File

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7008 0150 0001 1713 1760

February 24, 2009

Ms. Judy Kurki-Coleman , Administrator
Minnesota Veterans Home Minneapolis
5101 Minnehaha Avenue South
Minneapolis, Minnesota 55417

Re: Enclosed State Nursing Home Licensing Orders - Project Number SL00233020

Dear Ms. Kurki-Coleman:

The above facility was surveyed on February 9, 2009 through February 18, 2009 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 320 West Second Street, Suite 703, Duluth, Minnesota 55802. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

Please feel free to call me with any questions.

Sincerely,

Pat Halverson

Pat Halverson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218) 723-4637 Fax: (218) 723-2359

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

L0023s09.rtf

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00233	A. BUILDING _____ B. WING _____	02/18/2009

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
2 000	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 16-18, 2009 surveyors of this Department's staff, visited the above provder and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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2 000	Continued From page 1 Certification Program; 320 West Second Street, St #703, Duluth, MN 55802.	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.	
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the	2 265		

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2 265	Continued From page 2 development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to ensure responsible party notification of resident change of condition for 1 of 4 residents (#24) in the sample with identified change of condition. Findings included: Medical record review indicated that resident #24 developed respiratory distress and was sent to the hospital by ambulance at 1:50 AM on 1/25/09. Nursing notes at 3:52 PM on 1/25/09 stated "Resident under observation at (hospital)." Brother .... "now aware."	2 265		

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2 265	Continued From page 3 The Annual Minimum Data Set (MDS) completed 1/5/09 indicated the resident had short term memory loss and modified independence with daily decision making. When interviewed, at 9:00 AM on 2/11/09, resident #24 stated that his brother didn't know he went to the hospital until the next day. The registered nurse manager (RNM I), interviewed at 8:15 AM on 2/11/09, stated the resident's brother was "not happy he was not notified" when resident #24 was sent to the hospital on 1/25/09. RNM I stated that difficulty between shifts caused the problem. RNM I stated that she talked extensively with the resident's brother and educated all the licensed staff on the unit regarding the need to notify the resident's responsible person regarding all changes of condition. SUGGESTED METHOD OF CORRECTIONS: The Director of Nursing or her designee could develop policies and procedures to ensure that staff notify resident's families or their legal representative of a change in condition in a timely fashion. The Director of Nursing or her designee could educate all appropriate staff on the policy and procedure. The Director of Nursing or her designee could develop a system to ensure resident's families or their legal representative were notified of a residents change in condition TIME FRAME FOR CORRECTIONS: Fourteen (14) days	2 265		
2 540	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment	2 540		

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2 540	Continued From page 4 Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care as defined in part 4658.0405. Subp. 2. Information gathered. The comprehensive resident assessment must include at least the following information: A. medically defined conditions and prior medical history; B. medical status measurement; C. physical and mental functional status; D. sensory and physical impairments; E. nutritional status and requirements; F. special treatments or procedures; G. mental and psychosocial status; H. discharge potential; I. dental condition; J. activities potential; K. rehabilitation potential; L. cognitive status; M. drug therapy; and N. resident preferences. This MN Requirement is not met as evidenced by: Based on observation, record review and interview the facility failed to complete a comprehensive assessment for 2 of 14 residents (#7,#5) in the sample with a limited range of motion (ROM). Findings include;	2 540		

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2 540	Continued From page 5 Resident #7 had limited ROM of the neck without a comprehensive assessment of the resident's significant losses in functional capacity, daily life functions, and rehabilitation potential. The resident had diagnoses that included Parkinson's disease, diabetes, dementia and kidney disease. On 2/9/09 at 2:15 PM resident #7 was observed while seated in a high back wheelchair. His upper torso was leaning to the right side of the chair with his head tipped toward the right shoulder and downward to the chest. On all days of the survey, the resident's body alignment, neck and head remained leaning to the right side, while he slept, talked, and ate meals, assisted by staff. Nurse Practitioner notes on 10/17/08 indicated that Occupational Therapy (OT) should, "evaluate and treat for positioning", due to "holding head to right side". The evaluation indicated that the resident "had difficulty with leaning his head to the right and forward, seated in wheelchair". The occupational therapist noted that staff had used a rolled towel and placed it under his head on the right shoulder, while feeding the resident. The occupational therapist massaged his neck, and attempted to bring his head to midline, stating, "there was some movement to the midline". The resident had resistance during the session. "Goal will be for functional seating with optimal postural alignment". On 10/24/08, the occupational therapist indicated that the resident was sitting in a more midline posture with use of a bolster. The OT did a gentle massage on the left side of his neck, and the resident was able to" independently bring his head to midline and turn his head to the left" to look at a visiting dog. With observations of evidence that the resident was able to independently turn his head to midline from greater than 20 degrees and then to the left side,	2 540		

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2 540	Continued From page 6 after a neck massage, the facility provided no further treatment. There was no evidence that the resident was encouraged, or provided massage to promote comfort and improve functional range of motion limitations that interfered with daily functions, including effectively breathing and eating. On 11/17/08 a physicians order indicated, "discontinue all occupational therapy orders". On 10/21/08 a Positioning Evaluation form was completed by physical therapy, which indicated that the resident "leans to right side with trunk, rotate neck to right and lean laterally to right. Unsuccessful physical therapy in past. Goal; passive positioning changes, more neutral posture in Broda. Oblique pelvis, scoliosis". The physical therapy plan at that time was to use a " bolster wedge in chair, monitor, later cervical position, seen intermittently to assess". The evaluation also included reference to the resident's rotated spine, kyphosis, forward neck and flexed thoracic spine as continuing issues. However, on 12/3/08 a physicians order indicated, "discontinue all physical therapy orders. Positioning in wheelchair complete. Does not tolerate cervical stretch". The quarterly Minimum Data Set (MDS) dated, 11/10/08, the significant change MDS, dated 8/15/08 and the annual MDS, dated 4/16/08, indicated that the resident had no functional limitations in range of motion of the neck, or any other body area, that interfered with daily functions or placed the resident at risk for injury. In addition, none of the 3 MDS's indicated that the resident required therapies, including occupational and physical therapy. The resident had moderate cognition skills, which required cues and supervision, due to poor decision making.	2 540		

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2 540	Continued From page 7	2 540		

The care plan dated 2/9/09 indicated a "hankie be placed at his neck due to drooling". The resident was not in the either of 2 dining rooms for meals, but rather was assisted at a table outside the dining room door, in a corner area. Although the facility was aware of the resident's ongoing postural range of motion challenges, pursuing further interventions to prevent further decline in range of motion in the neck, promote comfort, dignity and maintain or improve daily function limitations, adequate interventions and identification of the resident's rehabilitation potential was lacking.

On 2/11/09 at 7:45 AM, the Charge Registered Nurse (RN), stated that the resident had used other wheelchairs, that OT and PT had been involved and that there was no protocol for nursing rehabilitation. The RN stated that the resident had diagnoses that affected body alignment, positioning and neck placement to the right shoulder and chest. At 8:50 AM, the OT and PT described the interventions previously added to the resident's bed and wheelchair and stated that the resident no longer received any therapies since being discontinued.

Resident #5 had limited range of motion of the neck without a comprehensive assessment of the resident's significant losses in functional capacity, daily life functions, and rehabilitation potential. The resident had diagnosis that included Alzheimer's disease, kyphosis and arthritis.

On 2/9/09 at 2:30 PM, resident #5 was observed while seated in a wheelchair sleeping. Her upper torso was slightly leaning forward and her head was forward with her chin resting on her chest. On all days of the survey, the resident's body

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2 540	Continued From page 8 alignment, neck and position of her head remained forward while she slept, talked, and ate meals assisted by staff. The resident sat in the dining room for 1/2 hour sleeping, until she was served a meal. The position of her head and neck remained in a forward position, while she ate and attempted to drink fluids from a "nosy cup". At 6:25 PM, the resident left the dining room. The resident was sitting quietly at the end lounge at 6:55 PM. Her chin was resting on her chest. Her nose was dripping. The HST assisted the resident from the lounge area into the corridor, and told her to, "Put your head up. Look forward. Look forward ahead". On the morning of 2/10/09, the resident was observed to slightly raise her head and eyebrows when an HST asked her, "Can you put your head up"? On 12/12/08 the GNP requested that OT evaluate the resident for wheelchair positioning. Staff reported that, "she is leaning forward at the waist with her head resting on her chest". The evaluation indicated, "resident is still leaning forward, yet the tilt in space feature of the chair places her head alignment in a good position for feeding and safe swallowing". The goal indicated was to have functional seating with optimal posture and alignment with a tilt in space wheelchair. Physical Therapy (PT) completed a screen for the resident on 1/29/09, focusing on the resident's balance. The PT screen lacked evaluation of the neck and head range of motion. A quarterly Minimum Data Set (MDS), dated 11/13/08 and an annual MDS dated 2/6/09 indicated the resident had moderate cognitive skills, had functional limitations in range of motion, with partial loss on both sides of her	2 540		

