needs related to his urinary status. The facility failed to complete a comprehensive	2 910		

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2 910	Continued From page 67 bowel and bladder assessment for resident #2 . Resident #2's most recent minimum data set (MDS) dated 11/03/06 indicated the resident was incontinent of bladder on a daily basis. Review of the resident's "urinary incontinence assessment" (form was not signed or dated) reveled the facility failed to identify the type of incontinence the resident was experiencing, did not include a visual exam of the residents perineal area, and did not include a comprehensive summary of the resident's urinary status or a plan to address the resident's needs related to his urinary status. Resident # 9 also lacked an individualized assessment of his voiding pattern that comprehensively integrated risks and causative factors, treatment approaches and how these factors or causes could be modified, stabilized or removed in order to accurately evaluate the appropriate time interval for providing assistance with the resident's toileting needs. Resident # 7 also lacked an individualized assessment of his voiding pattern that comprehensively integrated risks and causative factors, treatment approaches and how these factors or causes could be modified, stabilized or removed in order to accurately evaluate the appropriate time interval for providing assistance with the resident's toileting needs. The facility failed to complete a comprehensive bladder assessment for resident #27, which was consistent with the care plan. The facility failed to conduct complete bladder assessments for residents #13 and #15 were cognitively impaired, incontinent of bladder and were assessed for a toilet/check and change program of more than two hours and less than	2 910		

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2 910	Continued From page 68 four hours. A review of the annual Minimum Data Set (MDS) dated 5/23/06 indicated that resident #15 was totally incontinent of bowel and bladder and required total assist of one to use the bathroom. The Resident Assessment Protocol Summary (RAPS) dated 5/24/06 indicated, "He is incontinent of bowel and bladder and wears incontinence briefs. Toilet/change per schedule." The bladder assessment dated 11/16/06 indicated frequency of urination as every 2-4 hours. Although the facility completed a 3-day voiding pattern and concluded the resident had "functional incontinence" there was no assessment the causative factors, treatment approaches and how these factors or causes could be modified, stabilized or removed in order to accurately evaluate the appropriate time interval for providing assistance with the resident's toileting needs. A review of the annual Minimum Data Set (MDS) dated 4/13/06 indicated that resident #13 was totally incontinent of bowel and bladder and required total assist of one to use the bathroom. The Resident Assessment Protocol Summary (RAPS) dated 4/13/06 indicated, "He is incontinent of bladder and wears incontinence briefs. Change every 2 hours and as needed." The bladder assessment dated 2/2/06 indicated check and change program. The most current HST assignment sheet indicated, "Check and Change program - with toileting/changing greater then 2 hours and less than 4 hours." Although the facility completed a 3-day voiding pattern and concluded the resident had "functional incontinence" there was no assessment the causative factors, treatment approaches and how these factors or causes could be modified,	2 910		

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	00233	A. BUILDING _____ B. WING _____	11/17/2006

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2 910	Continued From page 69 stabilized or removed in order to accurately evaluate the appropriate time interval for providing assistance with the resident's toileting needs. Resident # 20 was observed to have a catheter leg bag attached to his leg while lying in bed which prevented proper drainage of urine. During AM cares observation 11/14/06 at 8 AM resident #20 was observed to be in bed lying on his right side, he was awake and the human service tech (HST) pulled back the covers to get him up. The resident had a indwelling catheter which was attached to a leg bag strapped to the residents leg. The catheter leg bag had 550 cc. of urine. The HST was interviewed and stated she wasn't sure why the leg bag was on his leg, she stated that she had not repositioned or emptied the catheter bag since she started her shift. The nurse manager was interviewed 11/16/06 at 8:30 AM and stated the resident had a plan to leave the leg bag attached at night to decrease the risk of urinary tract infections by breaking the seal of the system, but the leg bag should not be left attached to the leg. She stated the bag should be hung at the bedside. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) could review and revise existing policies and procedures as necessary to ensure residents have care and services to maintain or improve their incontinence. The DON could inservice all appropriate personnel and establish a monitoring system to ensure compliance. TIME PERIOD FOR CORRECTION: Thirty (30) days.	2 910		

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2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure 4 of 32 residents in the sample received appropriate assistive devices and treatment to aide in activities of daily living (#2. #27, #8 & #9). Findings include: The facility failed assess and provide a rehabilitation nursing program to prevent a decline in ambulation for resident #2. Resident # 2 was admitted to the facility 09/07/06 with diagnoses including paralysis agitans, hypothyroidism, and sciatica. The resident's initial physical therapy assessment completed 09/14/05 indicated that the resident was able to ambulate independently with a rolling walker.	2 915		

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2 915	Continued From page 71 The minimum data set (MDS) dated 06/01/06 indicated that the resident remained able to ambulate independently at the time of its completion. On 11/20/06 at 4:55 PM the resident was observed sitting in his wheelchair at the nursing station. The resident removed his lap buddy (soft foam device placed in front of the resident in the wheelchair to discourage unsafe standing or transfers). Staff responded immediately by reapplying the lap buddy and reminding the resident he could fall. The resident continued to attempt to stand. At 5:15PM staff were observed pushing the resident around the unit in his wheelchair. At 5:30 PM the resident was observed in the dining room again attempting to remove the lap buddy. Staff again reapplied the device and reminded the resident of the risk of falling. On 11/15/06 at approximately 11:00 AM during an interview with the nurse manager, she confirmed the resident #2 was no longer able to walk. The nurse manager stated the resident was recently transferred to the 4 north unit from the building 6 third floor unit and that the written information she was given at the time of the transfer indicated the resident was ambulatory. The nurse manager indicated the RN on the floor contacted his previous unit regarding the resident's inability to ambulate and was told the resident had not been walking for quite awhile. The RN on the unit indicated that after the resident transferred to her station she attempted to have the resident ambulate with a rolling walker, but the resident didn't "seem to track". Review of the medical record indicated the resident was seen by physical therapy for an	2 915		

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2 915	Continued From page 72 evaluation of his gait on 07/12/06. The evaluation concluded "In view of his functional ability to walk on the unit, fitness gym twice a week and inability to train for increased independence, no further PT (physical therapy) is warranted at this time. The therapist went on to indicate that she would discuss the resident's hip pain with nursing staff and inquire if x-rays were warranted. There were no documented notes regarding the resident's ability to ambulate between 07/12/06 and 07/17/06. On 07/18/06 the progress notes indicate that the physical therapist met with the RN on the resident unit regarding the resident's "variable skills in ambulation". The note stated "today he could walk with a walker, but at times he won't or can't get out of the wheelchair. The note continues on to indicate it was agreed that "nursing staff was in the best position to capitalize on his good skill episodes" and the plan was to continue to ambulate the resident on the nursing unit. On 11/15/06 The nurse manager confirmed there was no plan in place to ambulate the resident on the nursing unit, and the staff from his previous unit confirmed with her he had not been ambulating on that unit "for quite awhile". The resident's progress notes indicated that on 08/14/06 an order was received for another physical therapy evaluation due to resident's recent fall and high risk fall behavior. The physical therapy evaluation was completed 08/16/06. The evaluation stated "Resident has been an independent ambulator for sometime with recent sharp decline after medical and orthopedic concerns. Has old knee replacement on right with complaint of pain here". The evaluation goes on to state "no treatment identified. Will review care plan and revise in consultation with nursing".	2 915		

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2 915	Continued From page 73 The progress notes indicate that an x-ray of the right knee was obtained on 08/18/06 The x-ray was negative for any fractures of the knee, but did note osteoporosis of the right knee. There was no evidence in the record that physical therapy was made aware of the x-ray results or that there was any further evaluation of the resident's ability to ambulate in light of the x-ray being negative for fractures or orthopedic concerns related to his past knee replacement. There was no evidence in the record the facility reassessed the resident's knee pain, or attempted any change in his treatment to better address his level of pain with ambulation. An interview with the physical therapist on 11/17/06 indicated that the resident had never received physical therapy treatment to prevent the decline in the resident's ability to ambulate. The physical therapist stated " He was normally a good ambulator until he had too much pain. I don't have any record that he has been seen for regular treatment." The resident had a physician order authorizing him to attend the in-house fitness gym twice each week. On 11/16/06 at approximately 11:00AM during an interview with the fitness gym coordinator, she indicated that resident #2 had been attending the fitness gym regularly until the beginning of the summer. The coordinator indicated that the resident did leg press's and walked in the gym when he attended. Review of the fitness gym attendance records indicated that resident # 2 attended 7 times between 01/30/06 through 06/01/06. When asked about the resident's attendance from 06/01/06 to the present the coordinator indicated that they stopped taking attendance. When asked what	2 915		

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2 915	Continued From page 74 action she took when the resident stopped attending the fitness gym, the coordinator stated "I don't know, I guess we just thought he would walk on the floor. The fitness coordinator was unable to produce any progress notes or evidence of communication with nursing staff regarding the residents decline in participation. The fitness coordinator went on to state "we see so many people, for just one person we probably wouldn't have noticed if he's not in the gym. Resident #27 was not provided with a dry erase board for communication, or glasses for vision. Review of resident #27's comprehensive assessment dated 10/6/06 stated, "Has diagnoses of cataracts...has glasses that staff assist with". According to assessment, the resident was "hard of hearing" and refused hearing aides. The assessment said the resident was provided with a communication board, to which he responded appropriately. Review of resident #27's care plan dated 10/13/06 directed staff, "Write messages on dry erase board." The care plan also stated, "Assist to clean glasses and apply as he allows." On 11/13/06, the resident was observed from 4:45 PM until approximately 8 PM without wearing glasses, or staff utilizing the communication board. Staff spoke to the resident multiple times. On 11/14/06 at approximately 7:50 AM the resident was assisted with morning cares, and staff did not use the communication board during their interactions, and did not ask if he wanted to wear glasses. On 11/15/06 at approximately 8:30 AM the nurse reported the glasses were for reading, and then	2 915		

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2 915	Continued From page 75 on 11/16/06 at 10 AM stated she was "probably wrong", and didn't know if they were for reading or vision. The surveyor requested an ophthalmology report, however a report from 1997 was provided. On 11/15/06 at approximately 8:30 AM the nurse said that staff no longer utilized the communication board because "It didn't work." On 11/16/06 at approximately 10 AM the speech therapist demonstrated the use of communication board with resident #27 who read the written messages and responded appropriately. The therapist said, "He can't hear." The therapist questioned the resident (via the communication board) if staff used the board, and the resident responded, "they use to." Resident # 8's Plan of Care identified approaches for eating that included set up of the meals and provide partial to total feeding assistance. The HST Worksheet dated 11/9/06 identified the resident must be fed. During observations of the evening meal on 11/13/06, the resident was observed to receive his meal at 5:05 PM, but was unable to open the plastic wrapped container, closed his eyes and appeared to be sleeping. At 5:16 PM, an HST who assisted in the dining area woke him up, asked him "don't you want to eat your food?", stirred the mashed potatoes and left the resident. The resident was unable to feed himself and again closed his eyes until 5:28 PM when the HST returned to the table and began to feed the resident until this was completed at 6:10 PM. During the dining, the position of the Broda chair in which the resident was seated, in relation the height of the table and distance away from the food did not permit the resident to use his limited	2 915		

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2 915	Continued From page 76 upper extremity mobility to effectively reach the food without pain behaviors or rapid fatigue. On 11/14/06 at 3:30 PM, the nurse manager was interviewed. She reported she had not sent a referral to Occupational Therapy (OT) for the feeding issues, and that OT had been discontinued on 5/26/06. On 11/15/06 at 1:30 PM, the Occupational Therapist was interviewed. He reported OT had been requested to assess the resident's seating related to his dialysis treatment, but they had not evaluated the resident for a range of motion, feeding or dining room positioning issue. Resident # 9 who required the use of hearing assistive devices, did not have these devices applied consistently and maintained properly to provide the opportunity for functional communication during activities of daily living. The resident was admitted to the facility in 8/01 with diagnoses that included dementia, Alzheimer's, paralysis agitans, and hearing loss. The Significant Change of Status Minimum Data Set (MDS) dated 6/8/06 identified moderately impaired cognitive ability, a hearing loss, use of hearing aids, and both a diminished ability to make himself understood and ability to understand others. The Care Plan Summary Report also identified use of hearing aids and reduced social interaction with risk of social isolation. The current Plan of Care dated 9/18/06 also identified the problem of Sensory Loss/Communication from impaired hearing. It directed approaches to use hearing aids on both	2 915		

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2 915	Continued From page 77 sides, assistance to apply and checking batteries weekly or sooner if indicated. It also directed referral to audiology clinic as needed. The Human Services Technician (HST) Worksheet dated 11/9/06 identified the hearing loss problem and directed staff to assist with applying these devices in the morning and remove for sleep. During observations of the resident on the afternoon and evening of 11/13/06 and the mornings of 11/14 and 11/15/06, the resident was observed to not be wearing his hearing aids during the entire observation period. On 11/15/06 at 9:00 AM, the HST working with the resident was asked about the hearing aid use. She reported she had not seen the devices "for a long time" and stated she thought they may have been lost during a hospitalization. At 9:15 AM, the nurse manager was interviewed about the hearing aids and she reported she had seen them only a couple weeks earlier, but the resident preferred to manage their use and frequently misplaced them. She stated the staff would try to locate them. A referral to audiology had not been completed. On 11/15/06 at 10:20 AM, the nurse manager reported one of the hearing aids had been found, but the battery cover was broken and it did not work properly. She later added an entry to the Plan of Care that a referral was made to audiology at VAMC to replace hearing aids and in the future they would be kept on the nurses station treatment cart. The resident had agreed to have the staff apply them in the morning and remove at bedtime for storage. Resident # 9, who required the use of hearing assistive devices as identified in the Plan of Care,	2 915		

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2 915	Continued From page 78 did not have these devices applied consistently and maintained properly to provide the opportunity for functional communication during activities of daily living (ADLs). In addition, the Plan of Care was not being followed in the area of eating and feeding assistance ADLs. The resident was admitted to the facility in 8/01 with diagnoses that included dementia, Alzheimer's, paralysis agitans, and hearing loss. The Significant Change of Status Minimum Data Set (MDS) dated 6/8/06 identified moderately impaired cognitive ability, extensive assistance for eating, a hearing loss, use of hearing aids, and both a diminished ability to make himself understood and ability to understand others. The Care Plan Summary Report identified use of hearing aids and reduced social interaction with risk of social isolation. The current Plan of Care dated 9/18/06 also identified the problem of Sensory Loss/Communication from impaired hearing. It directed approaches to use hearing aids on both sides, assistance to apply and checking batteries weekly or sooner if indicated. It also directed referral to audiology clinic as needed. The Human Services Technician (HST) Worksheet dated 11/9/06 identified the hearing loss problem and directed staff to assist with applying these devices in the morning and remove for sleep. During observations of the resident on the afternoon and evening of 11/13/06 and the mornings of 11/14 and 11/15/06, the resident was observed not wearing his hearing aids during the entire observation period. On 11/15/06 at 9:00 AM, the HST working with the resident was asked about the hearing aid use. She reported she had not seen the devices "for a long time" and stated	2 915		

