File
00233

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7009 1410 0000 2304 0885

October 13, 2010

Ms. Pam Barrows, Administrator
Minnesota Veterans Home Minneapolis
5101 Minnehaha Avenue South
Minneapolis, Minnesota 55417

Re: Enclosed State Nursing Home Licensing Orders - Project Number SL00233021

Dear Ms. Barrows:

The above facility was surveyed on September 20, 2010 through September 23, 2010 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.

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 _____	09/23/2010

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 9/20, 9/21, 9/22, and 9/23/10, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health,	3 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Boarding Care Homes.	

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3 000	Continued From page 1 Division of Compliance Monitoring, Licensing and Certification Programs; 85 East Seventh Place, Suite 220; P.O. Box 64900, St. Paul, Minnesota 55164-0900.	3 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings is the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
31105	MN Rule 4655.7810 Distribution of Medications A system shall be developed in each boarding care home to assure that all medications are distributed safely and properly. All medications shall be distributed and taken exactly as ordered by the physician. Any medication errors or resident reactions shall be reported to the physician at once and an explanation made in the resident's personal care record.	31105		

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31105	Continued From page 2 This MN Requirement is not met as evidenced by: Based on observation, staff interview, record and policy review, the facility failed to determine if the practice of self-administration of medications was safe for 1 of 1 resident (R1) in the sample who was observed self-administering medication. Findings include: R1 lacked an assessment to determine if the practice of self-administration of medications was safe for the resident. On 9/23/10, at 10:40 a.m. registered nurse (RN-A) brought a nebulizer solution to R1's room. RN-A handed R1 the nebulizer breathing apparatus after the RN-A had set-up the medication in the nebulizer. The RN left and R1 then self-administered the medication. A licensed practical nurse (LPN-A) went in the resident's room ten minutes later to check on the resident. R1's recent diagnosis included pneumonia. The medical record lacked an assessment and a physician's order for the resident's ability to safely self-administer medications. A review of the Medication/Treatments Self-Administered policy, dated 12/7/05 indicated all residents would be assessed by the interdisciplinary team for the ability to self-administer medications when admitted to the facility. On 9/23/10, at 1:10 p.m. RN-A verified R1 lacked an assessment and a physician's order to self-administer medications. SUGGESTED METHOD FOR CORRECTION: The director of nursing or designee could review	31105		

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31105	Continued From page 3 policies and procedures, provide training as necessary, audit records for assessments, and ensure all residents who are self-administering medication have the necessary assessment, orders, and appropriate plan in place. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	31105		
31880	MN Rule 144.651 Subd. 20 Patients & Residents of HCF Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every non-acute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written	31880		

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31880	Continued From page 4 grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on record review and staff interview, the facility failed to resolve a grievance by 1 of 5 residents in the group interview (R1) who reported requesting a new physician. Findings include: R1 requested a new physician and the request was not addressed. During a the group meeting on 9/22/10, at 11:15 a.m. R1 stated he had requested a new physician, but a new physician had not been assigned to him. R1 also indicated he informed the staff of his request for a new physician :"some time ago," but still had the same physician was not satisfied. A physician's progress note dated 4/21/10, revealed the resident requested a new a physician. The physician questioned why the resident's request had not been addressed. The facility provided a form titled, Identity of Resident's Attending Physician and Facility's Allied Health Services. The form said, "The	31880		

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31880	Continued From page 5 attending physician at the Minnesota Veteran's Home--Minneapolis, responsible for your care is: _____." Physician names were then listed and the appropriate physician checked. The RN-B and the licensed social worker (LSW-B) were interviewed on 9/21/10, at 9:25 a.m. The LSW was queried regarding physician changes. The LSW said she was unsure who communicated to the residents "that they don't really have a choice--I don't tell them. I think if they object we maybe make that happen." A nurse practitioner (NP-A) was asked how information was conveyed to residents and whether they had a choice of physicians. She stated, "They can't" change physicians. She stated, "Several years ago there was talk of changing this, but that got nixed." She explained the reason was that several physicians refused to see residents on different units, and thought it would cause confusion among the staff as to who should be called. The NPs were employed by the facility and strictly saw residents on their assigned unit. The medical record indicated a physician had documented on 4/21/10, of the request for a new physician for R1, and the facility did not act upon the resident's grievance in the five months following the resident's request. SUGGESTED METHOD FOR CORRECTION: The director of social services could work with the administrator to ensure residents verbal and written concerns are addressed in a timely manner. The director of nursing administrator, director of social services could work with the physicians and nurse practitioners to determine an appropriate policy and procedure, should a resident wish to change physicians. The quality	31880		

