AH Form Approved
7/22/2008

## State Form: Revisit Report

| (Y1) Provider / Supplier / CLIA / Identification Number | (Y2) Multiple Construction | (Y3) Date of Revisit |
|---|---|---|
| 00233 | A. Building<br>B. Wing | 6/27/2008 |

| Name of Facility | Street Address, City, State, Zip Code |
|---|---|
| MN VETERANS HOME MINNEAPOLIS | 5101 MINNEHAHA AVENUE SOUTH<br>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 20550<br>Reg. # MN Rule 4658.0400 Subp.<br>LSC | 06/25/2008 | ID Prefix 20570<br>Reg. # MN Rule 4658.0405 Subp.<br>LSC | 06/25/2008 | ID Prefix 20835<br>Reg. # MN Rule 4658.0520 Subp.<br>LSC | 06/25/2008 |
| ID Prefix 20855<br>Reg. # MN Rule 4658.0520 Subp.<br>LSC | 06/25/2008 | ID Prefix 20860<br>Reg. # MN Rule 4658.0520 Subp.<br>LSC | 06/25/2008 | ID Prefix 20870<br>Reg. # MN Rule 4658.0520 Subp.<br>LSC | 06/25/2008 |
| ID Prefix 20900<br>Reg. # MN Rule 4658.0525 Subp.<br>LSC | 06/25/2008 | ID Prefix 20915<br>Reg. # MN Rule 4658.0525 Subp.<br>LSC | 06/25/2008 | ID Prefix 20945<br>Reg. # MN Rule 4658.0530 Subp.<br>LSC | 06/25/2008 |
| ID Prefix 21325<br>Reg. # MN Rule 4658.0725 Subp.<br>LSC | 06/25/2008 | ID Prefix 21375<br>Reg. # MN Rule 4658.0800 Subp.<br>LSC | 06/25/2008 | ID Prefix 21435<br>Reg. # MN Rule 4658.0900 Subp.<br>LSC | 06/25/2008 |
| ID Prefix 21540<br>Reg. # MN Rule 4658.1315 Subp.<br>LSC | 06/25/2008 | ID Prefix 21880<br>Reg. # MN St. Statute 144.651 Sul<br>LSC | 06/25/2008 | ID Prefix<br>Reg. #<br>LSC | |

| Reviewed By State Agency | Reviewed By | Date: | Signature of Surveyor: | Date: |
|---|---|---|---|---|
| | LB05 | 7/22/08 | 15507 | 7/1/08 |
| Reviewed By CMS RO | Reviewed By | Date: | Signature of Surveyor: | Date: |

Followup to Survey Completed on:
3/27/2008

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

AH Form Approved
7/22/2008
CB

## State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number
00233

(Y2) Multiple Construction
A. Building
B. Wing

(Y3) Date of Revisit
6/27/2008

Name of Facility
MN VETERANS HOME MINNEAPOLIS

Street Address, City, State, Zip Code
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 30805<br>Reg. # MN Rule 4655.4400 G<br>LSC | 06/25/2008 | ID Prefix 30830<br>Reg. # MN Rule 4655.4700 Subp.<br>LSC | 06/25/2008 | ID Prefix 31875<br>Reg. # MN Rule 144.651 Subd. 19<br>LSC | 06/25/2008 |
| ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | |
| ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | |
| ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | |
| ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | |

Reviewed By State Agency | Reviewed By 03015 | Date: 7/22/08 | Signature of Surveyor: 15507 | Date: 7/1/08

Reviewed By CMS RO | Reviewed By | Date: | Signature of Surveyor: | Date:

Followup to Survey Completed on:
3/27/2008

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: 00233 | (X2) MULTIPLE CONSTRUCTION A. BUILDING ___ B. WING ___ | (X3) DATE SURVEY COMPLETED R 06/27/2008 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: MN VETERANS HOME MINNEAPOLIS | STREET ADDRESS, CITY, STATE, ZIP CODE: 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 | {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 June 25, 26, & 27, 2008 surveyors of this Department's staff, visited the above provider. There are No Correction Orders Issued.

