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,

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).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix 20490 Reg. # MN Rule 4658.0270 LSC	02/27/2007	ID Prefix 20540 Reg. # MN Rule 4658.0400 Subp. 1 & 2 LSC	02/27/2007	ID Prefix 20560 Reg. # MN Rule 4658.0405 Subp. 2 LSC	02/27/2007
ID Prefix 20860 Reg. # MN Rule 4658.0520 Subp. 2 F. LSC	02/27/2007	ID Prefix 20870 Reg. # MN Rule 4658.0520 Subp. 2 H. LSC	02/27/2007	ID Prefix 20890 Reg. # MN Rule 4658.0525 Subp. 2 A LSC	02/27/2007
ID Prefix 20910 Reg. # MN Rule 4658.0525 Subp. 5 A.I LSC	02/27/2007	ID Prefix 20915 Reg. # MN Rule 4658.0525 Subp. 6 A LSC	02/27/2007	ID Prefix 20945 Reg. # MN Rule 4658.0530 Subp. 1 LSC	02/27/2007
ID Prefix 20955 Reg. # MN Rule 4658.0530 Subp. 3 LSC	02/27/2007	ID Prefix 20965 Reg. # MN Rule 4658.0600 Subp. 2 LSC	02/27/2007	ID Prefix 21055 Reg. # MN Rule 4658.0625 Subp. 2 LSC	02/27/2007
ID Prefix 21375 Reg. # MN Rule 4658.0800 Subp. 1 LSC	02/27/2007	ID Prefix 21435 Reg. # MN Rule 4658.0900 Subp. 1 LSC	02/27/2007	ID Prefix 21665 Reg. # MN Rule 4658.1400 LSC	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:

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ID Prefix **21670**	**02/27/2007**	ID Prefix **21685**	**02/27/2007**	ID Prefix **21855**	**02/27/2007**
Reg. # **MN Rule 4658.1405 A.B.C.D.**		Reg. # **MN Rule 4658.1415 Subp. 2**		Reg. # **MN St. Statute 144.651 Subd. 1**	
LSC		LSC		LSC	
ID Prefix **21880**	**02/27/2007**	ID Prefix **21920**	**02/27/2007**		
Reg. # **MN St. Statute 144.651 Subd. 2**		Reg. # **MN St. Statute 144.651 Subd. 2**			
LSC		LSC			

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

Followup to Survey Completed on: 11/17/2006

_____

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 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 revealed 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 receive 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 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 10/31/06 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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MN VETERANS HOME MINNEAPOLIS	5101 MINNEHAHA AVENUE SOUTH MINNEAPOLIS, MN 55417

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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	2 830		

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

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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 even though the fall occurred while staff was providing 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 again 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 (January), 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 "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. An 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	2 830		

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

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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	{2 895}		

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

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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) 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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{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 regular human insulin. The physician's order dated 3/21/06 indicated the resident was to regular human insulin 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 mellitus 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 regular human insulin 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)." A complaint investigation was initiated on 01/25 - 01/26/07, which alleged that staff administer medications to residents even though the residents have been identified as having an allergy to the medication. The complaint investigation was concluded on 02/26/07. For more details see Office of Health Facility Complaint (OHFC) Report #HL00233049 dated 2/26/07. Based on observation, interview and record review the following significant medication errors were identified for OHFC Resident #1 and #2. On 01/11/07, staff administered Roxanol to resident #1, when he had a documented allergy to Morphine.	{21545}		

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{21545}	Continued From page 39 On 12/28 and 12/29/06, staff administered Augmentin to resident #2 when he had a documented allergy to Penicillin. The facility does not identify a resident's allergies on the medication administration records. Allergies are identified on the Physician's orders (electronic) and on the front of the chart. One of the initial steps in the facility's Medication Administration policy requires that staff "Check for resident allergy," prior to medication administration. At the time of the above medication errors, the only mechanism available to staff to verify resident allergies, prior to medication administration, necessitated ascertaining allergy information from each resident's chart. Allergies are not identified on the Physician's order sheet (non-electronic), even though information on the sheet specifies "Identify All Allergies on Physician Order Sheet." In the medication errors involving residents #1 and #2, both prescribers provided orders on the Physician Order Sheet, which did not designate the resident's allergies. The facility failed to have a system in place to ensure the safe administration of medications.	{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	21620		

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21620	Continued From page 40 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 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 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	21620		

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21620	Continued From page 41 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 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	21620		

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21620	Continued From page 42 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 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	{21805}		

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{21805}	Continued From page 43 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 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.	{21805}		

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{21805}	Continued From page 44 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. 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	{21805}		

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{21805}	Continued From page 45 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 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	{21805}		

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{21805}	Continued From page 46 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 at a table would be served together. The feeders are served and fed last. The resident would reach for his food if served and no one was able to feed him." 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	{21990}		

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{21990}	Continued From page 47 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. 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	{21990}		

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{21990}	Continued From page 48	{21990}		

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 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

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{21990}	Continued From page 49 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 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, 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...."	{21990}		

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{21990}	Continued From page 50 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 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	22000		

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22000	Continued From page 51 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. (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	22000		

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22000	Continued From page 52 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 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	22000		

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22000	Continued From page 53 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 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.	22000		

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22000	Continued From page 54 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.' 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	22000		

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22000	Continued From page 55	22000		

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 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

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22000	Continued From page 56 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?" 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	22000		

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22000	Continued From page 57 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 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	22000		

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22000	Continued From page 58 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: 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 thorough 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		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{3 000}	INITIAL COMMENTS *****ATTENTION****** BOARDING CARE HOME LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 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

TITLE (X6) DATE

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