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31880	Continued From page 6 committe could monitor for compliance. TIME PERIOD FOR CORRECTION: Thirty (30) days.	31880		

MINNESOTA VETERANS HOME
Minneapolis
Plan of Correction
Quality code:

MINNESOTA HEALTH DEPARTMENT SURVEY
PLAN OF CORRECTION-SURVEY 09/20-23/2010

RULE STATUE	CORRECTION ORDER	TIME FOR CORRECTION	PLAN of CORRECTION	RESPONSIBLE PERSON	COMPLETION DATE
TAG 31105 MN RULE 4655.7810	BOARD AND CARE HOME DISTRIBUTION OF MEDICATIONS RESIDENT R1 LACKED AN ASSESSMENT TO DETERMINE IF THE PRACTICE OF SELF-ADMINISTRATION WAS SAFE FOR RESIDENT.	21 DAYS	Resident #1 had a self-administration assessment dated 9/15/10. Resident #1 does not have a diagnosis of pneumonia and does not use a nebulizer. DOMs staff will be re-educated about: placement of assessment in medical record.	ADON	9/15/10
TAG 31880 MN RULE 144.651 SUBD 20	BOARD AND CARE HOME BILL OF RIGHTS-GRIEVANCES R1 REQUESTED A NEW PHYSICIAN AND THE REQUEST WAS NOT ADDRESSED.	30 DAYS	Minneapolis Veterans Home will continue to ensure requests for Physician change are addressed. Residents R 1 progress notes reviewed that indicated that Social Worker did assist resident with information needed for residents request to select a new primary physician. To ensure consistent practice of supporting resident choice we will make available on each unit a listing of medical providers. An e-mail containing this was sent to each nursing unit. Social Services Director/ designees will report issues of non compliance to the Quality Council.	DIRECTOR SOCIAL SERVICES	11/4/10
TAG 2540 MN RULE 4658.0400 SUB 1&2	SKILLED CARE COMPREHENSIVE RESIDENT ASSESSMENT FACILITY FAILED TO ENSURE COMPREHENSIVE ASSESSMENTS WERE COMPLETED FOR	21 DAYS	Minneapolis Veterans Home will continue to ensure each resident has completed comprehensive assessments. R29 was reassessed for code alert use. R6 is no longer a resident in the facility.	ADON/Dietary Director	10/27/10

RULE STATUE	CORRECTION ORDER	TIME FOR CORRECTION	PLAN of CORRECTION	RESPONSIBLE PERSON	COMPLETION DATE
	RESIDENT **R29** WHO UTILIZED A CODE ALERT SYSTEM; **R6** WHO DEVELOPED WOUNDS; **R6** AND **R5** REVIEWED FOR INCONTINENCE; **R32** AND **R11** WHO ARE AT HIGH RISK FOR DEHYDRATION		**R5 was reassessed for incontinence.** **R32 no longer a resident.** **R11 was reassessed for hydration. Based on assessment continue with current plan of care.** **All residents will be reassessed according to the RAI/MDS process and schedule.** **Policies/procedures have been reviewed to ensure comprehensive assessments are completed.** **Staff is receiving education re: comprehensive assessment.** **ADONs or designees will conduct random audits to ensure compliance. Audit recommendations will be referred to the Quality Council for review or recommendations.**		**10/26/10** **11/5/10** **12/22/10**
TAG 2550 **MN RULE 4658.0400 SUB 4**	**SKILLED CARE COMPREHENSIVE RESIDENT ASSESSMENT-REVIEW** **R3** LACKED AN ASSESSMENT FOR BOWEL AND BLADDER CONTINENCE **R14** SKIN RISK FACTOR SHOWED INCONSISTENCIES **R10** QUARTERLY ASSESSMENT LACKED A DETERMINATION OF THE ADEQUACY OF FLUID INTAKE	**21 DAYS**	**Minneapolis Veterans Home will continue to ensure each resident has comprehensive assessments are completed.** **R3 was reassessed for bowel & bladder incontinence.** **R14 is no longer a resident in facility.** **R10 fluid intake was determined. Residents Hydration status was summarized in progress note.** **All residents will be reassessed according to the RAI/MDS process and schedule.**	**ADON**	**10/25/10** **10/29/10**