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2 540	Continued From page 9 neck, and limitations on one side of her arm, including shoulder, and was receiving no therapies, including OT and PT. The updated care plan, dated 2/10/09, failed to specifically address the resident's loss of range of motion or rehabilitation potential.. Although the facility was aware of the resident's ongoing postural range of motion challenges, pursuing further interventions to prevent further decline in range of motion in the neck, promote comfort, dignity and maintain or improve daily function limitations, adequate interventions were lacking. On 2/11/09 at 7:50 AM, the Charge Registered Nurse (RN), stated that the resident had used other wheelchairs, that OT and PT had not been recently involved and that there was no protocol for nursing rehabilitation. The RN stated that the resident had diagnoses that affected the body alignment, positioning and forward neck placement with her chin resting on her chest the majority of the time. The RN also stated, "yes, she can lift her head". At 8:50 AM, the OT and PT described the interventions previously added to the resident's wheelchair and stated that the resident no longer received neck, or any other therapies, since being evaluated. SUGGESTED METHOD OF CORRECTIONS: The Director of Nursing or her designee could develop policies and procedures to ensure that residents have a comprehensive assessment of the loss or potential for loss in range of motion. The Director of Nursing or her designee educate all appropriate staff on the policy and procedure. The Director of Nursing or her designee could develop a system to ensure that residents range	2 540		

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2 540	Continued From page 10 of motion is assessed accurately and timely. TIME FRAME FOR CORRECTIONS: Twenty one (21) days	2 540		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on record review and interview the facility failed to ensure that 2 of 18 residents (#20, #3) in the sample had care plans developed to direct staff of the residents needs. Findings include; Resident #20 did not have a care plan for respiratory status or oxygen use. Resident #20's diagnoses included chronic obstructive pulmonary disease (COPD). The quarterly MDS dated 12/8/08 did not identify the resident's use of oxygen. At 5:20 PM on 2/9/09 the resident was observed sitting in a chair in the hallway outside room 311, yelling out "help me! help me! I can't breathe! I'm dying!" The resident was extremely anxious, short of breathe, very pale, and was sweating profusely. The resident had a nasal cannula on	2 560		

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2 560	Continued From page 11 and was holding the end of the oxygen tubing in his hand. The tubing was not connected to an oxygen tank. RN-F approached the resident and attempted to calm him by talking to him. RN-F told the surveyor "The LPN is filling his portable oxygen tank." At that time RN-F stated the resident's oxygen saturation level was 68%. At 5:24 PM LPN-G arrived with the resident's portable oxygen tank, affixed the end of the oxygen tubing to the tank, and turned the oxygen liter flow to 4 liters. RN-F stated the resident should be on oxygen continuously from 2-4 liters, but he makes himself anxious and short of breathe due to behaviors. Review of the current Physician's Orders dated 2/4/09 indicated resident #20 had an order for continuous oxygen at 2-4 liters per nasal cannula. The Care Planning Report dated 1/29/09 did not address the resident's respiratory status or the use of oxygen. At 9:20 AM on 2/11/09 the RN Manager (RNM-E) verified the resident's respiratory status and use of oxygen were not on the the care plan. Resident #3's care plan did not reflect his repositioning needs or repositioning ability. Resident #3's diagnoses included Chronic Obstructive Pulmonary Disease (COPD) and Rheumatoid Arthritis. The "The Tissue Tolerance Evaluation (TT)" (a tool used to identify repositioning needs) dated 1/10/09 indicated resident #3 was independent with repositioning in bed. The TT for "sitting" indicated, "Summary-Resident can tolerate 2 hours while up in the chair. Individualized Intervention Plan: 1. Repositioning Schedule T&R (turn & reposition) q (every) 2 hours....4. [check mark] Documented in care plan [check mark] HST (Human Services	2 560		

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

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2 560	Continued From page 12 Technician) Sheet updates." The "Check list of Skin Risk Factors" dated 2/4/09 indicated a check list of pertinent risk factors for skin breakdown including a history of pressure ulcers, diabetes, decreased mobility, malnutrition, dehydration and steroid use. The check list identified the resident had 2 open areas on the lateral and medial aspects of the left heel and an open area on the buttock. The check list further indicted the resident had the treatment of washing with soap and water and applying zinc oxide to an "abraised area" on the the buttock. The interventions section of the checklist indicated, "Turn and reposition every: as resident requests." The checklist did not did not include information from the 1/10/09 TT evaluations. Review of resident #3's temporary care plan for "Potential Impaired Skin Integrity and/or Actual Wound Present," dated 1/19/09 identified the resident had impaired skin on the buttocks, right gluteal fold, "Stage I Pressure" was hand written unsigned and undated on the "Focus" section of the care plan. The "Interventions" section of the care plan had an undated, unsigned hand written note which directed, "enc (encourage)/assist repos. (reposition) q 2 hours." The "Care Planning Report" for "Mobility" dated for 9/11/08 identified resident #3 required "assist with transfers" and an undated handwritten note which directed "enc. reposition q 2 hours." The care plan later contradicted itself and directed, "Able to repos self in w/c (wheelchair)." Review of the "Nursing Assistant Assignment Sheet" dated 2/9/09 for resident #3 directed , "Enc (encourage) to lay down during the day. Check change repo q2hrs in w/c."	2 560		

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2 560	Continued From page 13 During continuous observations of resident #3 on 2/9/09 from 3:53 PM thru 7:05 PM resident #3 did not independently offload pressure while in the wheelchair and was not offered assistance with repositioning. At approximately 6:50 PM, HST-E stated resident #3 was last repositioned at 3:00 PM and "refused" repositioning at 6:30 PM. HST-E stated the resident was going to go to bed at 7:00 PM, but was waiting for his nebulizer treatment. HST-E further stated, "I'm a float, and don't usually work with him." At 6:52 PM, the Nurse Manager (NM-B) stated, "He repositions himself pretty good in the wheelchair." On 2/10/09 at 2:30 PM, NM-B verified the skin assessment for resident #3 was "not comprehensive" and the TT directed to "Turn and reposition every 2 hours." NM-B confirmed the documentation for resident #3's repositioning ability and needs on the care plan, TT and "Nursing Assistant Assignment sheets" was contradictory. At 2:35 PM, the assistant director of nursing (ADON) stated contradictory information for the resident's ability to reposition was a "care plan discrepancy." At 2:40 PM, resident #3 was asked to demonstrate his ability to reposition himself in the wheelchair. After cueing from staff, he was observed to quickly lift each buttock and scoot himself back in the wheelchair. The resident stated he was unable to offload for a full minute and only moved himself in the wheelchair to "keep from sliding." SUGGESTED METHOD OF CORRECTIONS: The Director of Nursing or her designee could develop policies and procedures to ensure comprehensive care plan are developed. The Director of Nursing or her designee could educate all appropriate staff on the policy. The Director of Nursing or her designee develop	2 560		

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2 560	Continued From page 14 a system to ensure compliance. TIME PERIOD FOR CORRECTIONS: Twenty one (21) days	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation interview and record review the facility failed to provide cares as directed in the care plan for 1 of 18 (#17) residents in the sample. Findings include; Resident #17 was not provided incontinence care the evening of 2/9/09 according to the Care Plan. Resident #17's diagnoses include Diabetes Mellitus II, Obesity, Alzheimer's Dementia, and Osteoporosis. Review of the quarterly Minimum Data Set (MDS) dated 1/27/09 indicated the resident had severely impaired cognitive skills. The MDS indicated the resident required total assistance with all ADL's, and was incontinent of bladder multiple times daily. The Elimination Care Planning Report dated 11/17/08 directed "Check/change q2h (every 2 hours) and prn (as needed)." On 2/9/09 resident #17 was observed to not receive incontinence care from 4:10 PM to 7:15 PM (3 hours, 5 minutes). At 7:45 PM HST-I was	2 565		

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2 565	Continued From page 15 questioned regarding the resident's toileting schedule. HST-I stated the resident should be checked/changed every 2 hours, and was last checked/changed at 3:30 PM (3 hours, 45 minutes). At 9:45 AM on 2/10/09 the RN Manager (RNM-E) verified the resident should have been checked/changed every 2 hours as the Care Plan directed. Resident #17 was not provided repositioning the evening of 2/9/09 according to the Care Plan. Resident #17's diagnoses include Diabetes Mellitus II, Obesity, Alzheimer's Dementia, and Psoriasis. Review of the quarterly Minimum Data Set (MDS) dated 1/27/09 indicated the resident had severely impaired cognitive skills and required total assistance with all ADL's. The Skin Integrity Care Planning Report dated 11/17/08 directed "turn and reposition resident q2h (every 2 hours) and prn (as needed)." On 2/9/09 resident #17 was observed to not be repositioned from 4:10 PM to 7:15 PM (3 hours, 5 minutes). At 7:45 PM HST-I was questioned regarding the resident's repositioning schedule. HST-I stated the resident should be repositioned every 2 hours, and was repositioned between 5:10 PM and 5:20 PM by being "lifted up a little" with the Hoyer lift in the dining room for 1-2 minutes. HST-I stated it was not necessary to transfer the resident to bed for repositioning, and the resident was last repositioned in bed before getting up for supper at 3:30 PM (3 hours, 45 minutes). At 9:45 AM on 2/10/09 the RN Manager (RNM-E) verified the resident should have been repositioned every 2 hours according to her care plan, and stated lifting her up a little in the Hoyer	2 565		