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2 915	Continued From page 79 she thought they may have been lost during a hospitalization. At 9:15 AM, the nurse manager was interviewed about the hearing aids and she reported she had seen them only a couple weeks earlier, but the resident preferred to manage their use and frequently misplaced them. She stated the staff would try to locate them. A referral to audiology had not been completed. On 11/15/06 at 10:20 AM, the nurse manager reported one of the hearing aids had been found, but the battery cover was broken and it did not work properly. She later added an entry to the Plan of Care that a referral was made to audiology at (Veterans Administration Medical Center) VAMC to replace hearing aids and in the future they would be kept on the nurses station treatment cart. The resident had agreed to have the staff apply them in the morning and remove at bedtime for storage. Resident # 9 was also observed during dining sessions on 11/13/06 from 5:00 PM to 6:00 PM and on 11/14/06 from 7:45 AM to 8:20 AM. On 11/13/06 he was served a plastic wrapped sandwich that he was observed to require 15 minutes to open and begin eating. He also required an additional 10 minutes to open the cardboard milk and juice containers. There was no staff assistance for set-up or feeding activity. On 11/14/06, he was served cereal and milk and demonstrated similar difficulty opening the containers, eventually using his fork to pry open the milk container slightly and add it to the cereal. When using the regular spoon to eat the cereal, he demonstrated an intention tremor of the right hand that caused the contents to frequently spill. He eventually began to feed himself the cereal/milk lifting the bowl with both hands to drink the contents. There was no staff assistance	2 915		

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2 915	Continued From page 80 for set-up or feeding during the dining period. The resident's Plan of Care dated 9/18/06 identified chewing, swallowing, meal safety problems with approaches for staff to provide reminders to chew and swallow, eat/feed slowly with small bites, and sips of liquid between bites of solid food. The current Human Services Technician (HST) Worksheet dated 11/9/06 identified staff to set up the tray for the resident, encourage eating-feeds self, and to See Swallowing Guide. On 11/14/06 at 3:15 PM, the nurse manager was interviewed. She reported that she was not aware of the difficulty the resident was having with meals and would contact Occupational Therapy (OT) for an evaluation. On 11/15/06 an entry was made in the Plan of Care that identified the problem with tremors and feeding issues and the OT referral for potential adaptive equipment for meals indicated. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) could review and revise existing policies and procedures, inservice all appropriate personnel and establish a monitoring system to ensure compliance. TIME PERIOD FOR CORRECTION: Thirty -(30) days.	2 915		
2 945	MN Rule 4658.0530 Subp. 1 Assistance with Eating - Nursing Personnel Subpart 1. Nursing personnel. Nursing personnel must determine that residents are served diets as prescribed. Residents needing help in eating must be promptly assisted upon	2 945		

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2 945	Continued From page 81 receipt of the meals and the assistance must be unhurried and in a manner that maintains or enhances each resident's dignity and respect. Adaptive self-help devices must be provided to contribute to the resident's independence in eating. Food and fluid intake of residents must be observed and deviations from normal reported to the nurse responsible for the resident's care during the work period the observation of a deviation was made. Persistent unresolved problems must be reported to the attending physician. This MN Statute is not met as evidenced by: Based on observation interview and record review the facility failed to ensure 11 of 45 residents in the sample (#30, #28, #31, #43, #40, #33, #35 , #5, #8, #9, #39) received timely or appropriate assistance and adaptive equipment in accordance with their needs. Findings include: The facility failed to ensure 3 resident's (#30 #28& #31) in the 2N dining room received timely assistance with their meals. Resident #30 was not provided with timely assistance at mealtime, and experienced a weight loss. During the initial tour on 11/13/06 resident #30 was observed sitting with food in front of him from 12 noon until 12:20 PM without any staff interventions . The resident was observed to sleep through the majority of the meal. Review of the intake record indicated the resident ate 50% of the meal.	2 945		

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2 945	Continued From page 82 On 11/13/06 at approximately 5:15 PM, the evening meal was served. Resident #30 was served at 5:20 PM. At 5:30 PM the resident was sleeping at the table, and at 5:35 staff awakened the resident and questioned him if he was going to eat, and then walked away. The resident continued to sleep at the table without any staff interventions until 6 PM, at which time staff pulled a chair next to the resident, and assisted the resident with a bite of chili, cornbread, and chocolate milk. When drinking the milk, the resident began to cough fiercely and his face turned red, at which point the nurse was called for an assessment. According to staff, this was not unusual for the resident. On 11/14/06 resident #30 was served breakfast at approximately 7:45 AM, per report of the social worker. At 8:20 AM the resident was sleeping at the table with a cover on the juice glass, milk container not opened, and food not touched. At 8:20 AM the surveyor alerted staff and requested assistance for the resident. The resident was poured a cup of coffee, which he drank, and began coughing fiercely, and turning red. The resident's plate was removed by staff because of the coughing. Review of the resident's comprehensive assessment dated 9/22/06 said the resident required supervision at meal time, such as cueing or encouragement. The care plan dated 1/10/06 stated the resident had potential for swallowing/choking episodes, and directed staff to refer to the swallow guide. The swallow guide dated 1/4/06 recommended staff pour all liquids into a nosey cup, eat at 90 degree angle, with chin down, and only 1 sip a time from a cup. According to the care plan, the resident and	2 945		

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2 945	Continued From page 83 family refused an altered texture diet. Review of the dietary intake for 11/13/06 stated the resident ate 50% for lunch, and 0 for dinner. Breakfast intake for 11/14/06 was documented as 25%, although on 11/15/06 at approximately 10 AM the nurse said she removed the tray, and the resident's intake was 0. The resident's September and October weight was documented as 196 pounds. On 11/14/06 at approximately 8:30 AM, the nurse manager stated the resident did not have a weight loss. However, record review revealed the resident's weight on 11/9/06 & 11/14/06 was 186 pounds, a 10 pound weight loss in a month. Review of the nutrition notes dated 11/14/06 stated "Resident is refusing meals, intake is 0 bites, fluid intake poor...add HNS and will provide chocolate flavor..." According to the speech therapist on 11/14/06 at 2 PM new orders included another speech evaluation for swallowing, house nutritional supplement twice a day and a calorie count for 3 days. Resident #28 was not provided with meal assistance. During the initial tour on 11/13/06 resident #28 was observed sitting with food in front of him from 12 noon until 12:20 PM without any staff assistance . At 12:20 PM, a staff member questioned resident #28, "aren't you hungry?" The staff member then retrieved a chair and assisted the resident with sherbet. On 11/13/06 at 5:20 PM the resident was served dinner. The resident reached for juice, drank some and then set it down. At 5:30 PM the nurse manager walked by the resident and attempted to	2 945		

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2 945	Continued From page 84 give some juice, and informed the surveyor, "this is recreational eating" and left. The resident did not attempt to feed self, other than several sips of juice. At 5:40 PM staff walked by the resident and questioned if he was eating. According to the intake for 11/13/06 the resident did not eat any breakfast, ate 50% of lunch and 0% for dinner. Review of the comprehensive assessment dated 10/2/06 stated the resident required extensive assistance of 1 person with eating. According to the resident assessment protocol dated 10/2/06, the resident received Isosource tube feeding from 7 PM to 7 AM daily. The assessment said the resident left 25% of meals uneaten. Review of nutritional notes dated 11/2/06 stated intake was 75%-100%, and that the resident required less assistance with eating. According to the notes, the dietician was going to discuss discontinuing the resident's tube feeding with the nurse practitioner. On 11/15/06 the nurse manager was questioned regarding the discrepancy of feeding assistance and said, "We usually give him a spoonful and ask if he needs help." When questioned regarding discontinuing the tube feeding, the nurse manager said, "I don't know if I agree with that." Resident #31 was not positioned at the table to facilitate independence with eating. On 11/13/06 at 5:20 PM, resident #31 was served his evening meal. The resident was seated an arms length away from the table, and was unable to reach the tray. Resident #31 was in a Broda wheelchair. The resident held a glass of milk in his right hand, and a container of ice cream in his left hand. At 5:42 PM the resident continued to hold the milk and ice cream in his hands, and	2 945		

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2 945	Continued From page 85 attempted to set the milk on the tray, but could not reach the table. At 5:45 PM staff pushed the resident closer to the table, cut the lettuce salad that was on the tray, and fed the resident a bite of salad and then left. At 5:50 PM staff gave the resident a sandwich, which the resident was able to eat independently. On 11/14/06 at 8:20 AM the resident was seated an arms length away from the breakfast table and unable to reach his food on the table. The surveyor requested the resident be positioned so that he could reach his food. The nurse manager said the resident was pushed to the table, but wheeled back and, "If we lock the wheelchair then it's considered a restraint." Review of resident #31's comprehensive assessment dated 1/5/06 revealed the resident had a diagnosis that included dementia with "moderately impaired" cognition. According to the resident assessment protocol dated 12/30/06, the resident was described as able to eat independently. Resident #43 did not receive timely assistance with her meal during the breakfast observation on 11/14/06 on 4 north. Resident #43 was observed up in her chair in the dinning room when the surveyor came on the floor about 7:15 AM. At 7:40 AM the food started to be delivered to other residents at their tables. By 8:17 AM most of #43's table mates had been fed and were done eating. The resident looked at their food as they ate. A staff was heard to say they were out of pureed meat. She was not given any coffee, juices or the hot cereal which were both available in the kitchenette where the meals were served from. At 8:20 AM, 40 minutes after others at her table were served, a nurse	2 945		

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2 945	Continued From page 86 supervisor brought her food. Resident #40 was observed being fed breakfast. His head hung down about 45% throughout the meal. His tray card indicated he was supposed to have nosey cup for beverages. He only had a regular glass. Half way through the meal the HST asked another staff to bring 2 additional glasses . The staff brought 2 more regular glass. During the breakfast observation on 11/15/06 residnet #40 was not provided his nosey cup (adaptive cup). Resident #33 didn't receive timely assistance with eating. Resident # 33 had a diagnoses that included dementia, hemiplegia and dysphagia (difficulty with swallowing). The care plan last updated 10/1/06, indicated, " observe for sign and symptoms of aspiration...monitor for choking at meals. Feed slowly, small bites as needed, able to feed self with cues". During the observation of the evening meal on 11/13/06, resident #33's tray was delivered at approximately 5:47 PM. The resident sat in a Broda Chair (a type of wheel chair) leaning to the right and not making any effort to feed himself until 6:23 PM when a nurse provided some verbal cues. (a period of 36 minutes). The resident then preceded to pick up a fork and eat his pureed chili and pudding. At 6:30 PM a nurse sat down next to resident and fed him the remainder of his meal. The staff did not offer to warm up the meal even though it was a period of 36 minutes from the time it was served until the resident started to eat. Resident # 35 had a diagnoses which included dementia. The care plan last updated, 11/06/06, indicated the resident was totally dependent upon	2 945		

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2 945	Continued From page 87 staff for cares. The care plan also identified the resident was to have a" laptray on her wheelchair for meals only to promote independence with eating per self". During observations of the evening meal on 11/13/06 and the breakfast meal on 11/14/06 the resident sat low in a wheel chair with a tray table attached to the wheelchair. The food was placed on the dining table in front of the wheel chair which was beyond the reach of the resident. In addition, staff were observed feeding the entire meal to the resident. In an interview with the dietician on 11/14/06 at 9:05 AM she verified that the resident is totally dependent upon staff for feeding and the tray table was unnecessary as the resident was no longer able to feed herself. Resident #5 was not provided meal assistance in accordance with his care plan, as delineated by the speech language pathologist (SLP). Resident #5 ' s swallowing evaluation 11/15/05 indicated he was " Difficult to feed due to advanced dementia. His care plan 3/21/06 indicated he was at risk for swallowing problems. Staff was to give reminders to chew and/or swallow. Sips of liquid were to be given between bites. Each bite was to be chewed and swallowed before offering the next bite. If the resident refused food on a utensil, he was to be offered small chunks of food with a gloved hand when the resident readily opened his mouth. The swallowing guide by the SLP dated 7/26/06 directed staff to watch for holding of liquids in his mouth. Staff was use a plastic coated spoon to protect the resident ' s teeth or offer solids in small chunks by hand.	2 945		

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2 945	Continued From page 88 During the meal observation at supper on 11/13/06 the staff person used a regular spoon (versus plastic coated) or a gloved hand to feed the resident. The staff also did not provide sips of liquid between bites. The HST gave approximately three bites of food, followed by liquids. Resident #5 coughed at times during the meal. During meal observations on 11/14/06 at 8:17 AM, resident #5 was fed using a gloved hand. The HST but did not give the resident liquids between bites. The HST tried to feed the resident a banana and a donut. The resident frequently resisted by pursing his lips or moving his head away. The resident appeared to be holding liquid in his mouth, and the HST encouraged him to swallow. The HST then said he was going to try using a spoon. He returned with a regular spoon (versus plastic coated). He placed the spoon inside the resident ' s mouth and removed food that was pocketed. Few liquids were provided throughout the meal and the resident ate poorly. Attempts were made to give more food, although the resident continued chewing, and some coughing was again noted. A registered nurse (RN) was interviewed on 11/15/06 at 9:15 AM. She said the resident ' s dementia had progressed, and he likely had forgotten to swallow. She said sometimes the resident chewed and chewed a bite of food. Because he was biting on the spoon, the plastic coated spoon was to be used. Resident # 8 Plan of Care identified approaches for eating that included set up of the meals and provide partial to total feeding assistance. The HST Worksheet dated 11/9/06 identified the	2 945		

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2 945	Continued From page 89 resident must be fed. During observations of the evening meal on 11/13/06, the resident was observed to receive his meal at 5:05 PM, but was unable to open the plastic wrapped container, closed his eyes and appeared to be sleeping. At 5:16 PM, an HST who assisted in the dining area woke him up, asked him "don't you want to eat your food?", stirred the mashed potatoes and left the resident. The resident was unable to feed himself and again closed his eyes until 5:28 PM when the HST returned to the table and began to feed the resident until this was completed at 6:10 PM. During the dining, the position of the Broda chair in which the resident was seated, in relation the height of the table and distance away from the food did not permit the resident to use his limited upper extremity mobility to effectively reach the food without pain behaviors or rapid fatigue. On 11/14/06 at 3:30 PM, the nurse manager was interviewed. She reported she had not sent a referral to Occupational Therapy (OT) for the feeding issues, and that OT had been discontinued on 5/26/06. On 11/15/06 at 1:30 PM, the Occupational Therapist was interviewed. He reported OT had been requested to assess the resident's seating related to his dialysis treatment, but they had not evaluated the resident for a range of motion, feeding or dining room positioning issue. Resident # 9 was also observed during dining sessions on 11/13/06 from 5:00 PM to 6:00 PM and on 11/14/06 from 7:45 AM to 8:20 AM. On 11/13/06 he was served a plastic wrapped sandwich that he was observed to require 15 minutes to open and begin eating. He also required an additional 10 minutes to open the	2 945		

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2 945	Continued From page 90 cardboard milk and juice containers. There was no staff assistance for set-up or feeding activity. On 11/14/06, he was served cereal and milk and demonstrated similar difficulty opening the containers, eventually using his fork to pry open the milk container slightly and add it to the cereal. When using the regular spoon to eat the cereal, he demonstrated an intention tremor of the right hand that caused the contents to frequently spill. He eventually began to feed himself the cereal/milk lifting the bowl with both hands to drink the contents. There was no staff assistance for set-up or feeding during the dining period. The resident's Plan of Care dated 9/18/06 identified chewing, swallowing, meal safety problems with approaches for staff to provide reminders to chew and swallow, eat/feed slowly with small bites, and sips of liquid between bites of solid food. The current Human Services Technician (HST) Worksheet dated 11/9/06 identified staff to set up the tray for the resident, encourage eating-feeds self, and to See Swallowing Guide. Resident #39 was not provided his nosey cup with the breakfast meal on 11/15/06. An interview with the HST (human services technician) on 11/15/06 at 8:25AM indicated it was the responsibility of the HST to make sure the resident has their necessary adaptive equipment, and they " must have overlooked it today." SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) could review and revise existing policies and procedures, inservice all appropriate personnel and establish a monitoring system to ensure compliance.	2 945		