Minnesota Department of Health

TITLE (X6) DATE

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00233 | (X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____ | (X3) DATE SURVEY COMPLETED R 06/27/2008 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: MN VETERANS HOME MINNEAPOLIS | STREET ADDRESS, CITY, STATE, ZIP CODE: 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 |
|---|---|---|---|---|
| {2 000} | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>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.<br><br>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.<br><br>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.<br><br>INITIAL COMMENTS:<br>On June 25, 26, & 27, 2008 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and | {2 000} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00233 | (X2) MULTIPLE CONSTRUCTION A. BUILDING ___ B. WING ___ | (X3) DATE SURVEY COMPLETED R 06/27/2008 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: MN VETERANS HOME MINNEAPOLIS | STREET ADDRESS, CITY, STATE, ZIP CODE: 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 |
|---|---|---|---|---|
| {2 000} | Continued From page 1<br><br>Certification Program; 1645 Energy Park Drive, Suite 300, St. Paul, MN 55108-2970. | {2 000} | | |
| 2 565 | MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use<br><br>Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the facility failed to ensure 4 of 16 residents in the sample dependent on staff for assistance were provided services in accordance with their plan of care (#'s 24, 42, 4 & 17).<br>Findings include:<br><br>Resident #24 was supposed to have thickened liquids and was given thin liquids along with the thickened. The resident's plan of care dated 3/25/08 identified the resident with swallowing problem/dysphagia and directed staff to provide "pureed w/ nectar thick, HNS tid, argnaid, bid, juvne BID."<br><br>The nursing notes on 11/3/08 revealed the resident was coughing after breakfast and had an emesis with "food particles". He had a low grade fever. A note of 11/6/07 indicated that after breakfast the resident was forcibly coughing and had an emesis of pureed food. On 11/7/08 the resident had a strong cough all day and a small emesis. The resident was sent to the hospital and admitted with a fever of 101. The admitting chest x-ray was consistent with pneumonia. On | 2 565 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00233 | A. BUILDING ______ B. WING ______ | R 06/27/2008 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 565 | Continued From page 2 | 2 565 | | |

1/7/08, a speech-language pathologist (SLP) performed a clinical swallowing evaluation. The SLP wrote resident #24 had oral and pharyngeal delays and his diet was to remain puree with nectar consistency liquids. The physician then ordered the puree diet with nectar thickened liquids. It was noted on the order the family could give the resident a beer when they visited as desired. (Whether the beer should have been thickened was not noted).

During meal observations, the resident was provided un-thickened liquids, and was noted to cough some during meals. At the lunchtime on 6/24/08 at 1:10 PM, resident #24 was observed as staff fed him. He was provided thickened liquids in glasses, plus un-thickened Dairy Ease. He was observed to do some coughing at the meal. At 4:45 PM, a large glass of ice water was observed on his dresser. There was also a can of thickener in the resident's room, and the resident would have been physically and cognitively unable to have retrieved the water on his own. The surveyor did not observed the staff giving the resident the water. At supper on 6/24/08 at 5:53 PM, resident #24 and another resident, who was not on thickened liquids, were both given the same product, "Dairy Ease". The licensed practical nurse (LPN) said it was okay for resident #24 to have the product and that his family also gave him thin liquids such as wine with a straw. She said some thin liquids were okay for the resident, too.

The following day the registered nurse (RN) was interviewed at 1:10 PM. She verified resident #24 again had water at his bedside, and a supplement that the RN verified was of a thin consistency. The HST told the RN they sometimes thickened a little water to give to the resident. The registered

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00233 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED R 06/27/2008 |
|---|---|---|---|

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 565 | Continued From page 3 | 2 565 | | |

Continued From page 3

nurse (RN), however, instructed the HST the resident should not have had thin water left in his room. The RN said to her knowledge there had not been an assessment by the SLP to indicate it was safe for the resident to consume thin liquids. There was also no evidence the risks were presented to the interested family member so an informed decision regarding the consistency of the liquids could be made.

Resident #42 was not repositioned or receive incontinent care according to his care plan.

Resident #42's "Care Plan - Temporary Skin Wound" indicated the resident was at high or severe risk for pressure ulcers. The care plan 6/24/08 further indicated the resident currently had a pressure ulcer on his left foot's big toe. The resident's care plan 1/15/08 indicated he was to be repositioned in his wheelchair every two hours. In addition, the nursing notes dated 6/23/08 indicated the resident had an ultrasound of his left lower extremity and the impression was deep vein thrombosis (blood clot). On 6/23/08 the physician ordered the resident be in bed except for meals for five days, "then may start increasing time up in w/c" (wheelchair).