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2 565	Continued From page 16 lift would not be adequate repositioning. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or her designee could develop policies and procedures to ensure care is delivered as directed in a residents care plan. The Director of Nursing or her designee educate appropriate staff on the policy. The Director of Nursing or her designee develop a system to monitor resident care to ensure compliance. TIME FRAME FOR CORRECTIONS: Fourteen (14) days	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 observation, interview and record review the facility failed to provided adequate respiratory care of 2 of 4 residents (#23,#20) in the sample on oxygen. Findings include	2 830		

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2 830	Continued From page 17 Resident #23 did not receive oxygen therapy based on his needs or as it was ordered. The physician's order dated 12/12/08 indicated resident #23 required oxygen (O2) at 2 liters per nasal canula, as needed, to keep his oxygen saturations levels above 90. The order also indicated the oxygen saturation levels were to be checked 4 times a day when the resident was awake. Review of the oxygen saturation levels from 02/01/09 through 02/10/09 indicated he had an average O2 saturation level of 92.2 % per the treatment record. The care plan dated 12/22/08 indicated the resident was to have O2 on at 2 to 4 liters to keep the O2 saturation above 86 %. Resident # 23 was observed at 7:10 AM on 02/11/09 with his oxygen nasal canula lying on the floor next to his bed as he slept. The resident remained sleeping until 8:30 AM when he woke up but remained in bed. At 9:40 AM the nurse manager (A) went into his room and requested the HST-R to help get the resident out of bed. The resident became short of breath as he sat up in his bed with help. As the staff continued to get him up out of his bed without his oxygen on he remained short of breath. After sitting at the edge of the bed the resident transferred himself to the wheel chair with stand by assist. HST-R then wheeled the resident into the bathroom and transferred to the toilet. The resident became more short of breath while sitting on the toilet. HST-R, interviewed regarding the resident's increased shortness of breath, stated she would put the O2 back on the resident. HST-R put the oxygen on the resident at 9:40 AM. The oxygen indicator on the portable tank was noted to be in the red zone, indicating it was empty. LPN-H was informed the portable tank was empty so he took it to be refilled, leaving the resident with out	2 830		

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2 830	Continued From page 18 oxygen. Per request of the surveyor at 9:45 AM the resident's oxygen saturation was measured and it was at 76 %. LPN-H returned with the portable O2 tank, connected the nasal cannula and turned on the oxygen; however, the resident remained short of breath. LPN-H , interviewed at approximately 9:50 AM, stated the large liquid oxygen tank was empty but he thought he may have gotten some O2 into the portable tank. When the portable tank was lifted again it was still in the red zone. After another attempt to refill the portable tank, the resident's O2 was re-applied at approximately 10:00 AM. At 10:07 AM the resident's O2 saturation level was re-measured and it was at 84 %. After the LPN-H had the resident deep breath a few times his O2 saturation level went up to 92 %. Interview with LPN-H at 10:10 AM on 02/11/09 indicated the resident's O2 saturation was to be kept at 90 % with the use of O2. Interview with the nurse manager at 10:20 AM on 02/11/09 confirmed the resident's O2 needs had not been met. Resident #20 was not provided continuous Oxygen (O2) therapy as ordered by the Physician. Resident #20's diagnoses include Chronic Obstructive Pulmonary Disease (COPD). The quarterly minimum data set (MDS) dated 12/8/08 indicated the resident had mild cognitive difficulties in new situations only. The MDS did not identify the resident had shortness of breath. At 5:20 PM on 2/9/09 the resident was observed sitting on a chair outside room 311 and yelling out "Help me! Help me! I can't breathe! I'm dying!" The resident was extremely anxious, short of breathe, very pale, and was sweating profusely.	2 830		

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2 830	Continued From page 19 The resident had a nasal cannula on and was holding the end of the oxygen tubing in his hand, which was not attached to an oxygen tank. RN-F approached the resident and attempted to calm him by talking to him. RN-F told the surveyor "the LPN is filling his portable oxygen tank." At the surveyor's request RN-F checked the resident's oxygen saturation and the RN identified it to be 68%. (normal percentage of oxygen in the blood expected to be >95% per Common Laboratory and Diagnostic Tests; Lippincott, 1998). At 5:24 PM LPN-G arrived with the resident's portable oxygen tank, affixed the end of the O2 tubing to the tank, and turned the O2 liter flow to 4 liters. The resident was observed to become less anxious and short of breathe, and his color improved. The resident stated "Thank you, you saved my life" to LPN-G. After approximately 2-3 minutes of oxygen use RN-F re-checked the resident's O2 saturation and identified it to be at 92%. RN-F stated the resident should be on oxygen continuously from 2-4 liters, but he makes himself anxious and short of breathe due to behaviors. RN-F stated the resident's portable tank was usually filled while he was in his room using his oxygen concentrator. When questioned by the surveyor the resident stated "they don't leave me without oxygen all the time, but sometimes it happens, and then I can't breathe." Review of the current Physician's Orders dated 2/4/09 indicated resident #20 had an order for O2 which directed 2-4 liters per nasal cannula continuous. At 9:45 AM on 2/10/09 RN Manager (RNM-E) verified the resident had a Physician's order for O2 continuously, but stated she wasn't sure the	2 830		

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2 830	Continued From page 20 resident even had a diagnoses that related to shortness of breathe. RNM-E added the resident says he has Emphysema but he has multiple behaviors and makes himself anxious all the time. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or her designee could develop policies and procedures to ensure resident receive the oxygen therapy they were assessed to need. The Director of Nursing or her designee could educate staff on the policy The Director of Nursing or her designee could develop a system to monitor that residents receive the continuos oxygen as ordered.. TIME FRAME FOR CORRECTIONS: Twenty one (21) 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:	2 895		

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2 895	Continued From page 21	2 895		

Based on observation, record review and interview the facility failed to ensure that 2 of 8 residents (#7, #5) in the sample with a limitation in range of motion receive service to maintain or improve their range of motion. Findings include;

Resident #7 had limited range of motion of the neck without adequate implemention of possible interventions based on a comprehensive assessment in an attempt to prevent further decline in range of motion in the neck, promote comfort and improve functional range of motion limitations that interfered with daily functions, including effectively breathing and adequate food and fluid intake. The resident had copious amount of saliva drool on a daily basis. The resident had diagnosis that included Parkinson's disease, diabetes, dementia and kidney disease.

On 2/9/09 at 2:15 PM, the resident was observed while seated in a high back wheelchair. His upper torso was leaning to the right side of the chair with his head tipped toward the right shoulder and downward to the chest. On all days of the survey, the resident's body alignment, neck and head remained leaning to the right side, while he slept, talked, and ate meals assisted by staff.

Nurse Practitioner notes on 10/17/08 directed Occupational Therapy (OT)," evaluate and treat for positioning", due to "holding head to right side". The evaluation indicated that the resident "had difficulty with leaning his head to the right and forward, seated in wheelchair". The occupational therapist noted that staff had used a rolled towel and placed it under his head on the right shoulder, while feeding the resident. The occupational therapist massaged his neck, and attempted to bring his head to midline, stating, "there was some movement to the midline". The

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2 895	Continued From page 22 resident had resistance during the session. "Goal will be for functional seating with optimal postural alignment". On 10/24/08, the occupational therapist indicated that the resident was sitting in a more midline posture with use of a bolster. The OT did gentle massage on the left side of his neck, and the resident was able to" independently bring his head to midline and turn his head to the left," to look at a visiting dog. With evidence that the resident was able to independently turn his head to midline from greater than 20 degrees and then to the left side after a neck massage, no further treatment or assessment was provided. There was no further information to indicate that the resident was encouraged or provided massage to promote comfort and improve functional range of motion limitations that interfered with daily functions, including effectively breathing and eating. However, on 11/17/08 a physicians order indicated, "discontinue all occupational therapy orders". On 10/21/08 a Positioning Evaluation form was completed by physical therapy, which indicated that the resident "leans to right side with trunk, rotate neck to right and lean laterally to right. Unsuccessful physical therapy in past. Goal; passive positioning changes, more neutral posture in Broda. Oblique pelvis, scoliosis". The physical therapy plan at that time was to use a " bolster wedge in chair, monitor, later cervical position, seen intermittently to assess". The evaluation also included reference to the resident's rotated spine, kyphosis, forward neck and flexed thoracic spine as continuing issues. However, on 12/3/08 a physicians order indicated, "discontinue all physical therapy orders. Positioning in wheelchair complete. Does not tolerate cervical stretch".	2 895		