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2 945	Continued From page 91 TIME PERIOD FOR CORRECTION: Twenty-One (21) Days.	2 945		
2 955	MN Rule 4658.0530 Subp. 3 Assistance with Eating - Risk of Choking Subp. 3. Risk of choking. A resident identified in the comprehensive resident assessment, and as addressed in the comprehensive plan of care, as being at risk of choking on food must be continuously monitored by nursing personnel when the resident is eating so that timely emergency intervention can occur if necessary. This MN Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure 1 of 3 resident's identified at risk for choking received appropriate monitoring and interventions to reduce choking. (Resident #30). Findings include: Resident #30 had diagnoses that included cerebrovascular accident (stroke) and hemiparesis. According to the comprehensive assessment dated 1/5/06, the resident was described as having both short term and long term memory impairment, with moderately impaired cognitive skills. The resident was described as requiring supervision with eating. According to the assessment "Staff set up his tray and monitor for choking, as he pockets food in his left cheek." Review of the care plan dated 1/10/06 identified the resident at risk for choking, and directed staff to use nosey cup for all liquids, alternate bites with sips of fluids, bites 1/2 to 1	2 955		

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2 955	Continued From page 92 teaspoon in size, and place chin down for liquids. During the initial tour on 11/13/06 resident #30 was observed sitting with food in front of him from 12 noon until 12:20 PM without any staff interventions . The resident was observed to sleep through the majority of the meal. Review of the intake indicated the resident ate 50% of the meal. On 11/13/06 at approximately 5:15 PM, the evening meal was served. Resident #30 was served at 5:20 PM. At 5:30 PM the resident was sleeping at the table, and at 5:35 staff awakened the resident and questioned him if he was going to eat, and then walked away. The resident continued to sleep at the table without any staff interventions until 6 PM, at which time staff pulled a chair next to the resident, and assisted the resident with a bite of chili, cornbread, and chocolate milk. When drinking the milk from the nosey cup, the resident began to cough fiercely and his face turned red, at which point the nurse was called for an assessment. According to staff, this was not unusual for the resident. At 6:10 PM, the surveyor alerted staff the resident was drinking milk from the container, and not the nosey cup. On 11/14/06 resident #30 was served breakfast at approximately 7:45 AM, per report of the social worker. At 8:20 AM the resident was sleeping at the table with a cover on the juice glass, milk container not opened, and food not touched. At 8:20 AM the surveyor alerted staff and requested assistance for the resident. The resident was poured a cup of coffee, which he drank, and began coughing fiercely, and turning red. The resident's plate was removed by staff because of the coughing.	2 955		

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2 955	Continued From page 93 Staff was not observed to provide interventions or remind the resident to follow the swallowing guidelines such as alternating bites with sips of fluids, bites 1/2 to 1 teaspoon in size, or chin down for liquids on 11/13/06 or 11/14/06. On 11/14/06 at 2 PM, the speech therapist said the resident was not always cooperative, and sometimes prompting or reminding had a "negative effect". According to the therapist the swallowing guidelines were ideally for the resident to follow, although he (the resident) was not provided with written instructions. The speech therapist said new orders dated 11/14/06 included a speech evaluation for swallowing, house nutritional supplement twice a day and a calorie count for 3 days. Record review revealed the resident had lost 10 pounds in a month. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) could review and revise existing policies and procedures, inservice all appropriate personnel and establish a monitoring system to ensure compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 955		
2 965	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served.	2 965		

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2 965	Continued From page 94 This MN Statute is not met as evidenced by: Based on observation, record review and interview the facility did not ensure that alternates were provided to residents who refused the food served during random meal observations. Findings include: On 11/15/06 at approximately 1:15PM during the resident group interview, the 3 residents who ate in a dining room up on the nursing station indicated they were not able to get an alternate food choice at meals, unless they requested it 24 hours in advance. The residents indicated that the alternate food choice for meals was not posted on the current menu. One resident stated he hoped this was a short-term problem, stating "It took us 5 years to get them to list the alternates on the menu, I hope they don't stop now." During random observations at the noon meal, a resident said she did not want sherbet and tossed the cup aside. She also said she didn ' t want the entree, however, after a short time ate it. At the supper meal, the same resident said she didn't like chili and corn bread. She put the cornbread into the chili and pushed it aside. A Human Services Technician (HST) informed the nurse that the resident didn't want to eat the chili. She suggested leaving the resident alone, because the previous meal she said the same thing but did eat it. The registered nurse (RN) later asked her why she wasn ' t eating her chili, to which the resident responded she didn ' t like it. The resident didn ' t eat the chili or corn bread, but was not offered an alternate.	2 965		

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	00233	A. BUILDING _____ B. WING _____	11/17/2006

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2 965	Continued From page 95 A RN was interviewed on 11/15/06 at 8:45 PM. She said the reason the resident was not offered an alternate was because, " We don ' t have anything. It ' s not an option to get anything. " She said that with the tray system that ended as of 11/13/06, resident preferences were noted on the tray cards with meals sent accordingly. The idea of the steam table was that residents would have a choice, but she said so far that had not happened. During random observations on 11/14/06 at 8:20 AM a resident in the dining room said he wanted breakfast and needed more than a donut, and requested eggs. A staff person gave the resident another donut, and the resident said, "Take it back. I don't want it." The staff person said they didn't have anything else. The breakfast served on 11/14/06 was a donut, hot or cold cereal, ham, applesauce, coffee, juice and milk. On the morning of 11/14/06, resident #52 the breakfast was "bad", and that he didn't like ham or donuts and "If I got a slice of bread I would have been much happier." They (staff)said, "That's all you get." On 11/14/06 at 9 AM the food supervisor reported an alternate breakfast was not available on 11/14/06 because of the meal time changes. On 11/15/06, at 10:40 AM, during interview the Dietary Director had that the alternate choice was not listed on the menus recently. Even though sandwich and soups are sent to each unit the residents would need to request the choice, however, the choice of soup and sandwich is not listed on the menu. The Director of Dietary provided information	2 965		

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2 965	Continued From page 96 related to alternates during the afternoon of 11/17/06. A memo dated 1/16/06 indicated alternates would be available for residents who refused the main entrée at lunch and dinner. Dietary and nursing were responsible to offer appropriate alternatives. The alternates were sandwiches that varied in type each day. Other items such as yogurt and cottage cheese were also available. The director said she was very disappointed nursing staff did not know alternates were available, and she sent another memo dated 11/16/06. The memo indicated if the resident refused the entrée, a sandwich should have been offered, and if refusing a vegetable, they were to offer soup. The available alternate entrées did not specify they were available for residents on altered texture diets. SUGGESTED METHOD OF CORRECTION: The Director of Nursing and Dietary departments could review and revise existing policies and procedures as necessary, inservice all appropriate personnel and establish a monitoring system to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days..	2 965		
21055	MN Rule 4658.0625 Subp. 2 Menus; Food Habits and Customs Subp. 2. Food habits and customs. There must be adjustment to the food habits, customs, likes, and appetites of individual residents including condiments, seasonings, and salad dressings. There must be resident involvement in menu planning. This MN Statute is not met as evidenced by:	21055		

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21055	Continued From page 97 Based on interview and observation the facility failed to accommodate the food habits, customs, likes and appetites of individual residents and involve residents in menu planning. Findings include: Residents had expressed dietary concerns at a monthly meeting for six months from May through October of 2006 such as, they would like apple pie instead of apple crisp, chicken breast instead of chicken patties, fresh vegetables, and liver and onions, and a better choice of salad dressings. However the residents were not given a response to their dietary concerns. On 11/25/06 at 10:00 am, the Director of Dietary said the responses to the dietary concerns did not get into the meeting minutes and the minutes with responses were not posted. On 11/15/06 at approximately 1:15PM during the resident group interview, the 3 residents who ate in a dining room up on the nursing station indicated they were not able to get an alternate food choice at meals, unless they request it 24 hours in advance. The resident's indicated that the alternate food choice for meals was not posted on the current menu. One resident stated he hoped this was a short-term problem, stating "It took us 5 years to get them to list the alternates on the menu, I hope they don't stop now." On 11/14/06, at 8:20 AM, during a confidential interview a resident in the dining room located on 2 south said the coffee was cold. On 11/15/06, at 7:50 AM, nutrition service staff was pouring coffee from two plastic pitchers. The temperature of the coffee was taken and verified by the dietician from each of the pitchers of coffee. The temperature of the coffee from the gold plastic pot was 127.4 degrees Fahrenheit and the	21055		

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21055	Continued From page 98 temperature from the tan plastic pot was 114.2 degrees Fahrenheit. On 11 14/06, at 8:00 AM, the dietician said the facility will need to get more insulated coffee pots. The coffee is not hot enough from the plastic pitchers, On 11/15/06, at 10:40 AM, during interview the Dietary Director said it is difficult to prepare food for two populations and said the alternate choice was not listed on the menus recently. Even though sandwich and soups are sent to each unit the residents would need to request the choice, however, the choice of soup and sandwich is not listed on the menu. On 11/15/06, at 10:25 AM, the Activity Director said we will need to be make sure the minutes are more specific about the dietary concerns. SUGGESTED METHOD OF CORRECTION: The Director of Dietary Services could review and revise existing policies and procedures as necessary, inservice all appropriate personnel and establish a monitoring system to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days..	21055		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment.	21375		

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21375	Continued From page 99 This MN Statute is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure infection control policies and procedures were implemented for sanitizing whirlpool tubs, dinning tables during a random wound observation. Findings include: Infection control practices were not followed when going from a soiled to clean area. Resident #27 had diagnoses that included a stage 2 pressure ulcer (a partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow creator) on the left foot, history of MRSA (methicillin resistant staphylococcus aureus) in the ulcer, and osteomyelitis (bone infection). On 11/15/06 at approximately 10 AM wound care was observed. The resident's dressing was removed, which contained a moderate amount of brown drainage, that was also observed on the outer Kerlix dressing. After removing the dressing, the nurse moved the bed (in order to complete the care on the other side), and obtained the treatment supplies. The nurse opened a package of 4x4 dressings and washed the wound with Carraklenz, and then applied Aquacel ointment to the wound, and covered the wound with a dressing. The dressing was then secured with Kerlix and taped. After completing the wound care, an ace wrap was applied to the left leg and secured with tape. During observations of the wound care, and application of the ace wrap, the hands were not washed, nor gloves changed. The nurse verified she did not change gloves or wash hands during the procedure. Review of the facility's policy "Wound	21375		

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21375	Continued From page 100 Management: Wound Care" dated 7/06, directed the following; "...Put on exam glove. Loosen tape, remove dressing. Pull glove over dressing and discard into plastic bag. Wash hands..." The facility failed to implement procedures to prevent the spread of infection or follow the manufacturer's and the facility protocols for adequate disinfection of whirlpool tubs. The facility provided showering and whirlpool tub baths and toileting for resident in common bathing rooms. On 11/15/06 at 2:30 PM, during General Observations of the environment, three Human Services Technicians (HSTs) that regularly bathed residents were separately asked to describe the disinfection method used for the Arjo whirlpool tubs. All stated after the tub was drained, a hand sprayer bottle containing Cen Kleen IV (an Ammonium compound) was dispensed along the sides of the tub and on the outside of the jet intakes and outflow, then scrubbed with a soft brush. They reported the disinfectant was left in contact for 5 minutes, then rinsed with an integral clear water sprayer (white). All HSTs reported they did not use the red integral sprayer to dispense disinfectant and they did not disinfect and flush the turbine mechanism. One HST thought the disinfectant sprayer was broken. Another HST stated she never used the whirlpool feature on the tub and did not know how it worked. One of the tubs had an ultrasonic resident cleansing feature, but the HST in that area did not use it and did not know how it worked. The HSTs were unable to locate the operation and disinfection instruction manuals that were supposed to be located in the bathing rooms for the two tubs. At 11:00 AM, the unit RN manager reported the	21375		

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21375	Continued From page 101 staff received some training on the tub operation during orientation, and they should be the individuals who knew how the tubs operated. She could not initially locate a manufacturer's manual on the unit. One hour later the RN manager located an Arjo tub manual. It identified the manufacturer's recommended cleaning and disinfecting procedure that required use of the integral red disinfectant solution sprayer. It also included instructions that detailed the necessary task of disinfecting and flushing the turbine mechanism and inlet/outlet areas in order to effectively remove pathogens from the system between individual bathing sessions. The manual included a Warning as follows: Carefully clean and disinfect all items of equipment after every bath. Failure to do so may result in biocontamination of others using the system. The disinfectant solution (Cen Kleen IV) bottle was also checked for instructions printed on the back and it directed for surface disinfection, the solution should remain in contact for 10 minutes before rinsing in order to properly eliminate pathogens. On 11/16/06 at 10:46 AM, maintenance staff were interviewed. They reported they do quarterly checks on the tubs, and respond to maintenance work slips from nursing. They were not aware of any current problems with the tubs or disinfectant sprayers. They were asked to open the compartment that contained the disinfectant solution for the tubs. One was completely empty, the other had a small amount below the dispenser intake tube. The maintenance staff reported nursing was responsible to ensure the disinfectant bottles in the system contained solution and were replaced as needed.	21375		

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21375	Continued From page 102 The facility failed to ensure the century tub on the 2N unit was properly sanitized between resident use. On 11/16/06 at approximately 3 PM the HST reported the century tub was cleaned as follows; the tub was filled (approximately) 6 inches. The HST showed the surveyors the water line, which was several inches below the intake and outlet valves. The HST reported the sanitizer was poured into the tub, but did not specify an amount, and said, "Just put some in. Pour it." The HST said the sanitizing solution was left for a couple of minutes 3-4 minutes, and that the whirlpool was not activated during cleaning. Review of the manufacture's recommendations which were posted in the bathroom, directed staff to activate the pump motor, allowing the solution to agitate until it discharges from both pump outlets. According to the "Classic whirlpool disinfectant" (quat ammonia solution) 2 ounces per gallon were to be used, and let sit for 10 minutes." An interview with a HST in Building 6 on the 3rd floor on the low side on 11/16/06 at 10:10 AM to determine how the whirlpool tub was cleaned revealed that the HST would turn on the water and sweep out the tub with a brush or a washcloth and then fill the tub part way with water and the disinfectant solution from a spray hose attached to the tub and let the disinfectant solution sit for approximately 5 minutes in the mornings between baths and then rinse out the tub. Another interview with another HST at 11:25 AM on the high side revealed that the HST would spray the disinfectant into the whirlpool tub, spray down the pads and the inside of the tub to "get all the dirt out" and then the HST would rinse the tub with water to make sure that there was no	21375		

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21375	Continued From page 103 disinfectant residue left to get on resident's skin during their baths. During the family council interview on 11/14/06 at 2:00 PM an anonymous family member shared a recent experience of observing their loved one, who resided on 2 North, during a bath where the human service technician (HST) had readied the resident for the bath but did not check or change the incontinent pad before going into the tubroom. The family member shared that the resident had been incontinent of bowel and that the HST had not done pericare on the resident before placing the resident into the whirlpool tub for a bath In addition, the facility failed to follow their policy and procedures for cleansing and sanitization of one unit's dining tables between usage by multiple residents. During dining room observations on 11/13/06 from 5:00PM until 6:15 PM, cleaning and sanitizing dining tables between usage by multiple residents was observed. A silverware soaking container with a solution of water and disinfectant was located on the clean-up cart. A single washcloth was used to clean all tables. The water level gradually diminished during use until the container held only a small amount of the cooled solution. There were numerous food particles and debris in the container and the washcloth became stained with food. The dietary server was asked how the solution was prepared and used. He stated he put "one pump" of disinfectant and filled the container with water at the beginning of dining. After the interview at 6:10PM, near the end of the dining session, the dietary aide then refilled the container with new solution and a clean washcloth..	21375		