The resident's Minimum Data Set (MDS) assessment dated 4/18/08 indicated the resident was totally incontinent of bladder and was completely dependent on staff for toileting and personal hygiene. The care plan (1/15/08) indicated he was to be checked and changed for incontinence every two hours.

Resident #42 was observed receiving cares on 6/24/08 at 4:00 PM. The staff changed the resident's wet incontinent brief and pants. A mechanical lift was required for the resident to

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00233 | (X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____ | (X3) DATE SURVEY COMPLETED R 06/27/2008 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: **MN VETERANS HOME MINNEAPOLIS** | STREET ADDRESS, CITY, STATE, ZIP CODE: **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 |
|---|---|---|---|---|
| 2 565 | Continued From page 4 | 2 565 | | |

Continued From page 4

stand. When one human services technician (HST) started to get the resident up at that time, another reminded him the resident was only to be up for meals. The first HST indicated the resident could get up and watch television. The second HST reminded him they were just told in report he was only to be up for meals "because of his leg". The first HST said he was going to get him up and the resident would be the first to bed after supper. The resident was assisted into his chair at 4:25 PM.

After supper, around 7:00 PM, a licensed practical nurse (LPN) attempted to center resident #42 who was leaning to the right, in his wheelchair. The resident was then assisted to his room. No instructions were heard given to the HST by the LPN reminding him the resident was to only be up for meals. Once in the room, the first HST sought help from a third HST to further straighten the resident in the chair. He was left in his room in the wheelchair in front of the television.

At 7:45 PM, the surveyor informed an assistant director of nursing (ADON) that the resident had been up for 3 hours, 20 minutes. The ADON said that because of "DVT (deep venous thrombosis) " the resident "probably should not be up long". A HST informed the surveyor and ADON the resident was boosted up in the chair at about 7:00 and said the resident wasn't ready to go to bed so they just boosted him up in the chair. During observations, the resident did not appear able to communicate his needs or wishes. The resident's Minimum Data Set (MDS) assessment dated 4/18/08 revealed the resident rarely made decisions and that his communication was rarely understood.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00233 | A. BUILDING ______ B. WING ______ | R 06/27/2008 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 565 | Continued From page 5<br><br>An LPN and two HSTs assisted the resident into bed at 8:05 PM, 3 hours, 40 minutes after the resident was assisted into the chair. When the resident's foam boot was removed from his left leg, the leg appeared somewhat swollen and reddened. The resident was assisted with incontinence care and his brief changed. One of the HSTs verified the resident was wet. The HST was asked to describe the resident's skin condition. She said that although she cleaned the resident, she did it so quickly she did not observe the skin.<br><br>A registered nurse (RN) was apprised of the findings on 6/25/08 at 1:10 PM. She told the surveyor the HSTs were informed just before the finding "at report" that the resident was to only be up for 1 1/2 hours for meals. The RN also noted the staff should have performed the cares in a manner than allowed them to note the condition of the resident's skin and to report any problems to the nurse. The RN reported the staff had all just been trained and she felt the training was very good<br><br>Resident #4 did not receive timely repositioning or incontinent cares on the evening of 6/24/08 according to his plan of care.<br><br>The resident had diagnosis which included Parkinson's disease and dementia with behavioral disturbances. The quarterly MDS dated 4/15/08 identified the resident as requiring extensive assistance with all transfers, bed mobility and ambulation, incontinent of urine and cognitively impaired. The plan of care dated 1/08/08 identified the resident with a potential for skin breakdown and directed the staff to reposition the resident every two hours and assist the resident with incontinence cares every two | 2 565 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00233 | A. BUILDING ______ B. WING ______ | R 06/27/2008 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 565 | Continued From page 6 | 2 565 | | |

hours (1/30/08). The plan of care also directed staff to provide perineal care after each incontinent episode.

On the evening of 6/24/08 at 4:00 PM, the resident was observed sitting in a wheelchair in his chair. The resident remained in his wheelchair during a music activity and through the supper meal. At 6:05 PM, the RN unit manager was observed to wheel the resident out into a lobby area where he was observed to sleep in his chair. At 7:00 PM, two HSTs assisted the resident with incontinence care. The resident was observed to be incontinent of urine and his skin was intact. The staff failed to provide perineal care. At 7:10 PM, the HST verified the resident had last been assisted with incontinence cares at 4:00 PM, three hours earlier. The HST stated the only time perineal care was to be completed was if the resident had a bowel movement or if they were receiving morning or bedtime cares.