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2 895	Continued From page 23 The quarterly Minimum Data Set (MDS) dated, 11/10/08, the significant change MDS, dated 8/15/08 and the annual MDS, dated 4/16/08, indicated that the resident had no functional limitations in range of motion of the neck, or any other body area, that interfered with daily functions or placed the resident at risk for injury. In addition, none of the 3 MDS's indicated that the resident required therapies, including occupational and physical therapy. The resident had moderate cognition skills, which required cues and supervision, due to poor decision making. The care plan, dated 2/9/09 indicated a "hankie be placed at his neck due to drooling". The resident was not in a dining room for meals, but rather was assisted at a table outside the dining room door, in a corner area. Although the facility was aware of the resident's ongoing postural range of motion challenges, pursuing further interventions to prevent further decline in range of motion in the neck, promote comfort, dignity and maintain or improve daily function limitations, adequate interventions were lacking. On 2/11/09 at 7:45 AM, the Charge Registered Nurse (RN), stated that the resident had used other wheelchairs, that OT and PT had been involved and that there was no protocol for nursing rehabilitation. The RN stated that the resident had diagnoses that affected the body alignment, positioning and neck placement to the right shoulder and chest. At 8:50 AM, the OT and PT described the interventions previously added to the resident's bed and wheelchair and stated that the resident no longer had received neck, or any other therapies, since being discontinued.	2 895		

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2 895	Continued From page 24	2 895		

Resident #5 had limited range of motion of the neck without adequate implemention of possible interventions, based on a comprehensive assessment, in an attempt to prevent further decline in range of motion in the neck, promote comfort and improve functional range of motion limitations that interfered with daily functions, including adequate food and fluid intake.

The resident had diagnosis that included Alzheimer's disease, kyphosis and arthritis.

On 2/9/09 at 2:30 PM, the resident was observed while seated in a wheelchair sleeping. Her upper torso was slightly leaning forward and her head was forward with her chin resting on the chest. On all days of the survey, the resident's body alignment, neck and position of her head remained forward while she slept, talked, and ate meals assisted by staff. The resident sat in the dining room for 1/2 hour sleeping, until she was served a meal. The position of her head and neck remained in a forward position, while she ate and attempted to drink fluids from a "nosy cup". At 6:25 PM, the resident left the dining room. The resident was sitting quietly at the end lounge at 6:55 PM. Her chin was resting on her chest. Her nose was dripping. The HST assisted the resident from the lounge area into the corridor, and told her to, "Put your head up. Look forward. Look forward ahead". On the morning of 2/10/09, the resident was observed to slightly raise her head and eyebrows when an HST asked her, "Can you put your head up"?

On 12/12/08 the GNP requested that OT evaluate the resident for wheelchair positioning. Staff reported that, "she is leaning forward at the waist with her head resting on her chest". The

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

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2 895	Continued From page 25	2 895		

evaluation indicated "resident is still leaning forward, yet the tilt in space feature of the chair places her head alignment in a good position for feeding and safe swallowing". The goal indicated was to have functional seating with optimal posture and alignment with a tilt in space wheelchair..

Physical Therapy (PT) completed a screen for the resident on 1/29/09, focusing on the resident's balance. The PT screen lacked evaluation of the neck and head range of motion.

A quarterly Minimum Data Set (MDS), dated 11/13/08 and an annual MDS dated 2/6/09 indicate the resident had moderate cognitive skills, had functional limitations in range of motion, with partial loss on both sides of her neck, and limitations on one side of her arm, including shoulder, and was receiving no therapies, including OT and PT.

The updated care plan, dated 2/10/09, failed to specifically address the resident's loss of range of motion. Although the facility was aware of the resident's ongoing postural range of motion challenges, pursuing further interventions to prevent further decline in range of motion in the neck, promote comfort, dignity and maintain or improve daily function limitations, adequate interventions were lacking.

On 2/11/09 at 7:50 AM, the Charge Registered Nurse (RN), stated that the resident had used other wheelchairs, that OT and PT had not been recently involved and that there was no protocol for nursing rehabilitation. The RN stated that the resident had diagnoses that affected the body alignment, positioning and forward neck placement with her chin resting on her chest the

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2 895	Continued From page 26 majority of the time. The RN also stated, "yes, she can lift her head". At 8:50 AM, the OT and PT described the interventions previously added to the resident's wheelchair and stated that the resident no longer had received neck, or any other therapies, since being evaluated. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing or her designee could develop polices and procedure to ensure that resident are assessed for and are provided services to maintain their range of motion. The Director of Nursing or her designee could educate all appropratie staff on the policy. The Director of Nursing or her designee coud develop a system TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 895		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent	2 900		

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2 900	Continued From page 27 new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide individualized interventions to prevent pressure ulcers for 2 of 12 residents (#17,#3) in the sample who were assessed to be at high risk for the development of pressure ulcers. Finding include; Resident #17, who was identified at high risk for skin breakdown, was not provided adequate repositioning for 3 hours and 45 minutes on the PM of 2/9/09. Resident #17's diagnoses include Diabetes Mellitus II, Obesity, Alzheimer's Dementia, and Psoriasis. Review of the quarterly Minimum Data Set (MDS) dated 1/27/09 indicated the resident had severely impaired cognitive skills. The MDS indicated the resident required total assistance with transfers, bed mobility, was incontinent, and was non-ambulatory. The Comprehensive Bowel and Bladder Summary dated 8/8/08 indicated the resident had end stage Dementia, was incontinent of bowel and bladder, and was at risk for UTI's and/or skin breakdown. The record noted a toileting plan to check and change every 2 hours and as needed. The human services technician (HST) care sheet (no date) and the Elimination Care Planning Report dated 11/17/08 directed "Check/change q2h (every 2 hours) and prn (as needed)." The Tissue Tolerance Evaluation dated 8/11/08 indicated the resident could tolerate 3 hours when in the chair, however, directed a repositioning schedule of every 2 hours to coincide with the	2 900		

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2 900	Continued From page 28	2 900		

resident's check/change schedule.
The Checklist of Skin Risk Factors dated 11/1/08 indicated the resident was at risk for pressure ulcers related to a Braden score of 12 (high risk), Incontinence, immobility, DM type II, and Psoriasis. The record further indicated "prone to bruising/skin tears related to very fragile skin", and "turn and reposition resident q2h (every 2 hours) and prn (as needed)."
The Skin Integrity Care Planning Report dated 11/17/08 directed "turn and reposition resident q2h (every 2 hours) and prn (as needed)."

At 4:10 PM on 2/9/09 resident #17 was observed in the dining room in a Broda wheelchair. The resident remained in the dining room and received her meal at 5:55 PM. The resident was totally fed by one staff and finished eating at 6:40 PM. At 6:42 PM the resident was assisted in the wheelchair to her room and was placed in front of the TV. At 7:00 PM the surveyor questioned HST-J regarding the resident's repositioning schedule. HST-J stated another staff member was caring for the resident and was unavailable. HST-J the resident was repositioned in the chair between 5:20 PM and 5:30 PM by being "lifted up a little" in the Hoyer lift in the dining room. At 7:15 PM HST-J and HST-K transferred the resident to bed with the Hoyer lift, and completed PM cares. The resident's incontinent product was observed to be wet a moderate amount, and the resident's skin was noted to be moist with a small patch of superficial open areas on her right upper buttock, but was otherwise intact. HST-J applied Aloe Vesta cream to the resident's right upper buttock area, and stated the resident had a skin condition (Psoriasis) and does scratch herself.
At 7:45 PM HST-I (was assigned to care for resident #17) was questioned regarding the resident's repositioning. HST-I stated the resident

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2 900	Continued From page 29 should be repositioned every 2 hours, and was repositioned between 5:10 PM and 5:20 PM by being "lifted up a little" with the Hoyer lift in the dining room for 1-2 minutes. HST-I stated it was not necessary to transfer the resident to bed for repositioning, and the resident was last repositioned in bed before getting up for supper at 3:30 PM (3 hours, 45 minutes). At 9:45 AM on 2/10/09 the RN Manager (RNM-E) verified the resident should have been Hoyer lifted to bed and repositioned to coincide with her check/change schedule, and stated lifting her up a little in the Hoyer lift would not be adequate repositioning. Review of the facility's Skin Integrity Management policy dated 09/08 indicated the policy did not address what would be required for appropriate repositioning. Resident #3, a resident currently with pressure ulcers on the left heel and a open area on the right buttock, was not assisted to reposition while in the wheelchair from 3:00 PM to 7:02 PM (4 hours and 2 minutes) on the 2/9/09. Resident #3's diagnoses included Chronic Obstructive Pulmonary Disease (COPD) and Rheumatoid Arthritis. The "The Tissue Tolerance Evaluation (TT)" (a tool used to identify repositioning needs) dated 1/10/09 indicated resident #3 was independent with repositioning in bed. The TT for "sitting" indicated, "Summary-Resident can tolerate 2 hours while up in the chair. Individualized Intervention Plan: 1. Repositioning Schedule T&R (turn & reposition) q (every) 2 hours....4. [check mark] Documented in care plan [check mark] HST (Human Services Technician) Sheet updates."	2 900		