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21375	Continued From page 104 Facility policy dated 5/2004 identified use of a bucket of hot water and clean towels to wipe tables. If the bucket became soiled with food particles, it directed staff to return to the dishroom for a new set-up and more towels. A new policy provided dated 11/06 now directed staff to clean tables for second seatings with an appropriate chemical designed for food contact surfaces in a spray bottle and clean towel. On 11/15/06, at 10:00 AM, the Director of Dietary was interviewed concerning the observation of staff washing the tables using a rag that had been dipped into a bucket of dirty water that contained scrapes of contaminated food. The Dietary Director said, "The staff should not have used the bucket of water to clean the tables. The staff are supposed to be using a spray bottle with sanitizer to clean the tables". SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) and Dietary manager could review and revise existing policies and procedures as necessary to ensure residents have care and services to maintain or improve their incontinence. The DON could inservice all appropriate personnel and establish a monitoring system to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21375		
21435	MN Rule 4658.0900 Subp. 1 Activity and Recreation Program; General Subpart 1. General requirements. A nursing home must provide an organized activity and recreation program. The program must be	21435		

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21435	Continued From page 105 based on each individual resident's interests, strengths, and needs, and must be designed to meet the physical, mental, and psychological well-being of each resident, as determined by the comprehensive resident assessment and comprehensive plan of care required in parts 4658.0400 and 4658.0405. Residents must be provided opportunities to participate in the planning and development of the activity and recreation program. This MN Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide a recreation program based on individual interests, strengths, and needs for 6 of 32 residents in the sample (#5, #29, #27, #28, #17, & #21). Findings include: Resident #5 was observed during the evening of 11/13/06 and morning of 11/14/06. The resident had Alzheimer ' s disease and could not communicate. During observations, he was either in the dining room for meals or in his room. He was alternately awake and sleepy. Sometimes classical music played in his room per family request. The activities available during the observations were Bingo and Blackjack, neither of which the resident could participate. A RN said the resident was "just off the unit for music" activities and they also had music activities on the unit. She said resident #5 could not benefit from activities such as Bingo. Resident #5 ' s interest assessment indicated he enjoyed gardening, fixing things, pets, music, sports, television, outdoors, and spiritual activities. He was identified a being appropriate for small and large group activities, as well as 1:1s. His care plan did not reflect his	21435		

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21435	Continued From page 106	21435		

individualized interests, nor his special needs related to his severe cognitive impairment. The goal and approaches were generic. He was to attend 2-3 activities a week, and staff was to provide him with a calendar, invite him to activities, 1:1 intervention, encourage social interaction, etc.

The activity attendance records from the previous four months revealed the resident attended activities on average, less than once a week. The activities were concerts, birthday parties, a picnic, and an outing. The RT progress notes from 11/9/06 and 8/17/06 were verbatim except for each note indicating a decline in numbers of activities from the previous quarter. A note on 7/10/06 indicated a 1:1 music activity took place. It said, " Music 1:1. 15 minutes. Resident in bed awake with eyes open. Resident did not initially acknowledge music, but when asked if he wanted more, resident nodded. During music, resident occasionally moved feet in time to music. As MT (music therapist) departed, resident made eye contact and smiled. " Subsequently, once monthly music 1:1 was listed for resident with " sleeping " or " unavailable " documented.

The RT director and a RT aide were interviewed on 11/16/06 at 3:45 PM. They said very few residents were provided 1:1 visits, and resident #5 ' s wife frequently brought him to activities.

Resident #29 ' s family member was interviewed on 11/14/06 at approximately 1:00 PM. He said his father loved to play cribbage and cards. Other than one instance where staff said they played cards with the resident, he visited frequently, and always found the resident lying on his bed.

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21435	Continued From page 107 During observations during the evening of 11/13/06 and the morning of 11/14/06, resident #29 was observed pacing back and forth from his room to the dining room. There were no activities on the unit during that timeframe. There was Bingo on another floor the evening of 11/13/06, and a few residents expressed a desire to go to the activity. Blackjack was offered on 11/16/06, but the resident wasn ' t present. The RN stated the resident did play cribbage and cards, however, did not understand the game of Blackjack. She said the resident sometimes walked away during an activity, but with returned when asked. The recreation therapy assessment indicated resident #29 was moderately cognitively impaired, and had interest in cards and other games, exercise and sports, music, spiritual activities, trips and shopping, walking outdoors, watching television, gardening, and plants. His attitude toward activities was described as willing to try, uninterested, and withdrawn. He was identified as cooperative, active, and passive at activities, and it was suggested he attended small and large groups, and 1:1 activities. The resident ' s care plan was generic, with a goal to attend 2-3 activities a week. Staff was to provide a calendar, remind, escort, provide 1:1 ' s encourage social interaction, etc. The activity attendance records showed the resident attended five activities in 10/06 which were a coffee social, cooking, cribbage, ice cream social, and a picnic. In 9/06 he attended one activity, a nature movie. On 11/17/06 at 9:35 AM, a hospice social worker was visiting with the resident. The social worker said the resident told her he would rather visit	21435		

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than sleep.

The recreation therapy (RT) director said on 11/16/06 at 3:45 PM, she would look into whether resident #29 ' s needs were being met related to activities. The RT director and RT aide were also interviewed related to the activity assessments, plans, and attendance in general. It was explained that some residents were frequently not available for activities because they were on bed rest, getting up only for meals. When asked whether there was a medical reason the residents needed to be in bed, the staff said it was a matter of routine. One of the staff persons said it had been a challenge to get all staff on board in making changes related to individualizing resident ' s activity needs. Some of the Human Service Technicians (HSTs) were not willing to assist in meeting residents needs regarding activities because they felt " they' re working out of class, " related to the union.

Resident #27 was not provided with an individualized activity program based on interests, needs and strengths.

Review of resident #27's comprehensive assessment dated 10/13/06, described the resident as HOH (hard of hearing), with difficulty understanding others, as well as being understood by others. In addition, the resident had vision impairment and wore glasses. The assessment stated the resident required total assistance with ADL's (activities of daily living), and at times was uncooperative with cares.

Resident #27 was observed on the evening of 11/13/06, the morning of 11/14/06, and the morning of 11/16/06. During observations the resident was either in the hall dining room, or in

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21435	Continued From page 109 his room sleeping with the television on. On 11/16/06 at approximately 10 AM the resident was observed in his room with Sesame Street on the television. Review of #27's interests included bingo, socials and pet visits. He was identified as being appropriate for large group activities and 1:1's. On the evening of 11/13/06 a bingo activity was held on the main floor at 7 PM. Resident #27 did not attend, and slept in his wheelchair in his room. According to the activity calender bingo was held at least 4-5 times a week. Review of the attendance for October revealed the resident attended the following activities; bingo on 10/21/06, ceramics on 10/13/06, pet therapy on 10/23/06 &10/16/06, and a piano concert on 10/24/06. According to the activity quarterly review dated 11/6/06, "Resident is provided with pet visits 1x weekly. Leisure time is spent on bedrest. Resident is in bed during times of RT programming... Leisure is impacted by HOH, potential for aggressive behavior and need for bedrest. Goal met and continue participation 1-2x weekly." The care plan dated 10/13/06 stated the resident was Presbyterian and, "Invite to weekly services." On 11/16/06 at 3:45 PM the RT (recreational therapist) and RT director were interviewed. The RT reported they (activity department) were not involved with the church services, and did not know if resident #27 attended. When questioned what 1:1 visits were provided the RT said "pet visits," which lasted about 5-10 minutes. According to the RT, only 1 resident on 2N was provided with 1:1 visits. The director of RT acknowledged that activity programming was frequently offered when resident #27 was	21435		

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sleeping, and that they needed to work on adapting their schedule to the resident.

On the afternoon of 11/17/06 the Chaplain reported resident #27 did not attend weekly worship services. Review of the record and interview with the Chaplain failed to identify why the resident did not attend, if he refused, or was not invited.

A chaplain was interviewed during the afternoon of 11/17/06. He explained that chaplains provided nursing staff on all units with updated lists as to who should be ready for various worship services. The unit staff was to access the list and have the residents ready for volunteers to transport to the services. He said it was a " valid concern " that residents may not be ready at the designated time, and it was not the job of the volunteers to round up the residents for worship services.

Resident #28 had diagnoses that included cerebrovascular disease (stroke), hemiplegia, and multiple sclerosis. Review of the comprehensive assessment dated 10/2/06, said the resident required total assistance with all activities of daily living, such as dressing, grooming and bathing. According to the assessment, the resident had short term and long term memory loss.

The resident was provided with only a limited number of activities. Review #28's interests included music, watching television, talking or conversing, socials and pet visits. The resident was identified as being appropriate for small group activities, and 1:1's. The resident's attitude towards activities was described as, "willing to try." Review of the activity attendance calender

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21435	Continued From page 111 revealed the following; July the resident attended only 4 activities, 2 of which matched his interests, 1 pet visit, and 1 music trivia; August the resident attended only 3 activities, 2 pet therapies, and 1 songwriting; September the resident attended 5 activities. Review of the annual review dated 9/21/06 stated, "...Resident attends RT programs an average of 1x a week...He attends concerts, socials, appropriate outings and is provided with pet visits...Goal to participate in RT programs and average of 1-2 times a week. Resident # 17 had a diagnoses which included dementia. The quarterly Minimum Data Set dated 10/24/06 identified the resident with severe cognitive impairment and rarely understands others. In addition, the resident could only be understood sometimes. The resident's interest assessment dated 10/13/06, indicated general activity preferences as music, talking or conversing, gardening or plants, spiritual and watching TV. This assessment also specified that resident "rarely or never understands but could participate in small and large group activities. The care plan dated 11/09/06 had generic goals and approaches. Resident was to attend 4-5 activities per week, and staff was to provide her with a calendar, invite to activities, provide appropriate seating ; verbal directions/redirections. The activity attendance records from the previous four months revealed the resident attended activities on the average of one time per week. The activities were music listening, brainteasers/Trivia, concerts, one/one music and	21435		

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21435	Continued From page 112 news. The activity progress notes indicated the resident "continues to meet her Recreation Therapy (RT) goal to participated in structured RT programs 2-3 times per week." In an interview with the recreation therapist on 11/15/06 at approximately 1:30 PM agreed that resident's goals were not individualized to resident ability and needs. Resident # 21 was not receiving an individualized activity program on a regular basis to to meet her needs. During observation of resident #21 on 11/13/06 from 4:30 PM to 8 PM and in the morning of 11/14/06 from from 6:30 AM to 10 AM the resident was not engaged in activities, she was observed to be sleeping, eating, or wandering in the hallways. On the evening of 11/13/06 staff offered her a magazine to read/look at. She immediately set it down again and continued to wander. During an interview with the nurse manager 11/14/06 at 8:30 AM she stated that activity staff had been seeing this resident for a 1:1 horticulture program at the suggestion of her family, and she had some positive response to the activity. These activities had been part of a falls prevention plan to divert the resident from wandering on the unit . She stated she did not think that this program was still in effect for resident #21 because of a change in the activity staffing. She verified that this resident needed a 1:1 approach to stay focused for all activities, and had responded to gardening and the Christmas lights last year. Review of the medical record revealed a recreation assessment dated 2/15/06 that identified the resident's activity preferences as	21435		

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21435	Continued From page 113 music, religious activities, and gardening. Past interests were gardening, macrame, movies, cooking, parties, reading, music,and walking. The resident's was assessed as withdrawn with a poor attention span and unable to verbally communicate. Her cognitive skills were assessed to be severely impaired. The suggested program duration for this resident was a 1-15 minute activity in a small group or 1:1. The resident's care plan dated 11/2/06 directed staff to provide an recreation calendar, remind and escort to activity, provide appropriate seating, verbal directions, redirection, 1:1 intervention, and to encourage social interaction. The care plan did not address the individual interests of the resident and provide for the 1:1 activity needed by this resident. The care plan also included a plan dated 5/22/06 to reduce stress by providing horticulture activities, laundry to fold, and cleaning tasks to provide meaningful activities. The plan is to attempt to increases safety and decrease her wandering. Review of attendance sheets for resident #21 for the past three months were active participation in 4 activities, and passive attendance in 4 activities, none of the groups were for religious activities or gardening. The staff had given the resident three manicures during this time. An interview with the activity therapist on 11/16/06 at 1:15 PM revealed that she was aware that resident #21 had enjoyed gardening activities but she had not been able to provide this 1:1 activity because of staff changes. She is able to provide 1:1 activity of a manicure weekly, she stated that an activity staff had left and was not replaced which has limited her ability to provide for 1:1 activity needs. She did not think that the	21435		

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21435	Continued From page 114 unit staff had been able to provide this resident with activities, she was also not aware of the plan to reduce falls and reduce stress by providing horticulture activity. On 11/13/06 at approximately 11:45AM during the intital tour of 4 north it was observed that none of the resident's on this unit had a copy of the activity calender in their room. SUGGESTED METHOD OF CORRECTION: The Administrator could review staffing levels and privde additional staff as warranted. The Director of Activities could review and revise existing policies and procedures as necessary, provide an inservice for all appropriate personnel and establish a monitoring system to ensure resident needs are being met. TIME PERIOD FOR CORRECTION: Thirty (30) days. ..	21435		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications.	21545		

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21545	Continued From page 115 B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and recipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a medication error rate of less than 5% (3 of 40 opportunities observed). Findings include: Resident #37 had diagnoses that included diabetes. The resident had physician orders for human regular insulin 16 units every morning and 18 units every evening, as well as human NPH insulin 22 units every morning and 10 units at bedtime. During the initial tour on 11/13/06 at 12 noon, the resident was identified by the nurse manager as interviewable, and reliable with information. On 11/14/06 at 8:15 AM the nurse was observed drawing insulin for resident #37, who had	21545		

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21545	Continued From page 116 returned from breakfast on the main floor. The breakfast time had changed on 11/14/06 from 7 AM to 7:30 AM. The nurse reported she was going to call the physician to see if the medication time could be changed later because, "He (the resident) didn't want to wait for the insulin." At about the same time, the resident said, "I never get it (insulin) before breakfast." According to the resident, the insulin was always given after breakfast because, "they're (staff) not ready." The resident said he usually left for breakfast at 6:55 AM. According to the medical administration record, the medication was to be administered at 7 AM. According to the 2005 Nursing Drug Handbook 22nd edition, regular humulin insulin should be administered 15 minutes before a meal, or immediately after a meal. On 11/16/06 during observation of a medication pass, one resident (#53) received epoetin alfa (Epogen) by intramuscular injection rather than sub-cutaneously, as it had been ordered. The current physician orders dated 11/06 were for 1 ml. (10,000 units) to be given sub-cutaneously once weekly. At 8:00 AM, the medication nurse removed the vial from the refrigerator and withdrew the medication in a syringe with a 1 1/2 inch needle. He then entered the resident's room, prepared the site at the left shoulder and then quickly delivered the medication via the intramuscular route by complete needle injection at a 90 degree angle to the skin. When the physician's orders were checked, it identified the sub-cutaneous (sub-q) route for the medication. At 8:10 AM, the medication nurse was interviewed, he checked the orders and reported that he had "made a mistake" in reading the order and the medication	21545		