On 6/25/08 at 10:30 AM, the RN unit manager verified the resident was to receive assistance with incontinence care and repositioning every two hours as directed by his plan of care. The RN unit manager stated all residents should receive perineal care after each incontinent episode as directed by the plan of care.

Resident #17 did not receive incontinence care for 2 hours, 45 minutes, when the resident's plan of care directed staff to check and change the resident every two hours.

Resident #17 had a plan of care dated 2/13/04 that noted the resident was incontinent of bowel and bladder, and needed total assist with toileting. The care plan directed the staff to provide a toileting/ change program every two

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00233 | (X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____ | (X3) DATE SURVEY COMPLETED R 06/27/2008 |
|---|---|---|---|

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 565 | Continued From page 7<br>hours and as needed during waking hours. The HST assignment sheet (undated) directed staff to assist with check and change every two hours while awake.<br><br>The resident was observed 6/24/08 at 4:45 PM. He received incontinence care by having his brief changed, then was transferred into his wheelchair and taken to a lounge at 5:00 PM. The resident remained in his wheelchair until 7:45 PM when two staff assisted to transfer him to bed and provide incontinence care. the resident's pad was wet with a moderate amount of urine, his skin was clear.<br><br>The charge nurse on the unit was interviewed 6/24/08 at 6:30 PM and verified that resident #17 should have been changed every two hours. The HST caring for the resident stated at 7:30 PM that she was waiting for a co-worker to return from break to help her lie down resident #17.<br><br>SUGGESTED METHOD OF CORRECTION: The administrator with the director of nursing could provide training to all staff on the importance of implementing the plan of care. The Director of Nursing could establish a system to audit to ensure staff were following the plan of care.<br><br>TIME PERIOD FOR CORRECTION: Thirty (30) days. | 2 565 | | |
| 2 830 | MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General<br><br>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 | 2 830 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00233 | A. BUILDING ______ B. WING ______ | R 06/27/2008 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 830 | Continued From page 8 | 2 830 | | |

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:
"Uncorrected based on the following findings. The original licensing order issued on 4/15/08 will remain in effect. Penalty assessment issued."

Based on observation, interview, and record review, the facility failed to ensure appropriate services were provided for 3 of 16 residents in the sample (#'s 24, 42, & 32 ). Findings include:

Resident #24 was supposed to have thickened liquids and was given thin liquids along with the thickened.

The nursing notes on 11/3/08 revealed the resident was coughing after breakfast and had an emesis with "food particles". He had a low grade fever. A note of 11/6/07 indicated that after breakfast the resident was forcibly coughing and had an emesis of pureed food. On 11/7/08 the resident had a strong cough all day and a small emesis. The resident was sent to the hospital and admitted with a fever of 101. The admitting chest x-ray was consistent with pneumonia.

On 1/7/08, a speech-language pathologist (SLP) performed a clinical swallowing evaluation. The SLP wrote resident #24 had oral and pharyngeal

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00233 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED R 06/27/2008 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: **MN VETERANS HOME MINNEAPOLIS** | STREET ADDRESS, CITY, STATE, ZIP CODE: **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 |
|---|---|---|---|---|
| 2 830 | Continued From page 9<br><br>delays and his diet was to remain puree with nectar consistency liquids. The physician then ordered the puree diet with nectar thickened liquids. It was noted on the order the family could give the resident a beer when they visited as desired. (Whether the beer should have been thickened was not noted). The resident's plan of care dated 3/25/08 identified the resident with swallowing problem/dysphagia and directed staff to provide "pureed w/ nectar thick, HNS tid, argnaid, bid, juvne BID."<br><br>During meal observations, the resident was provided un-thickened liquids, and was noted to cough some during meals. At the lunchtime on 6/24/08 at 1:10 PM, resident #24 was observed as staff fed him. He was provided thickened liquids in glasses, plus un-thickened Dairy Ease. He was observed to do some coughing at the meal. At 4:45 PM, a large glass of ice water was observed on his dresser. There was also a can of thickener in the resident's room, and the resident would have been physically and cognitively unable to have retrieved the water on his own. The surveyor did not observed the staff giving the resident the water. At supper on 6/24/08 at 5:53 PM, resident #24 and another resident, who was not on thickened liquids, were both given the same product, "Dairy Ease". The licensed practical nurse (LPN) said it was okay for resident #24 to have the product and that his family also gave him thin liquids such as wine with a straw. She said some thin liquids were okay for the resident, too.<br><br>The following day the registered nurse (RN) was interviewed at 1:10 PM. She verified resident #24 again had water at his bedside, and a supplement that the RN verified was of a thin consistency. The HST told the RN they sometimes thickened a | 2 830 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00233 | (X2) MULTIPLE CONSTRUCTION A. BUILDING ___ B. WING ___ | (X3) DATE SURVEY COMPLETED R 06/27/2008 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER **MN VETERANS HOME MINNEAPOLIS** | STREET ADDRESS, CITY, STATE, ZIP CODE **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 |
|---|---|---|---|---|
| 2 830 | Continued From page 10 | 2 830 | | |