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2 900	Continued From page 30 The "Check list of Skin Risk Factors" dated 2/4/09 indicated a check list of pertinent risk factors for skin breakdown including a history of pressure ulcers, diabetes, decreased mobility, malnutrition, dehydration and steroid use. The check list identified the resident had 2 open areas on the lateral and medial aspects of the left heel and an open area on the buttock. The check list further indicted the resident had the treatment of washing with soap and water and applying zinc oxide to an "abraised area" on the the buttock. The interventions section of the checklist indicated, "Turn and reposition every: as resident requests." The checklist did not did not include information from the 1/10/09 TT evaluations. Review of resident #3's temporary care plan for "Potential Impaired Skin Integrity and/or Actual Wound Present," dated 1/19/09 identified the resident had impaired skin on the buttocks, right gluteal fold, "Stage I Pressure" was hand written unsigned and undated on the "Focus" section of the care plan. The "Interventions" section of the care plan had an undated, unsigned hand written note which directed, "enc (encourage)/assist repos. (reposition) q 2 hours." The "Care Planning Report" for "Mobility" dated for 9/11/08 identified resident #3 required "assist with transfers" and an undated handwritten note which directed "enc. reposition q 2 hours." The care plan later contradicted itself and directed, "Able to repos self in w/c (wheelchair)." Review of the "Nursing Assistant Assignment Sheet" dated 2/9/09 for resident #3 directed , "Enc (encourage) to lay down during the day. Check change repo q2hrs in w/c." During continuous observations of resident #3 on 2/9/09 from 3:53 PM thru 7:05 PM the following	2 900		

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2 900	Continued From page 31 was observed: At 3:53 PM, the resident was observed to be up in his motorized wheelchair in the hallway going to the activity. From 3:53 PM - 4:20 PM the resident remained in the activity in the "River City Diner" (dining room). At 4:20 PM - 4:25 PM he wheel motored himself to the nursing desk, down the hall and back to the activity. From 4:25 PM - 4:37 PM he remained in the activity. At 4:37 PM he motored himself out of the activity and to the nursing desk. From 4:37 PM - 4:46 PM he remained sitting by the nursing desk. At 4:46 PM he motored down the hall to the licensed practical nurse (LPN-F) and stated he was "out of oxygen," returned to the nursing desk to have his liquid oxygen tank filled by 4:50 PM then motored himself to sit beneath the clock in the sitting area by the nursing desk. From 4:50 PM - 5:15 PM he remained sitting under the clock. At 5:15 PM he motored himself to the medication cart near LPN-F by the resident's room. At 5:20 PM the resident motored to the postings outside the dining room and into the dining room at 5:30 PM. From 5:30 PM - 6:30 PM resident #3 remained in the dining room for the meal. At 6:30 PM he motored to the nursing desk and then outside his room door. From 6:30 PM - 6:45 PM he remained outside his room and was interviewed by the surveyor and stated staff had not repositioned him. At 6:45 PM, the human services technician (HST-G) was asked when resident #3 was last repositioned and was unclear. At approximately 6:50 PM, HST-E stated resident #3 was last repositioned at 3:00 PM and "refused" repositioning at 6:30 PM. HST-E stated the resident was going to go to bed at 7:00 PM, but was waiting for his nebulizer treatment. HST-E further stated, "I'm a float, and don't usually work with him." At 6:52 PM, the Nurse Manager (NM-B) stated, "He repositions	2 900		

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2 900	Continued From page 32 himself pretty good in the wheelchair." At 7:00 PM resident #3 was wheeled by staff into his room. At 7:02 PM, HST-E washed his hands and face, applied the transfer belt and with the assistance of HST-G, transferred the resident with extensive assistance of 2 to the bed. Resident #3 was observed to have two small scabbed areas on the right gluteal fold of the buttock. At no time during the observations was the resident observed to offload pressure in the wheelchair or to be approached by staff to be repositioned. On 2/10/09 at 2:30 PM, NM-B stated the skin assessment for resident #3 was "not comprehensive" and the TT directed to "Turn and reposition every 2 hours." NM-B confirmed the documentation for resident #3's repositioning ability and needs on the care plan, TT and "Nursing Assistant Assignment sheets" was contradictory. The RN senior (RN-B) stated the open area on the resident's buttock was an "abrasion" from sliding in the wheelchair. At 2:35 PM, the assistant director of nursing (ADON) stated contradictory information for the resident's ability to reposition was a "care plan discrepancy." At 2:40 PM, resident #3 was asked to demonstrate his ability to reposition himself in the wheelchair. After cueing from staff, he was observed to quickly lift each buttock and scoot himself back in the wheelchair. The resident stated he was unable to offload for a full minute and only moved himself in the wheelchair to "keep from sliding." SUGGESTED METHOD FOR CORRECTION: Director of Nursing or her designee could develop policies and procedures to ensure resident receive individualized intervention to prevent the	2 900		

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2 900	Continued From page 33 development and promote healing of pressure ulcers Director of Nursing or her designee could educate all appropriate staff. Director of Nursing or her designee could develop a monitor system to ensure compliance TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 900		
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval. This MN Requirement is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to provide proper wheelchair positioning for 2 of 4 residents (#7, #5) in the sample who utilize wheelchairs . Findings include; Resident # 7, who the facility identified as dependent on staff for positioning, was not adequately positioned in the wheelchair to prevent leaning or obtain adequate body alignment. The resident had diagnosis that included Parkinson's disease, diabetes, dementia and kidney disease. On 2/9/09 at 2:15 PM, resident #7 was observed	2 905		

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2 905	Continued From page 34 seated in a high back wheelchair with his upper torso leaning to the right side of the chair and his head tipped toward the right shoulder and downward to the chest. On all days of the survey, the resident's body alignment, neck and head remained leaning to the right side, while he slept, talked, and ate meals, assisted by staff. On 10/17/08 the GNP requested that Occupational Therapy (OT)," evaluate and treat for positioning, due to "holding head to right side". The evaluation indicated that the resident "had difficulty with leaning his head to the right and forward, seated in wheelchair". The occupational therapist noted that staff placed a rolled towel under his head on the right shoulder while feeding the resident. The occupational therapist massaged his neck, and attempted to bring his head to midline, stating, "there was some movement to the midline". The resident had resistance during the session. "Goal will be for functional seating with optimal postural alignment". On 10/24/08, the occupational therapist indicated that the resident was sitting in a more midline posture with use of a bolster. The OT did gentle massage on the left side of his neck, and the resident was able to" independently bring his head to midline and turn his head to the left," to look at a visiting dog. With evidence that the resident was able to independently turn his head to midline from greater than 20 degrees and then to the left side, after a neck massage, the facility provided no further treatment. The resident was not encouraged or provided massage to promote comfort and improve functional range of motion limitations that interfered with daily functions, including effectively breathing and eating. On 11/17/08 a physicians order indicated, "discontinue all occupational therapy orders".	2 905		

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2 905	Continued From page 35 On 10/21/08 a Positioning Evaluation form was completed by physical therapy that indicated that the resident "leans to right side with trunk, rotate neck to right and lean laterally to right. Unsuccessful physical therapy in past. Goal; passive positioning changes, more neutral posture in Broda. Oblique pelvis, scoliosis". The physical therapy plan at that time was to use a " bolster wedge in chair, monitor cervical position, seen intermittently to assess". The evaluation also included reference to the resident's rotated spine, kyphosis, forward neck and flexed thoracic spine as continuing issues. However, on 12/3/08 a physicians order indicated, "discontinue all physical therapy orders. Positioning in wheelchair complete. Does not tolerate cervical stretch". The quarterly Minimum Data Set (MDS) dated, 11/10/08, the significant change MDS, dated 8/15/08 and the annual MDS, dated 4/16/08, indicated that the resident had no functional limitations in range of motion of the neck, or any other body area, that interfered with daily functions or placed the resident at risk for injury. In addition, none of the 3 MDS's indicated that the resident required therapies, including occupational and physical therapy. The resident had moderate cognition skills, which required cues and supervision, due to poor decision making. The care plan, dated 2/9/09 indicated a "hankie be placed at his neck due to drooling". The resident did not eat in a dining room, but rather, was assisted at a table outside the dining room door in a corner area. Although the facility was aware of the resident's ongoing postural range of motion challenges there was no plan to develop	2 905		