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administration record and had interpreted 1ml. as IM and had missed the sub-q instructions.
He stated he would check with pharmacy to find out what should be done, and the error was reported to the nurse manager. At 10:15 AM, the nurse manager reported the Nurse Practitioner was contacted and she requested the resident's hemoglobin levels be monitored closely for the near term.
The facility failed to administer medication at the appropriate time for resident #42. Resident #42 had an order for acetaminophen liquid (Tylenol) 650mg to be given four times per day at 8AM, 12N, 4PM and 8PM. On 11/13/06 at 6:30PM the LPN (licensed practical nurse) was observed administering the liquid acetaminophen by mixing it in the resident's milk which was served with his supper. An interview with the LPN and the nurse manager confirmed the acetaminophen was ordered to be given at 4:00pm which was 2.5 hours before it was actually given. The LPN stated this is the usual time that he administers the acetaminophen, despite the order. He stated it is easier to administer in the resident's fluids served with his meal. The surveyor inquired about what time they planned to administer the dose which was scheduled for 8:00PM and was told by the nurse manager that they would try and give that dose at 9:00PM (2.5 hours after the dose was administered at 6:30PM). The "Nursing 2005 Drug Handbook recommends acetaminophen doses be give 4-6 hours apart. The medication error was verified with the nurse manager and the director of nursing

SUGGESTED METHOD OF CORRECTION:

The Director of Nursing (DON) could review and revise existing policies and procedures, inservice all appropriate personnel and establish a

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21545	Continued From page 118 monitoring system to ensure compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21545		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Statute is not met as evidenced by: Based on observation and interview the facility failed to maintain a clean, functional and comfortable environment for residents who smoked. Findings include: On all days of the survey the air in smoking lounge on the ground floor of building 17 was cloudy with smoke. The smoke was in the air all throughout the entrance to the building. Residents complained the smoking room was so full of smoke they didn't want to smoke there. Residents in the board and care unit who use the smoking room in the Building 17, the nursing home, interviewed on 11/14/06 at 10:30 AM reported the air in the smoking room in building 17 was " blue " and it was so uncomfortable they didn't want to smoke there. During the resident group interview of nursing home residents 3 out 3 residents present who smoked reported the room is " too smoky " . One resident reported he will only smoked outside because the smoking room was too smoky.	21665		

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21665	Continued From page 119 SUGGESTED METHOD OF CORRECTION: The Director of Engineering could review the existing ventilation system and make modifications as necessary to increase the air exchange in the room. TIME PERIOD FOR CORRECTION: Forty-Five (45) days.	21665		
21670	MN Rule 4658.1405 A.B.C.D. Resident Units The following items must be provided for each resident: A. A bed of proper size and height for the convenience of the resident, a clean, comfortable mattress, and clean bedding, appropriate for the weather and resident's comfort, that are in good condition. Each bed must have a clean bedspread. A moisture-proof mattress or mattress cover must be provided for all residents confined to bed and for other beds as necessary. Rollaway type beds, cots, or folding beds must not be used. B. A chair or place for the resident to sit other than the bed. C. A place adjacent or near the bed to store personal possessions, such as a bedside table with a drawer. D. Clean bath linens provided daily or more often as needed. E. A bed light conveniently located and of an intensity to meet the needs of the resident while in bed or in an adjacent chair This MN Statute is not met as evidenced by: Based on observations and interview facility failed to provide bed linens that covered the mattresses and were comfortable for 1 randomly observed	21670		

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21670	Continued From page 120 resident #16. Findings include: Resident # 16 was observed to have an oversized mattress on a standard bed frame. The bottom bed sheet for this mattress was not fitted. The bed was made with sheets placed on top of the mattress and were unable to be tucked under the mattress due to its large size. During observations on 11/15/06 at 2:25 PM, the resident was observed laying in his bed with the bottom sheet intertwined around him while the parameter of the mattress was bare and exposed vinyl covering. In a interview with the unit manager on 11/16/06 at 10:05 AM she was not aware of the problem with the sheet and stated that she wouldl check into the matter. SUGGESTED METHOD OF CORRECTION: The Director of Housekeeping could review existing linen supplies and purchase additonal linens where necessary to fit the variety of mattresses observed throughout the facility. Nursing could inservice all appropriate personnel and establish a monitoring system to ensure adequate bedding is provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21670		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation	21685		

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21685	Continued From page 121 with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Statute is not met as evidenced by: Based on observation and interview the facility failed to maintain a safe, comfortable and sanitary environment. Findings include: During an environmental tour on 11/14/06 at 7:45 AM on 3 North, 12 of 15 exterior, wooden bedroom doors sampled, were found to be gouged and splintered along the lower edge of the doors. The splintered, gouged areas varied in length from approximately 3 inches up to 18 inches. These splintered edges could be a potential safety hazard for residents and the raw wood surface was unable to be cleaned. The 12 bedroom doors were: 301; 302; 303; 304; 305; 306; 310; 311; 312; 313; 314 and 315. In addition, the exterior door on the tub room door on 3 north was also found to have significant gouges in the wood resulting in a splintered and rough edge. During an interview with the assistant administrator on 11/14/06 at 8:15 AM, he agreed that the doors needed to be repaired. The facility failed to maintain all tub bathing systems in good repair and operation with regard to the comfort and safety of the residents according to a written routine maintenance and repair program. On 11/16/06 at 10:00 AM during general observations of the facility environment, one of the whirlpool tubs had a 4 inch jagged edge of	21685		

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21685	Continued From page 122 broken fiberglass on the upper right side of the unit near where the resident's hand would make contact support. At 10:46 AM, maintenance staff were interviewed and inspected the tub in question. They reported they do quarterly checks on the tubs, and respond to maintenance work slips from nursing. They were not aware of any current problems with the unit's tubs or the broken fiberglass area. They reported the tub should be repaired and would do so, but had not yet received a work order on the problem. SUGGESTED METHOD OF CORRECTION: The Director of Maintenence and Engineering could make the needed repairs and review and revise the preventative maintenance program to include doors and tubs. The Director could include doors and tubs in his regular building rounds. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21685		
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 Statute is not met as evidenced by: Based on observation, interview, and record review, the facility failed to promote courteous treatment for 17 of 50 residents (#26, # 32, #13,	21805		

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21805	Continued From page 123 #49, #15, #44, #45, #46, #47, #48, #11, #26, 54, #52, #55, #27, #28,) in the sample and during random observations. Findings include: Staff applied an incontinent pad on resident #26, who was identified as continent of bowel and bladder. Review of resident #26's comprehensive assessment dated 10/10/06, described the resident's cognitive status as, "Independent-decisions consistent and reasonable." According to the assessment, the resident was continent of urine. Review of the care plan dated 7/12/06 directed staff to assist the resident to the toilet per his request, and empty the urinal as needed. On 11/13/06 at 12 noon resident #26 said, "When I first got her they put those stupid diapers on me." The resident said, "I just went with the flow" and eventually started taking them off and no one said anything to me. On 11/15/06 at 10 AM the nurse manager said the resident was continent of urine, and did not see any reason why staff put incontinent pads on him. Facility failed to provide a dignified dining experience for resident #32 for the evening meal on 11/13/06. Resident #32 had a diagnoses which included Alzheimer's disease. The care plan last updated 9/28/06 identified the resident as dependent upon staff for all activities of daily living, in addition, the resident had behavior disturbances, which included "constant vocalizing during meals." During observations of the evening meal on	21805		

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21805	Continued From page 124 11/13/06, it was noted the resident was brought into the dining room in a wheel chair at 5:01 PM. The resident was moved from her location at the table seven times between 5:03 PM until 5:47 PM to accommodate other residents who needed to enter the dining room. In this period of observation, 6 of the 7 times the resident was moved, the staff pulled her chair backwards without first informing the resident that she was going to be moved. Interview with the unit manager on 11/16/06 at 10:25 AM she agreed that this was not an acceptable practice. Resident #13 During observations of morning cares on 11/14/06 at approximately 8:00 AM the human service technician (HST) ambulated resident #13 from the bed into the bathroom with the resident's pants down around the knees and the resident's feet were shuffling across the floor. When the HST was asked if this was a safe practice the response was, "It's only a risk if the pants are down around the ankles and they are above the knees." An interview with the NM on 11/15/06 at approximately 10:30 AM to follow up on the practice of ambulating a resident from the bed to the bathroom with pants down around the knees revealed that it was not okay. Resident #49 During the initial tour on 11/13/06 at approximately 11:15 AM with the nurse manager (NM) in Building 6 on the 3rd floor, the NM introduced resident #49 as "My Petutie" and stated that the resident was the NM's good friend. During evening observations at approximately	21805		

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21805	Continued From page 125 7:00 PM resident #49 was attempting to stand up after dinner and set off the tab alarm attached to his shirt and yelled, "Get out of here. Get away." The NM intervened and again referred to resident #49 as "Petutie". A review of the care plan dated 11/14/05 indicated that resident #49 had a diagnosis of progressive Alzheimer's Dementia with short and long term memory loss, impaired decision making and problems understanding others. An approach dated 3/31/06 used for the resident when exhibiting behaviors of wandering, verbal abuse, physical abuse or resistance to cares indicated, "Address resident respectfully by name." There was no reference to using any nickname such as "Petutie." Another random observation on 11/13/06 at 5:55 PM around the dinner hour a HST was observed to call out to a male resident down the hall, "(resident's name), suppertime dear." A review of the facility standards of practice and indicators for excellence indicated, "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. To be called by proper name." Residents #s 15, 44, 45, 46, 47, & 48. During random observations on 11/13/06 at lunchtime on the 3rd floor of Building 6 approximately 3-4 residents were noted to have their name written on the instep of their shoes. During a follow up tour of the 3rd floor in building 6 on 11/16/06 at approximately 10:00 AM there were 6 residents (#15, #44, #45, #46, #47, and #48) observed to have their name written legibly on the outside of their shoes. Residents #44 and #45 had black shoes with their names written in white on the back of the heels. Resident #46	21805		

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21805	Continued From page 126 had his name written in green on the back of the heels of his grey shoes. Residents # 15, #47, and #48 had their names written on the inside instep of their shoes. All 6 residents had short and long term memory loss and poor decision making abilities and unable to state whether their name located on the outside of their shoes bothered them or not. An interview with a registered nurse (RN) on 11/15/06 at approximately 2:00 PM revealed that the staff had tried to label the names of the residents on the inside of the shoes and that the names had rubbed off, so then the staff had tried to label the shoes on the instep of the shoes. An interview with the assistant director of nursing (ADON) on 11/16/06 at 10:40 AM related to the labeling of the shoes revealed that, "this is not our practice." The ADON thought maybe the families had labeled the shoes. An interview with a family member of resident #15 on 11/16/06 at 11:05 AM revealed that the family had not labeled the shoes on the outside and did not know who had labeled the shoes. Random observations took place on 11/13/06 at the supper meal in 3 North. Two male residents were dressed in street clothes; however, both had hospital gowns on underneath their shirts. A third resident emerged from the dining room with his pants mostly unzipped and a blue incontinent pad could be visualized as he passed through the dining room. A registered nurse (RN) was interviewed on 11/16/06 at 10:30 AM. She said the two residents were likely wearing the gowns after their baths. Resident #11 was not provided care in a manner and environment that maintained or enhanced his dignity. His wheel chair was pulled backwards during observations on 11/13/06.	21805		

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21805	Continued From page 127 Resident #11 had a diagnoses of dementia. A quarterly Minimum Data Set (MDS), dated 10/24/06, identified the resident as severely cognitively impaired with both long and short term memory problems. The MDS further indicated he was totally dependent on staff for all activities of daily living. The care plan dated 5/10/06, had approaches that included, a Broda chair with a lap tray, foot rests to be removed from the wheel chair when on the unit During observations on 11/13/06, at 4:55 PM, a nurse pulled the resident in his wheel chair backwards down the hall approximately 10 feet, without first informing the resident that he was going to be moved. His heels on both feet were dragging on the floor. Again on 11/13/06, at 6:06 PM, a human service technician (HST) held the resident's feet up and a second HST pulled the wheel chair backwards approximately 40 feet from the dining room to outside the resident's room. On 11/13/06, at 8:30 PM, a nurse manager said, "The resident doesn't have foot pedals on his wheel chair because the foot pedals are considered a restraint. He is pulled backwards so his feet wouldn't get caught." Residents 26, 54, 52, & 55, residing on the 2N unit, complained of long response times for call lights. During the initial tour on 11/13/06 at 12 noon, resident #26 reported the call light response time was long, especially during the 11 PM-7 AM shift. The resident could not specify the length of time, but said, "Sometimes they don't show up, and you have to hit the light a 3rd time." The resident expressed concern and said, "They don't know if	21805		

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21805	Continued From page 128 it's serious or not. It might be something I need help with right now." The resident was identified by the nurse manager as interviewable and reliable with information. On the morning of 11/15/06 resident #54 reported "Sometimes the call lights were answered right away and sometimes it took a while". The resident reported that sometimes staff turned the call lights off at the desk without going to the room, and expressed concerned because, "something could really be wrong." The resident was identified by the nurse manager as interviewable and reliable with information. On 11/15/06 at 10 AM, the nurse manager said she was unaware call lights could be turned off at the nurse's desk. After the inquiry, the nurse manager verified the call lights could be turned off at the desk, without staff entering the resident's room. On the morning of 11/15/06 resident #52 said "sometimes you have wait over an hour" for call light response. The resident denied any adverse outcomes, and said he had discussed the concern with the nurse manager. On 11/15/05 at 10 AM the nurse manager verified the resident had discussed the concern, and that she had "talked" with the night staff, although did formally document the complaint. The resident was identified by the nurse manager as interviewable and reliable with information. On the morning of 11/15/06 resident #55 reported the response time for call lights was long at night and that, "sometimes the wait is an hour or more". The resident reported that sometimes staff come in and turn the light off, and then leave. The resident was identified by the nurse manager as interviewable and reliable with	21805		

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information.

Residents #s 27 & 28,were observed in the dining room at mealtimes with urine in uncovered catheter bags.

During observations on 11/13/06 at approximately 5:15 PM, resident #27 was observed eating dinner in the hall dining room on 2N with approximately 100 cc's of urine in the drainage bag. The drainage bag was not covered.

During observations on 11/14/06 at approximately 7:30 AM resident #28 was wheeled to the dining room for breakfast with urine in his drainage bag, uncovered.

On 11/15/06 at approximately 10 AM the nurse manager said drainage bags were suppose to be covered, and that she had recently reminded staff to cover the bags.

During observation on Building 6 at 7 AM on 11/15/06 a loud overhead page lasting 3 minutes was heard while observing cares on a resident. The information relayed in the paging had to do with staff signing up for benefits for the next year. At the time of the announcement half of the residents on the unit were still in bed asleep. Interview with the receptionist at the front desk in the main lobby at 2:50 PM on 11/16/06 revealed that there were no hours when overhead paging is not done because of a possible emergency need but that she was directed to keep pages to a minimum to avoid disturbing residents.