little water to give to the resident. The registered nurse (RN), however, instructed the HST the resident should not have had thin water left in his room. The RN said to her knowledge there had not been an assessment by the SLP to indicate it was safe for the resident to consume thin liquids. There was also no evidence the risks were presented to the interested family member so an informed decision regarding the consistency of the liquids could be made.

Resident #24 was totally dependent on staff for bed mobility and deficits in his range of motion. Bed mobility was not provided in a manner that minimized the risk of injury.

Resident #24's Minimum Data Set (MDS) dated 6/4/08 revealed he had partial loss limitations of range of motion in both sides of his neck, arms, legs, and feet, and in one hand. The resident's diagnoses included paraplegia (paralysis of the lower extremities). The current care plan (initiated 12/14/04) stated: "one person physical assist for bed mobility" and directed staff to "position the resident in bed with sheet". The resident's 6/08 weight was 140 pounds.

Evening cares were observed for resident #24 on 6/24/08 at 7:00 PM. The resident was mechanically lifted into bed with the assistance of two HSTs. One HST left the other to finish the resident's cares. The HST removed the lift strap by rolling the resident to the side. The resident was then cradled by the HST as she tried to boost the resident up in the bed. The HST gave the resident two more boosts in the same manner, causing the resident's toes to hit the wall both times.

The registered nurse (RN) was interviewed on

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00233 | (X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______ | (X3) DATE SURVEY COMPLETED R 06/27/2008 |
|---|---|---|---|

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 830 | Continued From page 11 | 2 830 | | |

6/25/08 at 1:10 PM. She said the HST "should not have done that," and explained it wasn't how "they were just trained". The RN verified the HST did not use proper body mechanics and said more importantly, it was unsafe for the resident.

Resident #42 had deficits in range of motion (ROM) in his neck, and was not repositioned in a safe manner.