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2 905	Continued From page 36 interventions to prevent further decline in range of motion in the neck, promote comfort, dignity or maintain or improve daily function limitations. On 2/11/09 at 7:45 AM, the Charge Registered Nurse (RN), stated that the resident had diagnoses that affected the body alignment, positioning and neck placement to the right shoulder and chest. At 8:50 AM, the OT and PT described the interventions previously added to the resident's bed and wheelchair and stated that the resident received no therapies since being discontinued. Resident # 5, who the facility identified as dependent on staff for positioning, was not adequately positioned in the wheelchair to prevent leaning or to obtain adequate body alignment. The resident had diagnosis that included Alzheimer's disease, kyphosis and arthritis. On 2/9/09 at 2:30 PM, the resident was observed asleep in a wheelchair with her upper torso slightly leaning forward and her head forward with her chin resting on her chest. On all days of the survey, the resident's body alignment, neck and position of her head remained forward while she slept, talked, and ate meals assisted by staff. At approximately 6:00 PM on 2/9/09, the resident's head and neck remained in a forward position while she ate and attempted to drink fluids from a "nosy cup." At 6:25 PM, the resident left the dining room. The resident was sitting quietly at the end lounge at 6:55 PM with her chin resting on her chest and her nose was dripping. At approximately 7:00 PM the HST assisted the resident from the bathroom into the corridor and told her to "Put your head up! Look forward! Look	2 905		

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2 905	Continued From page 37 forward ahead". On the morning of 2/10/09, the resident was observed to slightly raise her head and eyebrows when an HST asked her, "Can you put your head up"? On 12/12/08 the GNP requested that OT evaluate the resident for wheelchair positioning. Staff reported that, "she is leaning forward at the waist with her head resting on her chest". The evaluation indicated that a tilt in space wheelchair was appropriate. "Resident is still leaning forward, yet the tilt in space feature of the chair places her head alignment in a good position for feeding and safe swallowing". The goal was to have functional seating with optimal posture and alignment. Physical Therapy (PT) completed a screen for the resident on 1/29/09, focusing on the resident's balance. The PT screen lacked evaluation of the neck and head range of motion. A quarterly Minimum Data Set (MDS), dated 11/13/08 and an annual MDS dated 2/6/09 indicate the resident had moderate cognitive skills, had functional limitations in range of motion, with partial loss on both sides of her neck, and limitations on one side of her arm, including shoulder, and was receiving no therapies, including OT and PT. The updated care plan, dated 2/10/09, failed to specifically address the resident's loss of range of motion. Although the facility was aware of the resident's ongoing postural range of motion challenges, there were no interventions to prevent further decline in range of motion in the neck, promote comfort, dignity and maintain or improve daily function limitations.	2 905		

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2 905	Continued From page 38 On 2/11/09 at 7:50 AM, the Charge Registered Nurse (RN), stated that the resident had used other wheelchairs, that OT and PT had not been recently involved and that there was no protocol for nursing rehabilitation. The RN stated that the resident had diagnoses that affected body alignment, positioning and forward neck placement with her chin resting on her chest the majority of the time. The RN also stated, "Yes, she can lift her head". At 8:50 AM, the OT and PT described the interventions previously added to the resident's wheelchair and stated that the resident no longer received neck, or any other therapies, since being evaluated. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing or her designee could develop policies and procedure to ensure residents are assessed and provided interventions to promote proper positioning. The Director of Nursing or her designee could educate all appropriate staff. The Director of Nursing or her designee could develop a system to monitor that residents are good body alignment. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 905		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that:	2 910		

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2 910	Continued From page 39 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 B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the facility failed to provide services to prevent incontinence for 1 of 14 residents (#17) in the sample. Finding include; Resident #17 was not provided incontinence care for 3 hours and 45 minutes the PM of 2/9/09. Resident #17's diagnoses included Diabetes Mellitus II, Obesity, Alzheimer's Dementia, and Osteoporosis. Review of the quarterly Minimum Data Set (MDS) dated 1/27/09 indicated the resident had severely impaired cognitive skills. The MDS indicated the resident required total assistance with transferring, toilet use, and was incontinent of bladder multiple times daily. The Comprehensive Bowel and Bladder Summary dated 8/8/08 indicated the resident had end stage Dementia, was incontinent of bowel and bladder, and was at risk for UTI's and/or skin breakdown. The record noted a toileting plan to check and change every 2 hours and as needed. The human services technician (HST) care sheet (no date) and the Elimination Care Planning Report dated 11/17/08 directed "Check/change q2h (every 2 hours) and prn (as needed)."	2 910		

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2 910	Continued From page 40 At 4:10 PM on 2/9/09 resident #17 was observed in the dining room in a Broda wheelchair. The resident remained in the dining room and received her meal at 5:55 PM. The resident was totally fed by one staff and finished eating at 6:40 PM. At 6:42 PM the resident was assisted in the wheelchair to her room and was placed in front of the TV. At 7:00 PM the surveyor questioned HST-J regarding the resident's toileting schedule. HST-J stated another staff member was caring for the resident and was unavailable. HST-J stated she wasn't sure if the resident's toileting schedule was every 2 or 3 hours, and was unaware when the resident had last been checked/changed. At 7:15 PM HST-J and HST-K transferred the resident to bed with the Hoyer lift, and completed PM cares. The resident's incontinent product was observed to be wet a moderate amount, and the resident's skin was noted to be moist with a small patch of superficial open areas on her right upper buttock. HST-J applied Aloe Vesta cream to the resident's right upper buttock area, and stated the resident had a skin condition (Psoriasis) and does scratch herself. At 7:45 PM HST-I (assigned to care for resident #17) was questioned regarding the resident's toileting schedule. HST-I stated the resident should be checked/changed every 2 hours, and was last checked/changed at 3:30 PM (3 hours, 45 minutes). At 9:45 AM on 2/10/09 the RN Manager (RNM-E) verified the resident should have been checked/changed every 2 hours. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing or her designee could develop policies and procedure to ensure that	2 910		

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2 910	Continued From page 41 residents receive the incontinence care they were assessed to need. The Director of Nursing or her designee could educate all appropriate staff. The Director of Nursing or her designee could develop a system to ensure the care is provided in accordance with the residents assessments. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 910		
21510	MN Rule 4658.1200 Subp. 2 A.B. SpecializedRehabilitative Services; Provision Subp. 2. Provision of services. If specialized rehabilitative services are required in the resident's comprehensive plan of care, the nursing home must: A. provide the required services; or obtain the required services from an outside source according to part 4658.0075. This MN Requirement is not met as evidenced by: Based on observation, record review and interview the facility failed to provided adequate positioning or 1 of 1 residents (#5) in the sample as the occupational therapy department had assessed to need. Resident #5 was not provided occupational therapy services to ensure appropriate positioning for eating The resident had diagnosis that included Alzheimer's disease, kyphosis and arthritis. On 2/9/09 at 2:30 PM, the resident was observed to be asleep in the wheelchair with her upper torso slightly leaning forward and her head forward with her chin resting on her chest. On all	21510		

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days of the survey, the resident's body alignment, neck and position of her head remained forward while she slept, talked, and ate meals assisted by staff. At approximately 6:00 PM on 2/9/09 the resident was served her meal. The resident's head and neck remained in a forward position while she ate and attempted to drink fluids from a "nosy cup". At 6:25 PM the resident left the dining room and was observed sitting quietly at the end lounge at 6:55 PM with her chin resting on her chest. The HST assisted the resident into the corridor and told her to, "Put your head up! Look forward! Look forward ahead!" On the morning of 2/10/09, the resident was observed to slightly raise her head and eyebrows when an HST asked her, "Can you put your head up?"

On 12/12/08 the GNP requested that OT evaluate the resident for wheelchair positioning. Staff reported that, "she is leaning forward at the waist with her head resting on her chest". The occupational therapy evaluation indicated "resident is still leaning forward, yet the tilt in space feature of the chair places her head alignment in a good position for feeding and safe swallowing". The goal indicated was to have functional seating with optimal posture and alignment.

On 2/11/09 at 7:30 AM the charge Registered Nurse stated that, although the resident's chair could be tilted, the ideal position of the tilt chair for the resident to eat and swallow was not implemented. The care plan was not revised. At 7:45 AM, the OT stated, "yes, the pedal Broda wheelchair tilts for eating and safe swallowing".