RULE STATUE	CORRECTION ORDER	TIME FOR CORRECTION	PLAN of CORRECTION	RESPONSIBLE PERSON	COMPLETION DATE
			Policies/procedures have been reviewed to ensure comprehensive assessments are completed. **Staff is receiving education re: comprehensive assessment.** **ADONs or designees will conduct random audits to ensure compliance. Audit recommendations will be referred to the Quality Council for review or recommendations.**		**1** **2/22/10**
TAG 2560 **MN RULE 4658.0405 SUB 2**	**SKILLED CARE** **CARE PLAN-CONTENT** **R30** HAD HOSPICE SERVICES, HOWEVER SERVICES WERE NOT COORDINATED SO PROVISIONS COULD NOT BE PROVIDED AS OUTLINED IN PLAN **R6** HOSPICE CARE PLAN LACKED DIRECTIVES FOR MANAGING PAIN, EDEMA AND SKIN INTEGRITY. COMMUNICATION BETWEEN HOSPICE AND NURSING HOME STAFF NOT CLEAR	**21 DAYS**	**Minneapolis Veterans Home will continue to ensure each resident has an accurate comprehensive care plan.** **R6 is no longer a resident in the facility.** **R30 hospice services are coordinated and on plan of care.** **All residents using hospice services will be reviewed to ensure plan of care reflects coordinated services.** **Meeting with hospice provider to discuss coordination of services.** **Policies/procedures have been reviewed to ensure care plan content reflects hospice coordination.** **Staff is receiving education re: coordination of hospice services.** **ADONs or designees will conduct random**	**Medical Director** **ADON**	**10/26/10** **11/2/10** **12/8/10**

RULE STATUE	CORRECTION ORDER	TIME FOR CORRECTION	PLAN of CORRECTION	RESPONSIBLE PERSON	COMPLETION DATE
			audits to ensure compliance. Audit recommendations will be referred to the Quality Council for review or recommendations.		
TAG 2565 MN RULE 4658.0405 SUB 3	**SKILLED CARE CARE PLAN-USE** **R2 FACILITY** FAILED TO ENSURE CARE PLAN FOLLOWED IN UTILIZATION OF SPLINT. CARE PLAN DID NOT HAVE EVIDENCE OF PLAN TO MINIMIZE DECREASE IN ROM **R8** WHOSE ORTHOTIC BLOOD PRFESSURES WERE NOT RECORDED **R32** CARE PLAN LACKED EVIDENCE THAT SHUNT FOR HEMODIALYSIS WAS BEING MONITORED **R18** WAS NOT TOILETED AS DIRECTED IN CARE PLAN	**21 DAYS**	**Minneapolis Veterans Home will continue to ensure each resident has an accurate comprehensive care plan.** **R2 splint is placed according to plan of care. R2 reassessed by OT to determine ROM needs.** **10/19/10** **R8 orthostatic blood pressures recorded on MAR.** **10/2/10** **R32 is no longer a resident in facility.** **R18 is toileted according to care plan.** **All resident care plans will be reviewed according to MDS/RAI process and schedule.** **10/26/10** **Policies/procedures have been reviewed to ensure care plan use is addressed.** **Staffs are receiving education re: care plan use.** **ADONs or designees will conduct random audits to ensure compliance. Audit recommendations will be referred to the Quality Council for review or recommendations.**	**ADON**	**12/8/10**
TAG 2570 MN RULE 4658.0405 SUB 4	**SKILLED CARE CARE PLAN-REVISION** **R8** CARE PLAN WAS NOT REVIEWED AND REVISED RELATED TO PACEMAKER	**21 DAYS**	**Minneapolis Veterans Home will continue to ensure each resident has an accurate comprehensive care plan.** **R8 care plan was revised.** **10/26/10**		