Cares for resident #42 were observed on 6/24/08 at 4:00 PM. Two human services technicians (HSTs) explained they were going to use the mechanical stand to change the resident's brief because he "doesn't fight so much". When the resident was brought to an upright position, he let out a groan. It took at least 20 minutes to complete the brief change. The brief was changed while the resident stood in the lift. Because the resident's pants were also a little wet, they were changed. The resident then sat on the edge of the bed while the foam boots were removed, new pants were donned, and the boots were placed back on the resident. The head of the bed was at 30 degrees and the resident's left buttock was partially on the raised area of the bed. The resident leaned into the HST who sat on the bed and was distracting him during the incontinence change to the point of lying down several times. One HST held the resident's hands and the other put his hand behind the resident's head to pull the resident back up to a seating position. The resident again laid down on the bed with his legs dangling off the bed. When the HST was again going to assist the resident up by pulling on the back of his head, the surveyor intervened. It was suggested the HST not pull on the resident's head and neck, but place his hands behind the resident's shoulders for more support.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00233 | A. BUILDING ______ B. WING ______ | R 06/27/2008 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 830 | Continued From page 12<br><br>The resident's MDS dated 4/18/08 indicated he had partial loss of ROM in both sides of his neck, severe cognitive deficits, and was totally dependent on staff for all cares. The care plan dated 1/15/08 directed staff to totally assist the resident with transfers and to use two people for bed mobility. His behavior was described as "very resistant" and one staff was to gently hold his hands and distract him while the other provided cares.<br><br>A registered nurse (RN) was informed of the observations on 6/25/08 at 1:10 PM. She verified the staff should not have been pulling on resident's head and neck when assisting him to a sitting position. In addition, she said it would have been "much easier" for the resident and staff to change the resident while in bed, and said the HSTs should have done so.<br><br>Resident #32 was not provided safe assistance with repositioning on 6/26/08.<br><br>The resident was diagnosed with dementia with behavioral disturbances. The quarterly MDS dated 6/11/08 identified the resident as being totally dependent upon staff for all activities of daily living and had bilateral limitations in range of motion. The plan of care dated 1/30/08 directed two staff to assist with transfers and one staff to assist with dressing.<br><br>On the morning of 6/26/08 at 6:50 AM, the resident was observed to be transferred from his bed to a wheel chair via a full body mechanical lift and two HSTs. Once in the chair, the second HST left the room and one HST was left to assist. with dressing the resident's upper body. The HST was observed to remove the mechanical lift sling by lifting the resident's legs and pulling the sling | 2 830 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00233 | (X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______ | (X3) DATE SURVEY COMPLETED R 06/27/2008 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: **MN VETERANS HOME MINNEAPOLIS** | STREET ADDRESS, CITY, STATE, ZIP CODE: **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 |
|---|---|---|---|---|
| 2 830 | Continued From page 13<br><br>out from under the resident's legs. The HST then leaned the resident forwards in the wheelchair to remove the sling from behind his back. However, the HST accomplished this task by standing in front of the wheelchair, placing his hand directly on the back of the resident's head/neck and pulling the resident towards himself with one hand and removing the sling the other hand. While the resident was positioned forward in the chair, he stated, "ow." The HST then assisted the resident with donning a shirt. The HST was again observed to lean the resident forward by holding onto the back of the resident's head and pulling him forward in the chair to allow the resident's shirt to be pulled down his back.<br><br>At 7:05 AM, the HST verified he should have supported the resident's shoulders to assist him to lean forward verses pulling on the resident's head and neck.<br><br>At 1:25 PM, the RN unit manager verified the HSTs should not have been pulling on residents' head or neck.<br><br>SUGGESTED METHOD OF CORRECTION: The administrator with the director of nursing could review and revise policies and procedures, provide education for involved staff, and establish a system to monitor to ensure policies and procedures are being implemented.<br><br>TIME PERIOD FOR CORRECTION: Thirty (30) days. | 2 830 | | |
| 2 895 | MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion<br><br>Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities | 2 895 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00233 | A. BUILDING ______ B. WING ______ | R 06/27/2008 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 895 | Continued From page 14 | 2 895 | | |

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:
Based on observation, interview, and record review, the facility failed to provide appropriate treatment and services to maintain and/or minimize the risk of further decrease in range of motion for 1 of 6 residents (#32) who had limitations in range of motion. Findings include:

Resident #32 had limitations in range of motion (ROM) and did not receive the necessary services to minimize the risk of further decline in range of motion.

The resident's medical record revealed the resident was diagnosed with Lewy Body dementia with behavioral disturbances. According to the Minimum Data Set (MDS) dated 6/11/08 resident #32 had severely impaired cognitive skills. The quarterly Minimum Data Set (MDS) dated 6/11/08 identified the resident as having bilateral limitations in his arms, legs and other areas of the body.

Resident #32 was observed on 6/26/08 at 6:50 AM to have limitations in range of motion of in his upper and lower extremities. The resident's plan

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00233 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED R 06/27/2008 |
|---|---|---|---|