SUGGESTED METHOD OF CORRECTION:

The Director of Nursing (DON) could review and revise existing policies and procedures, inservice

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21805	Continued From page 130 all appropriate personnel and establish a monitoring system to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21805		
21855	MN St. Statute 144.651 Subd. 15 Patients & Residents of HC Fac.Bill of Rights Subd. 15. Treatment privacy. Patients and residents shall have the right to respectfulness and privacy as it relates to their medical and personal care program. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly. Privacy shall be respected during toileting, bathing, and other activities of personal hygiene, except as needed for patient or resident safety or assistance. This MN Statute is not met as evidenced by: Based on random observations, interview, and record review, the facility failed to provide privacy during 4 randomly observed personal cares for residents (#36, #1, #2, #5, #22) and failed to knock before entering resident rooms or wait for a responses before entering resident rooms. Findings include: Resident #36 received care and services that were provided in a manner that was not within acceptable standards for privacy and dignity. The resident was admitted in 11/03 with diagnoses that included dementia and Alzheimer's disease. The Annual Minimum Data Set (MDS) dated 8/15/06 identified a severe cognitive impairment, diminished ability to understand others and inability to make himself	21855		

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understood, and total bowel and bladder incontinence. The current plan of care dated 11/13/06 identified approaches for transfers of use of a standing mechanical lift with 1-2 assists, use of incontinent briefs at all times and toilet/changes every 2-4 hours and as needed with perineal care twice daily and as needed.

On 11/13/06 at 6:30 PM, the resident was placed on the standing lift by two Human Services Technicians (HSTs) and wheeled into the bathroom for toileting. The door was not closed behind them and the HSTs then lowered the resident's clothing, removed the brief and the resident was totally exposed below the waist to his roommate who was seated in his chair directly across the room.The HST's were questioned if they normally close the door when taking residents to the toilet. They did not respond verbally, but then closed the door and continued to toilet the resident.

Resident #s 1 & 2 were not provided privacy in the bathroom.
During random observations on 11/17/06 at approximately 11 AM, the surveyor knocked on the 2N tub room, and was granted access. One resident was in tub #1, and another resident was standing near tub #2 naked, while staff was drying the resident with a towel. The divider curtain between the 2 tub areas was not pulled, leaving a view for both residents to see each other. The surveyor questioned if the curtains were usually pulled and staff replied, "yeah, we usually pull the curtains."

Observations of evening cares on resident #5 were conducted on 11/13/06 at 8:50 PM. The Human Services Technician (HST) began cares without pulling the privacy curtain. The resident '

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21855	Continued From page 132 s roommate was lying on the bed with his eyes closed. The HST them pulled the resident ' s pants down and removed the incontinent brief. He then wheeled the exposed resident to the bathroom in the standing lift. While resident #5 was using the bathroom, his roommate got up and left the room. A registered nurse (RN) was apprised of the findings in an interview on 11/15/06 at 9:15 AM. Resident #22 was observed 11/15/06 at 6:40 AM to be seated at the side of his bed in only an incontinence product (and no clothing) with the curtain left open to his roommate's view. The HST was in the hallway getting a lift and stated she was in the middle of getting him up. The curtain between the roommates was left open to view of the roommate. The multiple data set (MDS) dated 9/18/06, assessed resident #22 to have moderately impaired cognitive skills, and both short and long term memory impairment. Interview with the resident at the time revealed he was confused to time and events. During random observations after supper on 11/13/06, a nurse walked into resident #5 ' s room without knocking to administer medications. Human Services Technicians (HSTs) also walked into resident #5 ' s room without knocking on at least two occasions. During the entrance tour on 11/13/06 in Building 6 on the 3rd floor at approximately 11:20 AM a human service technician (HST) walked into room 325 and did not knock before entering. An interview with the HST at the time revealed that because there were others in the room the HST did not feel they had to knock before entering. During evening observations on 11/13/06 at	21855		

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21855	Continued From page 133 approximately 5:25 PM a registered nurse (RN) was observed entering room 345 and did not knock before entering. An interview with the RN at the time revealed that because the resident was sleeping and the door was open that the RN did not feel knocking was indicated; "Well he's sleeping and I just checked on him and you have to grab the opportunities when you can up here. I would normally knock if the door was closed." During observations of morning cares on 11/14/06 at approximately 7:25 AM a HST was observed walking into room 325 with some garbage bags in hand and did not knock before entering the room; Resident #13 was lying in bed awake at the time. A review of the facility's standards of practice and indicators of excellence indicated, "To have all staff knock before entering resident's room. Facility staff shall respect the privacy of a residents room by knocking on the door and seeking consent before entering." An interview with the director of nursing (DON) on 11/16/06 at 8:50 AM revealed that the DON communicates with staff via a newsletter and shared that the newsletter dated 9/29/06 stated, "Knock on resident doors before entering and introduce yourself." An interview with the family council on 11/14/06 at approximately 2:00 PM revealed a recent observation of a resident being changed in their room and left exposed with the door open while staff went to get supplies to assist the resident. A review of the facility standards of practice and indicators of excellence indicated, "Privacy shall be respected during toileting, bathing or other activities of personal hygiene." An interview with the director of nursing (DON) on 11/16/06 at 8:50	21855		

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21855	Continued From page 134 AM revealed that the DON communicates with staff via a newsletter and shared that the newsletter dated 9/29/06 stated, "Respect resident's rights and their privacy." SUGGESTED METHOD OF CORRECTION: The Director of Nurses could review and revise existing policies and procedures as necessary, provide an inservice for all appropriate personnel and establish a monitoring system to ensure resident needs are being met. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21855		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.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 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 nonacute care facility, and every facility employing more than two people that	21880		

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21880	Continued From page 135 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 Statute is not met as evidenced by: Based on interview and record review, the facility failed to encourage residents and families to understand and exercise their rights to file a grievance. Findings include: During an interview with the family council on 11/14/06 at 2:00 PM the council members revealed that they were unaware that they could file a grievance related to concerns about in the care of residents in the facility. The council members shared that when issues were brought up with the nursing supervisors related to resident concerns that there was no follow- up as to the result and how or if the issues were addressed. The council members also stated that they were "afraid to complain" and expressed a concern about retaliation to their loved ones and/or the	21880		

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21880	Continued From page 136 staff person who might be involved in the issue. The facility failed to develop a system that adequately addressed missing clothing and lack of clothing. The family member of resident #29 was interviewed on 11/14/06 at approximately 1:00 PM. He said his father was missing clothing items. He reported he had only one t-shirt and no underwear in his drawers when he checked earlier that day. He said he informed the staff that day as well as on other occasions, but staff did not have an answer as to what happened to the laundry. He explained that the resident names on the clothing could not be easily read. On 11/17/06 at 9:35 AM, permission was granted by resident #29 to check his drawers and closets for clothing. The drawers contained one pair of underwear, one t-shirt, and one pair of socks. The RN said, " We provide socks. Even if we mark them, they won ' t come back. " When the hanging clothing was examined, nearly half of the labels could not be easily read, and one of the labels was peeling off the collar. Resident #29 ' s roommate ' s shirt was also hanging in the wrong closet. A registered nurse (RN) was interviewed on 11/16/06 at 2:40 PM. regarding missing laundry, The RN said the personal laundry went to Faribault, and it sometimes took ten days or more for items to return. Although the problem with missing laundry was raised many times, she said there hadn ' t been a resolution to the ongoing problem. The Director of Engineering was interviewed about the turnaround time for laundry on 11/17/06 around 10:00 AM. He reported the laundry came back the next day but might need a	21880		

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21880	Continued From page 137 day or at the most two for sorting and return to the floors. The unit social worker was interviewd on 11/17 at 10:23 AM. She was not aware of that resident #29 didn't have enough clothes to wear or was missing clothes. "No one told me". When asked what she would do if she was aware of missing items she reported we'd look around and wait awhile to see if it came back from the laundry. If not the resident could complete fill out a "tort". When asked who a direct care staff would reported a resident with insufficient clothing or missing clothing to, the Social Worker indicated that maybe the Health Unit Coordinator (HUC). The HUC was interviewed on 11/17/06 about 10:30 AM she had not received any report of missing clothing or insufficient clothing for resident #29. When asked who and how reports of insufficient clothing or missing clothing were handled the Health Unit Coordinator (HUC) indicated that she completes a missing clothing report and it goes to the head of Housekeeping. When asked if there as a response back, "No not usually." A resident group interview was conducted on 11/15/06 at 1:15 PM. Four residents who had the facility launder their clothing reported missing clothing. Missing socks were a particular problem, as well as labels on clothing that were faded and couldn ' t be read. The residents stated they were told they would be reimbursed for lost clothing, but that so far had not happened. Two residents stated they were told, " We ' ll look into it, " and had not heard anymore about their missing items. Resident council minutes from 5/3/06 revealed	21880		

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21880	Continued From page 138	21880		

the facility was out of funds for laundry reimbursement and a staff person reported " will look into this and see what he can find out. ". The following month ' s old business was limited to, " dining room update, " with no follow up regarding the residents ' concerns of missing laundry or reimbursement issues.

A resident and his family member approached the surveyors on 11/17/06 at 2:20 PM. The family member complained staff didn ' t brush the resident ' s teeth. She said he had a partial which would get stuck in the resident ' s mouth since it wasn ' t removed and brushed. She added, " They don ' t even know he has it. " Additionally, she said they didn ' t shave the resident, wash his face and matter out of his eyes, or change his incontinent pad until it was " loaded. " The resident added, " Other people tell me I have wet pants. I don ' t even know it. " He also said it became difficult to shave when left too long. His family member said she reported this to a registered nurse (RN), who wrote it down, but, " Nothing happens. They just quit talking to me for awhile. " She said she did not want the staff to know she spoke to the surveyors because " They backlash. " When asked how, she replied, " They just ignore me. " She said she was worried about speaking up, for fear her husband would not receive care.

Continuing concerns about noise at the elevators was not being addressed.

Resident council minutes were reviewed. Continuing concerns about noise at the elevators was brought up by residents. In 8/06, the council said the alarm on the 3rd floor sound when it is supposed to, but also when it isn ' t supposed to. It goes off by people not wearing an alert

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21880	Continued From page 139 bracelet. Staff on 3rd floor was not responding timely to the alarm. Follow up in 9/06 indicated staff would look into what was causing it and how it could be fixed. Minutes from the 11/06 meeting revealed, " Elevator alarms are still an issue. Wondering why they are going off and staff are ignoring them. " Action taken indicated a meeting was scheduled and a staff person would be asking about this issue. During a resident group meeting on 11/15/06 at 1:15 PM, residents reported staff continued to ignore the elevator alarms in Building 17. They also said the alarms were set off when they shouldn ' t have been. An interview was conducted with the Maintenance Director on 11/17/06 at 11:00 AM. He said mechanical parts to eliminate the problem were supposed to be available in two weeks. Every alarm was to be considered " real " and all should have been responded to by ecurity or engineering, as well as nursing. The facility failed to assure that resident group concerns related to the dietary department and recommendations had been addressed and acted upon in a timely manner. .... Resident council minutes were reviewed. The Director of Dietary said that the facility had two meetings each month, the first meeting, "The Resident Council General Meeting" was the meeting where residents could express concerns. The second meeting, a follow-up meeting. "The Resident Council/Administrative Meeting" was where a response to the concerns raised at the first meeting could be expressed.	21880		

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21880	Continued From page 140 During the May 17, 2006 "Resident Council General Meeting" the minutes indicated that the daily menu was not being written on the white board on 4 North. The resident said what was written on the white board was "menus not available." Or, if a menu was placed on the white board, it was too high for residents to read." At the June 7, 2006 meeting, "The Resident Council/ Administration Meeting" (The second meeting of the month) the issue concerning the availability of menus on the white board was not addressed. During the July 19, 2006 Resident Council General Meeting the minutes said, "There seems to be a lack of communication between nursing and dietary when a resident returns from the hospital. A resident on 3 south said after she returned from the hospital her meal tray was being sent to the unit and she eats in the main dining room." The issue was not responded to at the Resident Council/Administration Meeting on August 2, 2006. The August 16, 2006 Resident Council General Meeting said "The chicken patties are like hockey pucks. The chicken breast is preferred. Meal tickets are not being read. This could be dangerous for those on special diets." The September 6, 2006 Resident Council/Administration Meeting minutes did not respond to the issue concerning chicken. The response to the concern about meal tickets not being read was: the Director of Dietary asked for specifics and will bring this to staff on the 7th. (month not identified) The minutes for September 20, 2006 meeting indicated "The apple crisp is too sweet. All the resident's in the council agreed and do not eat it. One resident suggested serving apple pie in	21880		

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21880	Continued From page 141 place of crisp. The residents requested more broccoli florets and less stems. They also said fresh raw vegetables and dip once in a while would be nice, and they requested liver and onions on the menu more often. The 4 North dry erase board is not changed every day. There is a menu posted in the locked glass case by the board but most of the residents can't read it. These concerns were again not addressed at the October 4, 2006 Resident Council/Administration Meeting. The issue brought up at the previous month's meeting concerning meal tickets not being read had the same response as the earlier minutes by the Director of Dietary, "to bring it to her staff on the 7th."(Again the month was not identified). The October 18, Resident Council General Meeting minutes indicated that 6 of 7 residents requested to have liver and onions as a main meal not the alternate. The residents said they are not getting it as often as they would like. The Director of Dietary indicated at the November 8, 2006 Resident Council/Administrative Meeting that there will be a main meal of liver and onions offered on the next meal. On 11/15/06, at 10:00 AM, the Director of Dietary said that "The responses on dietary concerns did not get into the meeting minutes. She further said, "The minutes from the second meeting have not been posted. So if the concerns had been addressed, residents would not be able to know what the response was unless they attended the meetings. During an interview with the resident council of the board and care unit on 11/14/06 at 10:30 AM the residents revealed they are unable to get the forms to file grievances. The residents reported	21880		

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21880	Continued From page 142 trying to get grievance forms from the main switchboard (the nursing home) and the social worker and were not able to get the forms. The residents indicated there was also some fear of retaliation for filing grievances. The residents reported that their concerns went nowhere. During the survey on 11/15/06 at 3:00 PM the state ombudsman met with state surveyors and reported that she had heard a complaint from a resident that they couldn't get a grievance form at the main switchboard. The ombudsman then went to the switchboard and asked for a grievance form. The employee manning the switchboard did not know where any grievance forms were. The facility's Operating Policy and Procedures : Resident Grievance Procedure" revised 1/21/04 states " 1. A resident may complain or bring a suggestion to any staff person, however he or she is encouraged to contact the relevant department supervisor. 2. The resident resident may request the assistance of his/her social worker. 3. Any staff person perceiving grounds for or receiving either a verbal or written complaint from a resident, significant other or fellow staff person, and is unable him/herself to correct the problem, will at once refer the complaint to his/her supervisor." The facility's current (undated) "Resident Orientation Handbook" states: "Residents may voice complaints and concerns without retaliation of reprisal. Residents are encourage to resolve concerns on an informal basis. If the resolution is not satisfactory, a grievance may be filed. Grievance forms are available at the Switchboard in Building 17 or through Social Services.	21880		

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21880	Continued From page 143 SUGGESTED METHOD OF CORRECTION: The Administrator could review and revise existing policies and procedures as necessary, provide an in-service for all appropriate personnel and establish a monitoring system to ensure resident/family grievances and concerns are being addressed. . TIME PERIOD FOR CORRECTION: Thirty (30) days.	21880		
21920	MN St. Statute 144.651 Subd. 28 Patients & Residents of HC Fac.Bill of Rights Subd. 28. Married residents. Residents, if married, shall be assured privacy for visits by their spouses and, if both spouses are residents of the facility, they shall be permitted to share a room, unless medically contraindicated and documented by their physicians in the medical records. This MN Statute is not met as evidenced by: Based in interview the facility failed to have a system to provide privacy for visits by spouses. Findings include: During the group interview on 11/14/06 at 10:30 AM with the residents of the board and care unit, which serves a young population, the residents were asked about the ability of privacy during visits with spouses. The residents laughed and one stated "If you want conjugal visits you have to go prison." The residents further stated that they were told when they had visitors they had to stay in a public area. The facility's "Resident Orientation Handbook" for nursing home residents dated 5/28/03 was	21920		