SUGGESTED METHOD FOR CORRECTION: The Director of Nursing or her designee could provide polices and procedure to ensure that

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21510	Continued From page 43 resident are provided the services that rehab services had assessed they need. The Director of Nursing or her designee could educate all appropriate staff and departments. The Director of Nursing or her designee could develop a system to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21510		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by:	21535		

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21535	Continued From page 44 Based on interview and record review the facility failed to adequately identify, assess and monitor clinical indications for ongoing use of medications for 1 of 25 residents (#8) in the sample on medications. Findings include; Resident # 8 had been on Sertraline 75 mg daily (antidepressant medication) since 5/19/05; however, the physician did not document clinical indications for use. Pharmacy reviews dated 1/31/08 indicating resident #8 could be a candidate for assessment and potential gradual dose reduction of Sertraline. The pharmacist noted the resident had been on this does of antidepressant since 2005. A note by the nurse practitioner in response to the pharmacist request indicated it was discussed with the physician "who recommends that the dosing stay the same for now." Review of Behavior Monitoring Form for Anti-Depressant Medications from January 2008 through February 11, 2009 indicated the resident had no symptoms of depression and required no interventions to address depression during that time. The annual MDS dated 12/12/08 indicated the resident had no concerns or changes in mood. The pharmacist, interviewed at 2:50 PM on 2/10/09, verified the lack of documented clinical indications for ongoing use of Sertraline at the same dose. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing or her designee could develop policies to ensure that residents medications are reviewed to ensure on going clinical indications for use. The Director of Nursing or her designee could	21535		

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21535	Continued From page 45 educate all appropriate staff and physicians. The Director of Nursing or her designee could develop a system to monitor compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21535		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observations, interview, and record review, the facility failed to ensure 2 of 3 residents (#8, #1) observed self-administering medications were deemed safe to do so. Findings include: Resident # 8 was observed to self administer his Nebulizer and did not have an assessment, a plan of care or a physician's order to ensure he could self - administration this medication safety. The quarterly MDS dated 12/30/08 indicated resident #8 had short term memory loss with moderate cognitive impairment. Physician's orders dated 1/21/09 directed Albuterol 0.083 % Solution Nebulizer 3 ml (1 vial) four times daily. The LPN (LPN-A) was observed at 5:19 PM on 2/09/09 to set up the nebulizing treatment for the resident and leave the room. She went to the nursing station, down the hall and around the	21565		

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corner from the resident's room. The LPN-A returned to resident #8's room at 5:30 PM to remove the nebulizer treatment. The LPN-A did not return to the room while the resident was taking this medication to ensure the treatment was completed appropriately.

Interview and review of the record with nurse manager-A, at 9:55 AM on 2/10/09 confirmed there was no physician's order, assessment nor had self administration been addressed on the plan of care.

Resident #1 was not assessed for ability to safely self-administer medications and was observed to have Primatene Mist and Vicks Vapo Rub at the bedside on 2/9/09 and 2/10/09.

Resident #1's was admitted on 1/20/09 with diagnoses to include chronic airway obstruction, atrial fibrillation and type II diabetes mellitus. The admission minimum data set (MDS) dated 2/2/09 indicated he was cognitively intact, required staff assistance with personal cares and had limitations in functional range of motions with a partial loss of voluntary movement in both arms. The resident assessment protocol (RAP) for ADL Functional Rehabilitation Potential indicated the resident ADL ability and, "Res. (resident) strives to be independent."

Review of resident #1's clinical record revealed the following:
The 1/21/09 physician's order directed, "Ok for Primatene Mist to be supplied by resident/family for SOB (shortness of breath) q (every) 4 hours 1-2 puffs PRN not to exceed 9 puffs per day." The 1/24/09 physician order directed, "Primatene Mist okay at bedside." A physicians's order dated 2/5/09 also indicated, "Vicks vapo rub to nose

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21565	Continued From page 47 PRN for dryness. Ok for bed side." Resident #1's medication administration record (MAR) for January 2009 identified the order for the Primatene Mist and documented it had been administered on 1/22/09, 1/23/09 and 1/24/09, but did not indicated the number of puffs administered by the resident or staff. Another page of the January 2009 MAR indicated, "Primatene Mist okay at bedside. FYI" The MAR lacked further documentation the inhaler had been used and did not record the number of puffs the resident may have taken. Resident #1's MAR for February 2009 identified the resident used Vick's vapo and recapitulated the order. The MAR indicated to administer the Primatene Mist inhaler 1-2 puffs every 4 hours as needed and "Not to exceed 9 puffs/day. Family to provide." the MAR and the clinical record did not reflect if the resident had used the medication and did not document how many puffs were used. The clinical record lacked evidence a self-administration of medication assessment had been completed for resident #1. On 2/9/09 at approximately 2:00 PM during the initial tour, a inhaler of Primatene Mist labeled 1-2 puffs every 4 hours PRN. Do not exceed 9 puffs/day" was observed to be on the bedside table. Resident #1 was sitting in his recliner chair within reach of the inhaler. At 3:56 PM, the inhaler was observed to be within reach on the bedside table, resident #1 was sitting in his recliner chair in the room. At 4:00 PM, resident #1 stated the inhaler lasted approximately "4 months" and he always takes "one puff four times per day." On 2/10/09 at 2:45 PM, the RN senior (RN-B) stated she "had the paperwork" for resident #1's	21565		

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21565	Continued From page 48 self-administration assessment, but was "waiting to talk to the resident." The nurse manager (NM-B) confirmed the clinical record lacked a self-administration of medications assessment for resident #1.	21565		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure that medications were appropriately labeled for 4 of 25 residents (#9, 26, 27 and 28) in the sample on medications. Findings include; Resident #9's insulin vial was not labeled with an open date to determine the expiration date of the medication. At 8:50 AM on 2/10/09 the medication refrigerator in building 6, 1st floor, contained an open insulin vial for resident #9. The vial of Novolog Aspart Insulin was not labeled with an open date to determine when it expired. Nurse manager-A, present at the time of the observation, confirmed no open date was recorded on the insulin vial. She indicated the insulin should be discarded 25 days after opening and needed to be dated when it was opened. The nurse manager indicated it appeared the insulin bottle had been relabled on 1/29/09; however, there was no way to tell if that's when it was opened. Resident #26's Genteal 0.3% eye drops were not labeled with the number of drops he was to	21620		

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receive. The physician's order was not specific to direct the number of drops to administer.

Physician's orders dated 1/31/09 and the medication label directed Genteal eye drops 0.3% instill drop (s) 6-8 times a day in both eyes.

At 4:00 PM on 2/09/0, during observation of the medication pass on the 1st floor of building 6, resident #26 received 2 drops of Genteal 0.3% in each eye.

LPN-A confirmed she would always give two drops in each eye. She also confirmed the directions were unclear as to how many drops should be given. The resident indicated at that time he was unsure how many drops the physician wanted him to have. He further indicated he got different numbers of drops depending on which nurse administered the drops. He further indicated he liked to get 4 drops in each eye. Interview with nurse manager-A at 9:00 AM on 2/10/09 indicated she expected the number of drops to be included on the bottle label and on the physician's order.

Resident #27's insulin was not labeled to ensure the correct dose would be given at the correct time. The insulin vial and physician's order were unclear to when the dose of sliding scale insulin should be given.

The physician's order dated 2/01/09 and label on the insulin vial indicated to administer Novolog Aspart insulin per sliding scale 4 times daily, before meals and at bedtime. Hold if not eating or bedtime blood sugar less than 140.

At 6:37 PM on 2/10/09, during observation of the medication pass for building 6 on the 1st floor,

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21620	Continued From page 50	21620		

resident #27 received Novolog Aspart Insulin, 4 units, per the sliding scale. LPN-D indicated at that time the resident was to receive his insulin half way through his meal to ensure he had eaten before it was given. At 9:20 AM on 2/10/09 nurse manager-A confirmed the insulin label directed insulin administration both before the meal and to ensure the resident had eaten before administration.
During observations of the 2 North #3 medication cart on 2/10/09 at 9:40 AM, two bottles of Travaprost (Travatan) 0.004% eye drops (a medication used to treat narrow angle glaucoma) were observed to be opened, but lacked an affixed label from the pharmacy which identified directions for use, the resident's name, prescription number, name of the practitioner, date of original issue or renewal, the generic or trade name and strength of the medication.

The first bottle of Travaprost had the hand written name of resident #28; however, there was no affixed pharmacy label with directions for administering the medication, the date the medication was dispensed and other required pharmacy data. Review of the clinical record indicated a physician's order which directed, "Travaprost 0.004% OP SOL (Ophthalmic solution) Instill one drop in both eyes at bedtime."

The second bottle of Travaprost was observed to be stored loose in the top drawer of the medication cart. The medication had no affixed pharmacy label. LPN (LPN-A), present during the observations of the medication cart, confirmed the two bottles of Travaprost should have affixed pharmacy labels. At 9:30 AM, the nurse manager (NM-B) stated the eye drops should have been labeled, nurses should "report" when a label was missing and further stated, "(The facility) have

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 _____	02/18/2009

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
21620	Continued From page 51 used a lot of pool (agency) nurses lately." SUGGESTED METHOD FOR CORRECTION: The Director of Nursing or her designee could develop policies and procedures to ensure that medications are appropriately labeled. The Director of Nursing or her designee could educate all staff on the policy. The Director of Nursing or her designee develop a system to monitor medication labels to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21620		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation and interview the facility failed to maintain a home like environment. Findings include; During the environmental tour of the resident rooms with the Plant Manager on 2/10/09 beginning at 10:00 AM, the following was observed: Resident #3's bed was observed to have a box of Kleenex, a small fan and the bed controls duct taped to the left side rail. A cable cord for the television was observed to be duct taped to the wall and the bulb call light had a cut piece of oxygen tubing duct taped to the call light cord,	21665		