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 895 | Continued From page 15<br>of care dated 12/26/07 indicated the resident received physical therapy to address decreased range of motion. According to the plan physical therapy was discontinued on 1/24/08 and a ROM program was set up to be performed daily on the unit. Review of the "Rehabilitation/Rehabilitation Nursing Communication" form dated 1/18/08 stated: "Nursing complete UE/LE (upper extremity/lower extremity) ROM (range of motion) program to maint. ROM/prevent contractures QD (every day)." The current plan of care did not identify this intervention and staff were not aware they were to perform the range of motion exercises.<br><br>On 6/26/08 at 1:05 PM, a human services technician (HST) stated only the licensed staff were able to do ROM for the resident. At 1:10 PM, the charge nurse reviewed the resident treatment record and her daily "To Do List" and stated it did not indicate the resident was on a ROM program. The treatment records reviewed from 3/08 to 6/08 did not include any documentation that the resident received ROM services.<br><br>At 1:15 PM, the registered nurse (RN) unit manager stated the physical therapy communication had not been processed correctly and she was unaware the physical therapy department had established a ROM program for the resident. She verified the resident was not receiving ROM at that time.<br><br>At 1:30 PM, the RN attempted to perform passive ROM for the resident. The resident was observed to be resistive and would not allow the ROM to be completed. The RN verified the resident had limitations in his upper and lower extremities. | 2 895 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00233 | (X2) MULTIPLE CONSTRUCTION A. BUILDING ___ B. WING ___ | (X3) DATE SURVEY COMPLETED R 06/27/2008 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: **MN VETERANS HOME MINNEAPOLIS** | STREET ADDRESS, CITY, STATE, ZIP CODE: **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 |
|---|---|---|---|---|
| 2 895 | Continued From page 16<br><br>At 1:40 PM, the HST and the RN unit manager verified the resident had limitations in ROM; however, said those limitations remained unchanged in the previous six months.<br><br>SUGGESTED METHOD OF CORRECTION:<br><br>The administrator with the director of nursing could review the method of communication between the therapy and nursing department and make necessary changes to the system to ensure resident's needs related to therapies are met. A monitoring program could be established in order to assure an on-going effective rehabilitative program for residents with ROM needs.<br><br>TIME PERIOD FOR CORRECTION: Thirty (30) days. | 2 895 | | |
| 2 910 | MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence<br><br>Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that:<br>A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and<br>B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. | 2 910 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00233 | (X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____ | (X3) DATE SURVEY COMPLETED R 06/27/2008 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: MN VETERANS HOME MINNEAPOLIS | STREET ADDRESS, CITY, STATE, ZIP CODE: 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 |
|---|---|---|---|---|
| 2 910 | Continued From page 17 | 2 910 | | |

This MN Requirement is not met as evidenced by:
"Uncorrected based on the following findings. The original licensing order issued on 4/15/08 will remain in effect. Penalty assessment issued."

Based on observation, interview, and record review, the facility failed to ensure 3 of 16 residents in the sample dependent on staff for assistance were provided incontinence care in accordance with their plan of care (#'s 42, 4 & 17). Findings include:

Resident #42 did not receive incontinent care according to his care plan.

Resident #42's Minimum Data Set (MDS) assessment dated 4/18/08 indicated the resident was totally incontinent of bladder and was completely dependent on staff for toileting and personal hygiene. The care plan (1/15/08) indicated he was to be checked and changed for incontinence every two hours. During the 6/24/08 PM observation the resident did not receive assistance for 3 hours, 40 minutes.

Resident #42 was observed receiving cares on 6/24/08 at 4:00 PM. The staff changed the resident's wet incontinent brief and pants. A mechanical lift was required for the resident to stand. When one human services technician (HST) started to get the resident up at that time, another reminded him the resident was only to be up for meals. The resident was assisted into his chair at 4:25 PM.

After supper, around 7:00 PM, a licensed practical nurse (LPN) attempted to center resident #42 who was leaning to the right, in his

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00233 | (X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______ | (X3) DATE SURVEY COMPLETED R 06/27/2008 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: **MN VETERANS HOME MINNEAPOLIS** | STREET ADDRESS, CITY, STATE, ZIP CODE: **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 |
|---|---|---|---|---|
| 2 910 | Continued From page 18 | 2 910 | | |

wheelchair. The resident was then assisted to his room. Once in the room, the first HST sought help from a third HST to further straighten the resident in the chair. The resident was left in his room in the wheelchair in front of the television.

At 7:45 PM, the surveyor informed an assistant director of nursing (ADON) that the resident had been up for 3 hours, 20 minutes. The ADON said that because of "DVT (deep venous thrombosis) " the resident "probably should not be up long". A HST informed the surveyor and ADON the resident was boosted up in the chair at about 7:00 and said the resident wasn't ready to go to bed so they just boosted him up in the chair. During observations, the resident did not appear able to communicate his needs or wishes. The resident's Minimum Data Set (MDS) assessment dated 4/18/08 revealed the resident rarely made decisions and that his communication was rarely understood.