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21920	Continued From page 144 reviewed for visits and privacy. The Handbook indicated that "Residents may receive visitors daily from 7:00 a.m. to 12 Midnight. Visitors are expected to comply with facility rules." The handbook did not address the availability of privacy for spousal visits. There are very few private rooms in the nursing home or board and care units and those are assigned to residents based on a waiting list. Outside of a provision for spouses to share a room if they are both residents there were no provisions for private visits. During the environmental tour on 11/15/06 that started at 8:45 AM the assistant administrator was asked if there were private spaces, rooms for residents to have private visits with their spouses or significant others either in the board and care units or the nursing home or on campus. The surveyor was told that there were not. SUGGESTED METHOD FOR CORRECTION: The Administrator could review and revise existing policies and procedures, provide private areas for visitation, train personnel, and designate someone to monitor the implementation of those policies. TIME PERIOD FOR CORRECTION: Fourt-five (45) days.	21920		
21990	MN St. Statute 626.557 Subd. 4 Reporting - Maltreatment of Vulnerable Adults Subd. 4. Reporting. A mandated reporter shall immediately make an oral report to the common entry point. Use of a telecommunications device	21990		

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21990	Continued From page 145 for the deaf or other similar device shall be considered an oral report. The common entry point may not require written reports. To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment, any evidence of previous maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment. A mandated reporter may disclose not public data, as defined in section 13.02, and medical records under section 144.335, to the extent necessary to comply with this subdivision. This MN Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to fully investigate and report to the common entry point allegations of theft/missing property against 3 of 3 residents who reported missing personal items (#50, 51 & #52). Findings include: On 07/13/06 resident #50 reported to the social worker a book of checks had been stolen from his room, and 3 bad checks had been written. The copy of the"Resident Security Report" dated 07/13/06 indicated the resident was self sufficient in decision making and the report was substantiated by bank paperwork. Question #8 on the "Resident Security Report" ask's what "investigation/follow-up/corrective actions" were taken, with the following response "He had not come to tell me when this occurred. I advised him we need to know as soon as possible. Too little too late at this point." Question #12 on the "Resident Security Report" asked if the common entry point was notified, this question was left	21990		

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21990	Continued From page 146 unanswered. Question #13 on the "Resident Security Report" asked if there was a police report made, this question was left unanswered. The section of the form which asked "recommendation/action plan implemented and documented has the following response "We will have a resident council meeting 07/20/06 form 10-11AM. We will reinforce with all resident's necessity for vigilance, safeguarding their belongings, locking up possessions." The "Resident Security Report" included the following statement "IF THE VALUE IS OVER $50.00 IMMEDIATELY CONTACT SECURITY" There is no documentation to indicate that security was notified of the missing checks. On 11/17/06 at approximately 11:00 AM during an interview with the nurse manager who took the initial report form the resident, she indicated that the common entry point was not notified because the theft occurred a month ago. She when on to indicated she did not know if the incident had been reported to the police. The nurse manager indicated that she met with the resident following the incident and instructed the resident to lock his valuables in his locked drawer in his room. On 11/17/06 an incident report from General Security Services Corporation (GSSC) was reviewed. This incident report included the following narrative"On Friday 8/25/06 at 1310 (military time) received a call from(nurse managers name) that a resident reported some checks missing. Resident was at bank 8/24/06 and was notified that a personal check for $300 was cashed. Resident did not write a $300 check. Resident noticed this morning that 3 additional checks were missing form checkbook 8/25/06 top check was still in book. No further information is	21990		

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	00233	A. BUILDING _____ B. WING _____	11/17/2006

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21990	Continued From page 147 available at this time. We do know that his drawers where he keeps them were not locked at the time. End of report 1539 (military time) 8/25/06." The section of the report that asked if police were involved was left blank. During an interview with the assistant director of nursing and the facility safety officer on 11/17/06 at 10:20AM they indicated they had no further information regarding the incidents. The safety officer indicated that the decision to notify police would be decided by the safety officer and the clinical staff. She went on to indicate she "wasn't sure why it wasn't called in" to the police or the CEP. Review of the facility's policy "Vulnerable adult act reporting maltreatment-guidelines for the decision making process" dated 8/97 contains a section addressing missing items versus theft. The policy directs staff to report to the common entry point "Incidents when there is reason to believe, strong suspicion or actual evidence to indicate that a theft occurred. The decision is not dependant on the amount of money." Resident #51 reported a theft of money form his locked drawer that was not fully investigated by the facility nor reported to the common entry point. Review of a resident incident report dated 11/02/06, resident #51 reported to a nurse on 11/02/06 at 10 PM that "someone took $80.00 from my drawer. Pt. said his money was missing between 3-6 PM. Pt. said he locked his drawer, and then placed his key in the upper drawer." According to the incident report resident #51 was alert and oriented to person and place, and makes his own decisions. The resident had made	21990		

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21990	Continued From page 148	21990		

no past reports of missing items, and he managed his own trust account.

The staff on duty at the time of the report searched the room and encouraged resident to not have so much cash on hand and to carry the key with him. The incident was reported to the security company for investigation- which did not further investigate and stated there were no known suspects.

The assistant director of nursing was interviewed on 11/17/06 at 10:30 AM and stated the incident was reported to the evening nursing supervisor and then reported to the facility's security agency. She stated at that point the investigation stopped and agreed it was not complete. She also verified that the incident was not reported to the common entry point or to the police.

The facility failed to investigate an incident of a missing wallet.

During the resident family council meeting on the afternoon of 11/17/06 a concern regarding a missing wallet was verbalized. On 11/16/06 at 2 PM resident #52, and their family member were questioned regarding the missing wallet. Resident #52 was identified by staff on the initial tour as being interviewable and reliable with information.

According to resident #52 and their family member, a missing wallet was reported to the social worker and nurse manager approximately 6 months ago. The wallet contained $11 dollars, a social security card, veterans administration card, drivers license, and pictures. The wallet was kept in a locked cabinet, and according to resident #52 and family, "It had to be someone

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21990	Continued From page 149 who knew where the key was." According to the resident and family, there were several conversations (with the nurse and social worker) regarding the wallet, and it was determined the wallet could not be located. On 11/16/06 at 3 PM the nurse manager reported a "missing log report" was typically completed when resident's personal possessions were missing. The nurse manager denied any knowledge of resident #52's missing wallet, and stated a report had not been completed. At the same time the social worker denied any knowledge of resident #52's missing wallet, or if a report had been completed. Review of the facility 'operating policy and procedure for theft and fraudulent activity' dated 11/01 directs staff to report incidents to the department head. The department head "when advised of a suspected theft, a thorough investigation will be conducted." Review of the facility's policy "Vulnerable adult act reporting maltreatment- guidelines for the decision making process" dated 8/97 contains a section addressing missing items versus theft. The policy directs staff to report to the common entry point "Incidents when there is a reason to believe, strong suspicion or actual evidence to indicate that a theft occurred. The decision is not dependent on the amount of money." Review of the facility's policy "Vulnerable Adult Acts" revised 1/06 stated, "Reports of missing items/theft are to be recorded on the Resident Security Report form. Nursing in collaboration with the Health & Safety Officer or designee and with the director of social services will investigate reports of missing items..."	21990		

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21990	Continued From page 150 SUGGESTED METHOD FOR CORRECTION: The administrator could review and revise existing policies and procedures, train personnel, and designate someone to monitor the implementation of those policies. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21990		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Hand delivered on December 7, 2006

December 7, 2006

Mr. Bob Wikan, Administrator
Minnesota Veterans Home Minneapolis
5101 Minnehaha Avenue South
Minneapolis, Minnesota 55417

Re: Enclosed State Boarding Care Home Licensing Orders - Project Number SL00233015

Dear Mr. Wikan:

The above facility survey was completed on November 17, 2006 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.

The order form should be signed and returned to this office when all orders are corrected. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

Please feel free to call me with any questions.

Sincerely,

E M Laumark

Ellie Laumark, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651)643-2566 Fax: (651)643-2538

Enclosure(s)

cc: Original - Facility
Licensing and Certification File
Program Assurance Unit
Mary Lou Heider, Stratis Health

00233s07bch.rtf

Minnesota Department of Health

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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 November 13, 14, 15, 16, & 17, 2006 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	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 Boarding Care Homes.	

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3 000	Continued From page 1 Minnesota Department of Health, Division of Compliance Monitoring, Licensing and Certification Program; Complaints; 85 East Seventh Place, Suite 220; P.O. Box 64900, St. Paul, Minnesota 55164-0900.	3 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings is 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.	
3 750	MN Rule 4655.4160 Withdrawal of Funds from the Account Upon the request of the patient or resident or the patient's or resident's legal guardian or conservator or representative payee, the nursing home or boarding care home shall return all or any part of the patient's or resident's funds given to the nursing home or boarding care home for safekeeping, including interest, if any, accrued from deposits. The nursing home or boarding care home shall develop a policy specifying the	3 750		

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3 750	Continued From page 2 period of time during which funds can be withdrawn. This policy must ensure that the ability to withdraw funds is provided in accordance with the needs of the residents. This policy must also specify whether or not the nursing home or boarding care home will establish a procedure allowing patients or residents to obtain funds to meet unanticipated needs on days when withdrawal periods are not scheduled. The nursing home or boarding care home shall notify patients and residents of the policy governing the withdrawal of funds. Funds kept outside of the facility shall be returned within five business days. This MN Statute is not met as evidenced by: Based on observation, interview and policy review the facility failed to ensure residents could access their funds when needed to mange their personal affairs. Findings include: The facility's policy did not address any provision to allow residents to obtain funds to meet unanticipated needs. During the resident group interview for Board and Care residents held on 11/14/06 at 10:30 AM the residents reported it was difficult to access their funds when they needed to due to the limited hours the cashier's office was open. One resident reported he wanted to access his funds on Veterans' day but the office was closed. The " Minnesota Veterans Home Minneapolis Things to Know " from the resident handbook indicated the Cashier Window is open Monday, Wednesday and Friday from 9:30 AM to 11:30 AM and 1:00 PM to 2:30 PM. On Tuesday and Thursday it is only open in the AM. The hours	3 750		

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3 750	Continued From page 3 were posted at the Cashier's Window. In addition the sign indicated the window was closed weekends and holidays. There was no other method for residents to access their funds during off hours. This was confirmed by interview with the assistant administrator the morning of 11/15/06. SUGGESTED METHOD OF CORRECTION: The Administrator could review and revise existing policies and procedures as necessary to ensure residents have access to their funds for unanticipated needs. The Administrator could inservice all appropriate personnel and establish a monitoring system to ensure adequate access to trust funds. TIME PERIOD FOR CORRECTION: Thirty (30) days.	3 750		
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 Statute is not met as evidenced by: Based on observation, interview and record	3 945		

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3 945	Continued From page 4 review the facility failed to assist 1 of 1 residents in the sample with incontinence (#24), with maintaining or improving his continence. Findings include: During the initial tour of building #9 at 12 noon on 11/13 and again during the physical environmental tour on 11/15 starting at 9:00 AM resident #24's room had a pervasive stale urine odor. A review of the resident's record indicated that last bladder assessment was performed on admission and was dated 11/13/94. The assessment indicated the resident had occasional incontinence and self-catheterized himself at night to empty his bladder. The resident's plan of care last updated on 4/9/06 stated " does not change linen/incontinent products in timely manner; odorous laundry/trash contributed to room odor on occasion. The only intervention was to provide teaching for proper laundering and room check for soiled clothes. There was no comprehensive assessment of the reason for the resident's incontinence, type of incontinence or other factors that could be contribute to the incontinence including medications or any plan to help the resident manage his incontinence. The nurse manger interviewed on 11/16/06 indicated the resident no longer used a catheter and indicated the only bladder assessment was the one performed on admission. SUGGESTED METHOD OF CORRECTION:	3 945		

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3 945	Continued From page 5 The Director of Nursing (DON) could review and revise existing policies and procedures as necessary to ensure residents have care and services to maintain or improve their incontinence. The DON could inservice all appropriate personnel and establish a monitoring system to ensure compliance. TIME PERIOD FOR CORRECTION: Thirty -(30) days.	3 945		
31010	MN Rule 4655.7000 Subp. 1A Patient or Resident Units; Comfortable bed Subpart 1. Requirements. The following items shall be provided for each patient or resident: A. A comfortable bed at least 36 inches wide, good springs, and a clean, firm, comfortable mattress and mattress pad. At least one clean, comfortable pillow with extra pillows available to meet the patient's needs. Clean, lightweight blankets and bed linen in good condition and of the proper size shall be kept on hand for use at all times. Clean sheets and pillow cases shall be furnished at least once a week. Each bed shall have a washable bedspread. A moisture-proof mattress cover or rubber or plastic sheeting shall be provided for mattresses of all bed patients and for other beds as necessary. Rollaway type beds, cots, or folding beds shall not be used. This MN Statute is not met as evidenced by: Based on observation and interview the facility did not provide linens that fit all the mattresses in use. Findings include: During the resident group interview on 11/14/06 at 10:30 AM residents reported that the sheets	31010		

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31010	Continued From page 6 didn't fit their beds and that they came off at night all the time. One resident reported he had a set of linens that fits his bed and washed them himself so he didn't loose them. During the environmental tour on 11/15/06 starting at 9:00 AM in the Board and Care unit 3 out of 4 beds checked either did not have bottom sheets, or sheets that did not fit. In room 305 there was only one flat sheet on the bed. In room 304 the resident was using a bedspread as a bottom sheet. In room 211 the bottom sheet was there but had slid off the bottom of the mattress. When the surveyor stretched the sheet back on the mattress it was too tight to cover the mattress edges. During the tour three different types of mattresses were observed in use, green vinyl, blue vinyl and foam egg-crate. The linen available did not appear to fit the mattresses that were green vinyl but did fit beds that were blue vinyl or egg-crate foam. The Director of Engineering and Assistant Administrator present during tour confirmed that there was a problem with some sheets not fitting the mattresses. SUGGESTED METHOD OF CORRECTION: The Director of Housekeeping could review existing linen supplies and purchase additional linens where necessary to fit the variety of mattresses observed throughout the facility. Nursing could inservice all appropriate personnel and establish a monitoring system to ensure adequate bedding is provided. TIME PERIOD FOR CORRECTION: Thirty (30) days.	31010		

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31285	Continued From page 7	31285		
31285	MN Rule 4655.8630 Subp. 3 Quality and Variety; Food Habits/Customs Subp. 3. Food habits and customs. There shall be reasonable adjustment to the food habits, customs, likes, and appetites of individual patients and residents. This MN Statute is not met as evidenced by: Based on interview and record review the facility failed to provide foods to meet the food habits, customs, likes and appetites of the younger population of the board and care units. Findings include: During the board and care resident group interview held on 11/14/06 starting at 10:30 AM the residents reported they were unhappy that some of their favorite foods were taken off the menu, things like lasagna and enchilada pie. They reported the salad bar is sparse,mostly lettuce and celery and sometimes a tomato and there are too limited variety of salad dressings. They complained the food is too bland and there are too many hot dishes. They also indicated they were tired of chicken patties and that they were tough. When asked if they had brought this up at their council meetings they indicated that they had but nothing was changed. The "Minutes from DOMS Resident Council" were reviewed back to February of 2006. In February the residents asked if they could vote on dishes they liked and didn't like. The residents wanted more egg bake, more lasagna and cube steak and less meatballs and tuna casserole . They reported they didn't like the chili and enchilada pie following each other on same day due to digestion problems. In the minutes from	31285		

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MN VETERANS HOME MINNEAPOLIS	5101 MINNEHAHA AVENUE SOUTH MINNEAPOLIS, MN 55417

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31285	Continued From page 8 June the residents were told they were discontinuing the lasagna, Tater Tot hot dish and enchilada pie because there was a lot of wasted food thrown away. The residents were also told they could only take the food that was listed on their tickets with "No extra food that isn't listed on your ticket". A staff present at the meetings interviewed on 11/16/07 around 2 PM reported that the residents concerns were relayed by e-mail to the Dietary Director. The staff indicated the dietary department indicated that they couldn't cook for two different populations (the nursing home and the board and care units). On 11/15/06, at 10:40 AM, during interview the Dietary Director said it is difficult to prepare food for two populations. She indicated the winter menus have more casseroles than the summer menus. SUGGESTED METHOD OF CORRECTION: The Dietary Director could review existing policies and procedures and make modifications to the menus to ensure variety and type of food preferred by residents in the board and care unit is provided. The Director could inservice all appropriate personnel and establish a monitoring system to ensure resident preferences are being met. The Director could attend the resident council meetings on occasion to get resident input into the menu. TIME PERIOD FOR CORRECTION: Thirty (30) days.	31285		
31460	MN Rule 4655.9000 Subp. 2 Housekeeping; Cleaning Program	31460		

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31460	Continued From page 9	31460		

Subp. 2. Development of cleaning program. A program shall be established for routine housekeeping. Besides the daily duties, the program shall include policies and procedures for any special cleaning necessary.