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 _____	02/18/2009

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

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21665	Continued From page 52 with the opposite end of the oxygen tubing duct taped to the pull cord of the light over the bed. The cup holder on resident #3's wheelchair was observed to have duct tape around the circumference of the cup holder. The Plant Manager confirmed the items should not have been duct taped, were put there by the resident's family, and the duct taped items should have been reported to him by staff. The light over the door to resident room 297 was loose from the ceiling on the left side of the light. The Plant Manager confirmed the light needed to be repaired. SUGGESTED METHOD FOR CORRECTION: The Housekeeping Manager along with the Plant Manager could develop policies and procedures to ensure the physical plant is maintained in a home like manner. The Housekeeping Manager along with the Plant Manager could educate all appropriate staff. The Housekeeping Manager along with the Plant Manager could develop a monitoring system to ensure compliance TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21665		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program.	21685		

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	00233	A. BUILDING _____ B. WING _____	02/18/2009

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
21685	Continued From page 53 This MN Requirement is not met as evidenced by: Based on observation and interview the facility failed to maintain a environment in good repair. Findings include; During the environmental tour of the facility with the Plant Manager on 2/10/09 beginning at 10:00 AM, the following was observed: The vent above the entrance to the "River City Diner" was observed to have a build up of grey dust on the vent. A section of baseboard trim under the serving window in the "River City Diner" was missing and edges of the existing trim were loose. The baseboard trim around the central pillar in the diner was loose and/or missing from the base. A corner protector on the first corner to the left, upon entering the diner, was missing. Two metal brackets with potentially sharp edges were observed to be exposed. The Plant Manager confirmed the baseboard trim was missing and loose and a corner piece was missing. The Plant Manager stated the items should have been reported for repair and confirmed they were not. An abutting section of the wall, in the hallway and to the right of the "River City Diner," was observed to have chipped corners. The Plant Manager confirmed the corners were chipped and were missing the "corner protectors." SUGGESTED METHOD FOR CORRECTION: The Housekeeping Manager along with the Plant Manager could develop policies and procedures to ensure the physical plant is maintained in a clean and safe manner. The Housekeeping Manager along with the Plant	21685		

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 _____	02/18/2009

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
21685	Continued From page 54 Manager could educate all appropriate staff. The Housekeeping Manager along with the Plant Manager could develop a monitoring system to ensure compliance TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21685		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation and interview the facility failed to maintain a a clean and sanitary environment. Finding include; During the environmental tour of the facility with the Plant Manager on 2/10/09 beginning at 10:00 AM, the following was observed: The large garbage cans and yellow storage bins stored in the resident eating areas of the 2 North "River City Diner" and 2 South "Bluff View Lounge," were observed to appear visibly soiled and to have multiple dried spills on the outsides of the garbage cans. The microwave in the 2 Center dining area was observed to have spills and splatters of dried food on the inside of the microwave. The Plant Manager confirmed the findings and stated the cleaning of the garbage cans and microwaves were a "housekeeping"	21695		

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 _____	02/18/2009

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
21695	Continued From page 55 responsibility and was unclear when they were last cleaned. SUGGESTED METHOD FOR CORRECTION: The Housekeeping Manager could develop policies and procedures to ensure that the dining areas are free of debris. The Housekeeping Manager could educate all appropriate staff. The Housekeeping Manager could develop a system to monitor compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21695		
23070	MN Rule 4658.5010 Clothes Wardrobe or Closet; Existing Constr A nursing home must provide each resident with individual wardrobe or closet space in the resident's bedroom with clothes racks and shelves accessible to the resident. Locks may be provided, with keys for the residents, when a pass key is provided at the nurses' station. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to provide accessible wardrobe or closet space in the resident's bedroom for residents on the third floor of building 6. Findings included: During observations on the evening of 2/9/09 at 4:13 PM, it was noted that there were locks on the closet doors in all the resident's rooms. The locks were rods that extended up into the door frames at the top of the closet doors, approximately seven feet up. The locks had key holes to be accessed to unlock the doors.	23070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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23070	Continued From page 56 When interviewed at 2:30 PM on 2/10/09, RN Manager-H stated that all the closets on that floor were locked. She said that sometimes during the day they are left open by the HSTs for easier access. She added that all the closets are locked because some of the residents go into others' rooms and go through their things and some resident family members have complained in the past because things were missing. She said that none of the residents on the locked unit [6-3] had assessments for the restrictive practice of locking the closets. She acknowledged that, although she didn't think any of the residents were capable using keys to access the locks, she didn't know for sure since there was not an assessment to address the restrictive practice. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing or her designee could develop policies to ensure residents have unrestricted access to their personal belongings. The Director of Nursing or her designee could educate all appropriate staff. The Director of Nursing or her designee could develop a system to ensure compliance TIME PERIOD FOR CORRECTION: Twenty one (21) days.	23070		

MDH LTC 3201

SENDER: *COMPLETE THIS SECTION*

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
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1. Article Addressed to:

Ms. Judy Kurki-Coleman, Administrator
MN Veterans Home Minneapolis
5101 Minnehaha Avenue South
Minneapolis, MN 55417

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) C. Date of Delivery 2/26/09

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FEB 26 2009
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☐ Insured Mail ☐ C.O.D.

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

7008 0150 0001 1713 1760

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00233 File

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7008 0150 0001 1713 1982

April 13, 2009

Ms. Judith Kurki-Coleman, Administrator
Minnesota Veterans Home Minneapolis
5101 Minnehaha Avenue South
Minneapolis, Minnesota 55417

Re: Enclosed State Boarding Care Home Licensing Orders - Project Number SL00233020

Dear Ms. Kurki-Coleman:

The above facility survey was completed on February 18, 2009 for the purpose of assessing compliance with Minnesota Department of Health Boarding Care Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Boarding Care Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings is Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 320 West Second Street, Suite 703, Duluth, Minnesota 55802. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

Please feel free to call me with any questions.

Sincerely,

Pat Halverson

Pat Halverson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218) 723-4637 Fax: (218) 723-2359

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

L0023s209.rtf

RECEIVED
APR 17 2009
MN Dept of Health
Duluth

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00233	A. BUILDING _____ B. WING _____	02/18/2009

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
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 16 - 18, 2009 surveyors of this Department's staff, visited the above provder (Board and Care) and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the	3 000 OK 4/20/09 RLH	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.	

linnesota Department of Health

Judith Lee Coleman Administrator 04.14.09

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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3 000	Continued From page 1 Minnesota Department of Health, Division of Compliance Monitoring, Licensing and Certification Program; 320 West Second Street, St #703, Duluth, MN 55802.	3 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings 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.	
34645	MN Rule 4660.7800 Subp. 2 Plant Operation & Maint. Existing/New Constr Subp. 2. Walls, floors, and ceilings. Walls, floors, and ceilings shall be kept in good and acceptable repair at all times. They shall be of a type or finish to permit good maintenance	34645		

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34645	Continued From page 2 including frequent washing, cleaning, or painting. This MN Requirement is not met as evidenced by: Based on observation and interview the facility failed to ensure locked storage for oxygen cylinders. Findings included: At 4:30 PM on 2/9/09 the door to the oxygen storage room on the 4th floor of building 17 was unlocked. The room contained 13 E tanks. The registered nurse manager (RNM D) stated the door could only be opened with a key; however, when she tried the door it was not locked. RNM D stated the door was scheduled to be replaced and until it could be locked the oxygen tanks would be moved to a secure storage room. SUGGESTED METHOD OF CORRECTIONS: Director of Nursing or her designee could develop policies and procedures to ensure that oxygen is stored in a secured room. Director of Nursing or her designee educate all appropriate staff on the policy and procedure. Director of Nursing or her designee could develop a system to ensure compliance TIME FRAME FOR CORRECTIONS: Twenty one (21) days	34645	**Tag 34645** The door to the O2 storage room was unlocked due to a door replacement project. It was locked immediately upon discovery. Completion: Immediately upon discovery	

STATE OF MINNESOTA
MINNESOTA VETERANS HOME – MINNEAPOLIS
5101 MINNEHAHA AVENUE SOUTH
MINNEAPOLIS, MINNESOTA 55417-1699
(612) 721-0600

April 14, 2009

Pat Halverson, Unit Supervisor
MN Department of Health
Licensing and Certification
320 West Second Street, Room 703
Duluth, MN 55802

Dear Ms. Halverson:

Enclosed, please find our signed licensing orders for the February, 2009 Boarding Care survey. Even though we are not required to submit a plan of correction, we have included one. Please let me know if you have any concerns/comments regarding the plan of correction.

Thank you.

Sincerely,

Judy Kurki-Coleman

Judy Kurki-Coleman
Administrator

MDH LTC 3201

SENDER: *COMPLETE THIS SECTION*

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
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1. Article Addressed to:

Ms. Judith Kurki-Coleman, Administrator
MN Veteran's Home – Minneapolis
5101 Minnehaha Avenue South
Minneapolis, MN 55417

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) C. Date of Delivery 4/14/09

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

APR 17 2009

3. Service Type
☑ Certified Mail ☐ Express Mail
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

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

7008 0150 0001 1713 1982

Pls. return in 5 days

PS Form 3811, February 2004 Domestic Return Receipt SL00233020 EP 02595-02-M-1540