An LPN and two HSTs assisted the resident into bed at 8:05 PM, 3 hours, 40 minutes after the resident was assisted into the chair. The resident was assisted with incontinence care and his brief changed. One of the HSTs verified the resident was wet. The HST was asked to describe the resident's skin condition. She said that although she cleaned the resident, she did it so quickly she did not observe the skin.

A registered nurse (RN) was apprised of the findings on 6/25/08 at 1:10 PM. She told the surveyor the HSTs were informed just before the finding "at report" that the resident was to only be up for 1 1/2 hours for meals. The RN also noted the staff should have performed the cares in a manner than allowed them to note the condition of the resident's skin and to report any problems

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00233 | (X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______ | (X3) DATE SURVEY COMPLETED R 06/27/2008 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: **MN VETERANS HOME MINNEAPOLIS** | | STREET ADDRESS, CITY, STATE, ZIP CODE: **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 |
|---|---|---|---|---|
| 2 910 | Continued From page 19<br>to the nurse.<br><br>Resident #4 did not receive incontinent cares on the evening of 6/24/08 according to his plan of care. The plan of care dated 1/08/08 directed the staff to assist the resident with incontinence cares every two hours (1/30/08). The plan of care also directed staff to provide perineal care after each incontinent episode.<br><br>The resident had diagnosis which included Parkinson's disease and dementia with behavioral disturbances. The quarterly MDS dated 4/15/08 identified the resident as requiring extensive assistance with all transfers, bed mobility and ambulation, incontinent of urine and cognitively impaired.<br><br>On the evening of 6/24/08 at 4:00 PM, the resident was observed sitting in a wheelchair in his chair. The resident remained in his wheelchair during a music activity and through the supper meal. At 6:05 PM, the RN unit manager was observed to wheel the resident out into a lobby area where he was observed to sleep in his chair. At 7:00 PM, 3 hours later, two HSTs assisted the resident with incontinence care. The resident was observed to be incontinent of urine and his skin was intact. The staff failed to provide perineal care. At 7:10 PM, the HST verified the resident had last been assisted with incontinence cares at 4:00 PM, three hours earlier. The HST stated the only time perineal care was to be completed was if the resident had a bowel movement or if they were receiving morning or bedtime cares.<br><br>On 6/25/08 at 10:30 AM, the RN unit manager verified the resident was to receive assistance with incontinence care and repositioning every | 2 910 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00233 | (X2) MULTIPLE CONSTRUCTION A. BUILDING ___ B. WING ___ | (X3) DATE SURVEY COMPLETED R 06/27/2008 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: **MN VETERANS HOME MINNEAPOLIS** | STREET ADDRESS, CITY, STATE, ZIP CODE: **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 |
|---|---|---|---|---|
| 2 910 | Continued From page 20 | 2 910 | | |

two hours as directed by his plan of care. The RN unit manager stated all residents should receive perineal care after each incontinent episode as directed by the plan of care.

Resident #17 did not receive incontinence care for 2 hours, 45 minutes, when the resident's plan of care directed staff to check and change the resident every two hours.

Resident #17 had a plan of care dated 2/13/04 that noted the resident was incontinent of bowel and bladder, and needed total assist with toileting. The care plan directed the staff to provide a toileting/ change program every two hours and as needed during waking hours. The HST assignment sheet (undated) directed staff to assist with check and change every two hours while awake.

The resident was observed 6/24/08 at 4:45 PM. He received incontinence care by having his brief changed, then was transferred into his wheelchair and taken to a lounge at 5:00 PM. The resident remained in his wheelchair until 7:45 PM when two staff assisted to transfer him to bed and provide incontinence care. the resident's pad was wet with a moderate amount of urine, his skin was clear.

The charge nurse on the unit was interviewed 6/24/08 at 6:30 PM and verified that resident #17 should have been changed every two hours. The HST caring for the resident stated at 7:30 PM that she was waiting for a co-worker to return from break to help her lie down resident #17.

SUGGESTED METHOD OF CORRECTION:
The administrator with the director of nursing could provide training to all staff on the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00233 | (X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____ | (X3) DATE SURVEY COMPLETED R 06/27/2008 |
|---|---|---|---|

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 910 | Continued From page 21<br>importance of implementing the plan of care. The Director of Nursing could establish a system to audit to ensure staff were following the plan of care.<br><br>TIME PERIOD FOR CORRECTION: Thirty (30) days. | 2 910 | | |