This MN Statute is not met as evidenced by:
Based on observation, interview and record review the facility failed to maintain a clean, comfortable and odor free environment for resident #24. Findings including.

During the initial tour of building #9 at 12 noon on 11/13 and again during the physical environmental tour on 11/15 starting at 9:00 AM resident #24's room had a pervasive stale urine odor. There were no incontinent products in the trash can or obvious soiled clothing in the closet.

The resident's plan of care last updated on 4/9/06 stated " does not change linen/incontinent products in timely manner; odorous laundry/trash contributed to room odor on occasion. The only intervention was to provide teaching for proper laundering and room check for soiled clothes.

According to the council minutes (June) individual room cleaning occurred only once a month.

The facility did not provide adequate housekeeping to keep resident #24's room odor free.

SUGGESTED METHOD OF CORRECTION:

The Director of Housekeeping could review existing policies and procedures and make modifications where necessary to maintain and

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31460	Continued From page 10 clean and comfortable, odor free environment. The Director could inservice all appropriate personnel and establish a monitoring system to ensure adequate cleanliness throughout the building. TIME PERIOD FOR CORRECTION: Thirty (30) days.	31460		
31810	MN Rule 144.651 Subd. 6 Patients & Residents of HCF Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Statute is not met as evidenced by: Based on interview and record review the facility failed to pursue a timely referral to a physician for 1 out of 1 residents in building #9 (#38), the board and care unit, with an identified medical need. Resident # 38 reported during an interview on 11/14/06 at 1:36 PM that he wasn't allowed to go to urgent care to see a physician when needed to. The resident indicated that his foot was rapidly swelling, starting up his leg, was painful and warm to touch. The resident stated he went to nursing and told them he wanted to go to urgent care. The resident indicated he did not see a physician until the next day and that when he saw the physician the physician asked " Why	31810		

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31810	Continued From page 11 didn't ' Bt you come in sooner. " The resident ' s record revealed that on 6/29/06 at 10:00 PM the resident came to the nursing station complaining of right foot pain. The nurse observed the resident's foot was swollen with increased warmth in the foot and ankle area. The foot was described with 1 plus pitting edema. The nurse noted a 1 cm round open area and called urgent care. Urgent care indicated they would call back as the medical officer of the day (MOD) was very busy. At 10:23 PM the resident came to the nursing station and again asked about going to the Veterans Hospital urgent care stating it was taking too long and he would go himself. Nursing informed the resident to stay and they would let him know when urgent care called back. There were no additional attempts to call urgent care until 1:00 AM the next morning. On 6/30/06 at 1:00 AM the night nurse documented that she tried the urgent care number again and it was busy. That was the only other attempt to contact urgent care that night. At 3:51 AM the night nurse documented " he does not appear to be in severe pain/discomfort and no SOB (shortness of breath) noted or c/o by resident. The resident reported at that time that he didn't want staff to wake him unless it was for the ride to urgent. On 6/30/06 at 11:02 AM nursing wrote, " Resident went to urgent care to check lower right leg/ankle. Area continues to be swollen, reddened and warm to touch. " The Veterans Administration Medical Center (VAMC) record indicated the resident was seen at 12:35 PM with 2+ pitting edema right foot, erythema, swollen	31810		

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31810	Continued From page 12 tender right leg from mid calf to foot and right inguinal lymphadenopathy. The resident was diagnosed with cellulitis and received intramuscular antibiotic Rocephin 1 gm. The resident returned home at 2:18 PM with oral antibiotics Keflex 500 mg QID for ten days and a pain medication, Vicodin 1-2 tabs as needed every 4 hours and an order for bedrest for at least two days. On 7/1/06 the resident had increased edema and pain in his right ankle and foot and was sent to the emergency room for evaluation. He was admitted to the hospital for treatment of cellulitis with intravenous antibiotics and was not discharged until 7/7/06. Nursing staff interviewed on 11/14/06 around 3:00 PM indicated that their protocol indicated that a referral from the Medical Officer of Day was required to be seen at urgent care. The nurse manager interviewed on 11/15/06 around 9:15 AM when asked what the protocol was when the Veterans Hospital Medical Officer of Day didn't return calls, the manager indicated the staff should have called the medical director. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) could review and revise existing policies and procedures as necessary to ensure residents have timely access to medical care. The DON could inservice all appropriate personnel and establish a monitoring system to ensure compliance. TIME PERIOD FOR CORRECTION: Seven (7) days.	31810		

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31875	Continued From page 13	31875		
31875	MN Rule 144.651 Subd. 19 Patients & Residents of HCF Bill of Rights Subd. 19. Personal privacy. Patients and residents shall have the right to every consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Facility staff shall respect the privacy of a resident's room by knocking on the door and seeking consent before entering, except in an emergency or where clearly inadvisable. This MN Statute is not met as evidenced by: Based on interview and record review the facility failed to ensure residents were afforded privacy. Findings include: The facility failed to resolve residents' ongoing complaints of lack of privacy: The residents when interviewed at the group meeting on 11/14/06 at 10:30 AM and during the initial tour of the building reported problems with lack of privacy as well as security in their rooms. The residents indicated that staff knock but walk right in. The residents reported that they don't have locks on their doors and anyone can walk into their room whenever. They reported other residents check the sign out book and know when they are away on weekends or for meals. The residents stated they had asked for locks on their doors. The minutes from the "DOMS Resident Council" revealed the residents complained about lack of privacy and security: In March they complained about staff not waiting to be invited into their room and walking in on them when they are undressed.	31875		

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31875	Continued From page 14 In April a resident complained about stealing and other residents reading the log book to see when they are going and take things from their rooms. They also complained of staff walking in on them when they need privacy. In May the residents complained about other residents entering their rooms when they aren't there. They felt this was a violation of security and privacy. June "Residents entering each others' room without permission still not resolved." In July the resident council reported problems with stealing. In September concerns about privacy were brought up again. The social worker when asked on about responses to resident concerns that come out of the council meetings indicated that they e-mail the relevant department heads but that they had not responded with actions plans. A second social worker when interviewed during the physical plant tour on 11/15/06 around 9 AM when asked about responses to resident council members concerns indicated that they hadn't gotten back to the residents and responses weren't documented in the minutes but they were starting to do so. SUGGESTED METHOD FOR CORRECTION: The Administrator could review and revise existing policies and procedures or provide locks for the doors to ensure resident security and privacy, provide training to appropriate personnel and designate someone to monitor the implementation of those policies.. TIME PERIOD FOR CORRECTION: Thirty -(30) days.	31875		

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31880	Continued From page 15	31880		
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 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	31880		

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31880	Continued From page 16 requirement for a written internal grievance procedure. This MN Statute is not met as evidenced by: Based on interview and record review, the facility failed to promote the grievance process in a manner that assisted residents to understand and exercise their rights and failed to respond to resident concerns. Findings include: During an interview with the resident council of the board and care unit on 11/14/06 at 10:30 AM residents revealed they are unable to get the forms to file grievances. The residents reported they had tried to get grievance forms from the main switchboard and the social worker and were not able to get the forms. The residents indicated there was also some fear of retaliation for filing grievances. The residents reported that their concerns went nowhere. The residents brought up several issues that have not been addressed: problems with staff treatment, food preferences, lack of privacy and security of their possessions. The facility failed to respond to resident complaints about an employee: The residents during the group interview complained about how they were treated by a particular staff person. They complained of being treated like children. When asked if they had reported this or filed a complaint they indicated that they had reported it to the social worker and tried to get a grievance form but couldn't. When asked they also indicated they had shared their concern with the employee's supervisor. During an interview with social services the morning of 11/16/06 the staff reported being	31880		

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31880	Continued From page 17 aware of the residents' complaints about their treatment by the above employee and aware of the issues but indicated the employee was well intentioned. When told about the residents stating they weren't able to get grievance forms the social worker indicated that they weren't allowed to hand them out for three days and that residents were to first try to resolve the issues themselves. When asked if she reported the employee issue to the employee's supervisor the social worker indicated they had not. An interview was conducted on 11/16/06 at 10:10 AM with the supervisor of the employee the residents complained about. The supervisor reported that she had not heard of any complaints about the employee. She also indicated that her department had not been involved in any meetings of the resident council for the board and care units because she hadn't been invited. The Director of Social Services was interviewed on 11/16/06 at 3:45 PM about the facility's grievance policy. She indicated that if social services or any other employee hears about a complaint about another department they are supposed to talk to the other department director. During the survey on 11/15/06 at 3:00 PM the state ombudsman met with state surveyors and reported that she had heard a complaint from a resident that they couldn't get a grievance form at the main switchboard. The ombudsman then went to the switchboard and asked for a grievance form. The employee manning the switchboard did not know where any grievance forms were or what they were. The facility's current (undated) "Resident	31880		

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31880	Continued From page 18 Orientation Handbook" for the Domiciliary Program" states: "Residents may voice complaints and concerns without retaliation of reprisal. Residents are encourage to resolve concerns on an informal basis. If the resolution is not satisfactory, a grievance may be filed. Grievance forms are available at the Switchboard in Building 17 or through Social Services. If you need assistance with filing a grievance, please contact Social Services. A written response will follow within 7 days." The Operating Policy and Procedures "Resident Grievance Procedure" states that "1. A resident may complain or bring a suggestion to any staff person; however, he or she is encouraged to contact the relevant department supervisor. 2. The resident may request the assistance of his/her social worker. 3. Any staff person perceiving grounds for or receiving either a verbal or written complaint from a resident, significant other or fellow staff person, and is unable him/herself to correct the problem, will at once refer the complaint to his/her supervisor." The policy further states "7. Within three working days of receipt of complaint the responsible supervisor or his/her designee, having addressed the complaint, will report to the resident and/or significant others/staff person who originated it. The facility failed to respond to resident complaints of ongoing theft and lack of privacy: The residents when interviewed at the group meeting on 11/14/06 at 10:30 AM and during the initial tour of the building reported problems with theft and lack of privacy in their rooms. The residents indicated that staff knock but walk right in. About half of the 8 residents present reported missing items in the last 6 months: a computer	31880		

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31880	Continued From page 19 modem, fishing reel, two clock radios, a checkbook, credit cards, and a ring. They stated you can't keep radios or alarm clocks. The residents reported that they don't have locks on their doors and anyone can walk into their room when they are away. They reported other residents can check the sign out book and know when they are away. The residents indicated that they did have a cupboard and drawer with locks on them in their room but that didn't work for everything. They reported they have asked for locks and were told they couldn't because of fire regulations. The minutes from the "DOMS Resident Council" revealed the residents complained about lack of privacy and security: In March they complained about staff not waiting to be invited into their room and walking in on them when they are undressed. In April the residents complained about stealing and other residents reading the log book to see when they are going and take things from their rooms. They also complained of staff walking in on them when they need privacy. In May the residents complained about other residents entering their rooms when they aren't there. The resident felt this was a violation of safety and security. June "Residents entering each others' room without permission still not resolved." In July the resident council reported problems with stealing. In September concerns about privacy were brought up again. Residents during the tour of the facilty reported they had asked for locks on their rooms. The surveyor met with staff from the security department regarding the above missing items. They did not have any reports of the thefts. The facility failed to respond to the resident	31880		

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31880	Continued From page 20 choices and complaints about food. (See tag 1285) The social worker when asked about responses to resident concerns that come out of the council meetings indicated that they would e-mail the relevant department heads but that they had not in the past responded with action plans. On 11/15/06, at 10:00 AM, the Director of Dietary said building 9 had a different system than the nursing home council in that they do not have a second meeting to follow-up on concerns that were brought up. A second social worker when interviewed during the physical plant tour on 11/15/06 around 9 AM when asked about responses to resident council members concerns indicated that they hadn't always responded back to the residents or documented those responses but were starting to do so. SUGGESTED METHOD FOR CORRECTION: The Administrator could review and revise existing policies and procedures, provide training to appropriate personnel and designate someone to monitor the implementation of those policies to ensure resident concerns were being addressed. TIME PERIOD FOR CORRECTION: Thirty -(30) days.	31880		
31920	MN Rule 144.651 Subd. 28 Patients & Residents of HCF Bill of Rights Subd. 28. Married residents. Residents, if married, shall be assured privacy for visits by their spouses and, if both spouses are residents	31920		

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31920	Continued From page 21 of the facility, they shall be permitted to share a room, unless medically contraindicated and documented by their physicians in the medical records. This MN Statute is not met as evidenced by: During the group interview on 11/14/06 at 10:30 AM with the residents of the board and care unit, which serves a younger population, the residents were asked about the ability of privacy during visits with spouses or significant others. The residents laughed and one stated "If you want conjugal visits you have to go prison." The residents further stated that they were told when they had visitors they had to stay in a public area. During the environmental tour on 11/15/06 that started at 8:45 AM the assistant administrator was asked if there were private spaces, rooms for residents to have private visits with their spouses, family or significant others. The surveyor was told that there were not. The facility's "Resident Orientation Handbook" (undated) was reviewed for visits and privacy. The Handbook indicated that "Residents may receive visitors daily from 7:00 a.m. to 12 Midnight. Visitors are expected to comply with facility rules." The handbook did not address the availability of privacy for spousal visits. There are very few private rooms in the nursing home or board and care units and those were assigned to residents based on a waiting list. Outside of a provision for spouses to share a room if they are both residents there were no provisions for private visits. SUGGESTED METHOD FOR CORRECTION:	31920		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME MINNEAPOLIS	5101 MINNEHAHA AVENUE SOUTH MINNEAPOLIS, MN 55417

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
31920	Continued From page 22 The Administrator could review and revise existing policies and procedures, provide private areas for visitation, train personnel, and designate someone to monitor the implementation of those policies. TIME PERIOD FOR CORRECTION: Forty-five (45) days.	31920		