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	CHECKS AND SHIN GUARDS		**All resident care plans will be reviewed according to the MDS/RAI process and schedule.** **Policies/procedures have been reviewed to ensure care plan revision is addressed.** **Staffs are receiving education re: care plan revision.** **ADONs or designees will conduct random audits to ensure compliance. Audit recommendations will be referred to the Quality Council for review or recommendations.**	**ADON**	**12/8/10**
TAG 2830 **MN RULE 4658.0520 SUB 1**	**SKILLED CARE ADEQUATE AND PROPER NURSING CARE** **R6 WAS** NOT PROVIDED ADEQUATE EDUCAITON REGARDING PAIN MEDICATIONS IN ORDER TO MAKE INFORMED DECISION REGARDING PAIN MEDICATION AVAILABLE TO RELIEVE EXCRUCIATING PAIN. **R44** HAD SKIN INDENTATIONS FROM LEANING ON ALARM PRONGS ON BACK OF CHAIR **R29** ARM AND LEG SPLINT WERE SOILED WITH SPILLS	**21 DAYS**	**Minneapolis Veterans Home will continue to ensure each resident receives adequate and proper nursing care.** **R6 is no longer a resident in facility.** **R12 & R44 alarm bracket was replaced upon discovery.** **R29 splints were cleaned. Clothing is changed per resident choice.** **Standards of Work have been reviewed to ensure adequate and proper nursing care is addressed.** **Staff is receiving education re: Work Standards** **Pain Management Policy/Assessment will be reviewed at the November/December Skills Fair.**	**RNM** **RNM** **ADON**	**9/22/10** **9/23/10** **12/8/10**

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			ADONs or designees will conduct random audits to ensure compliance. Audit findings/recommendations will be referred to the Quality Council for review.		
TAG 2895 MN RULE 4658.0525 SUB 2.B	**SKILLED CARE RANGE OF MOTION** **R2** DID NOT HAVE INTERVENTIONS TO MAINTAIN/MINIMIZE RISK OF FURTHER DECREASE IN ROM	**21 DAYS**	**Minneapolis Veterans Home will continue to ensure each resident receives adequate range of motion.** **R2 was reassessed for ROM by OT (See TAG 2565). ROM identified on plan of care.** **Policy & Procedures have been reviewed to ensure adequate ROM is addressed.** **Nursing Staff is receiving education re: ROM completion.** **ADONs or designees will conduct random audits to ensure compliance. Audit recommendations will be referred to the Quality Council for review or recommendations.**	**ADON**	**10/21/10**
TAG 2900 MN RULE 4658.0525 SUB 2.B	**SKILLED CARE PRESSURE ULCERS** **R13** WAS NOT PROVIDED APPROPRIATE CARE AND SERVICES TO PREVENT THE DEVELOPMETNM OF PRESSURE ULCERS. RESIDENT WAS IDENTIFIED AS AT RISK FOR PRESSURE ULCERS AND EVERY TWO HOUR TURNING SCHEDULE WAS INSTITUTED BUT NOT FOLLOWED **R14 WAS** NOT PROVIDED APPROPRIATE CARE AND SERVICES TO PREVENT THE	**21 DAYS**	**Minneapolis Veterans Home will continue to ensure each resident receives appropriate care to prevent pressure ulcer development.** **Resident R13 is repositioned according to plan of care and resident choice. R13 uses foot protectors according to his choice. R13 is own decision-maker. R13 is provided alternatives and is educated when the choice made does not follow the care planned intervention.** **Resident is no longer a resident in facility.R14 was diagnosed 11/3/10 with a rare disorder that causes skin necrosis. Wounds were not preventable. R14 was in end stage renal**	**RNM RN Sr**	

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	DEVELOPMENT OF PRESSURE ULCERS.		**disease and is on dialysis. R14 is not compliant with diet and fluid restrictions. R14 was not compliant with repositioning. R14 was own decision-maker. R14 was provided alternatives and is educated when the choice made does not follow the care planned intervention. R14 is no longer a resident in facility.** **All residents at risk for skin break down will be reassessed according to the RAI/MDS process and schedule.** **Policies/procedures have been reviewed to ensure comprehensive skin assessments are completed.** **Staff is receiving education re: comprehensive assessment.** **ADONs or designees will conduct random audits to ensure compliance. Audit recommendations will be referred to the Quality Council for review or recommendations.**	**ADON**	**12/22/10**
TAG 2910 MN RULE 4658.0525 SUB 5.A &B	**SKILLED CARE REHAB-INCONTINENCE** **R3** LACKED AN ASSESSMENT AND PLAN PROMOTING BOWEL AND BALDDER CONTINENCE **R13** WAS NOT PROVIDED SERVICES (ASSISTANCE WITH INCONTINENCE) IN ACCORDANCE WITH CARE PLAN **R8** WAS NOT PROVIDED	**21 DAYS**	**Minneapolis Veterans Home will continue to ensure each resident receives appropriate bowel & bladder plans to promote continence.** **R3 reassessed for bowel & bladder continence plan (see TAG 2550).** **R 8 & R13 are provided assistance with toileting according to care plan.** **R5 was reassessed for bowel and bladder continence (See TAG 2540).**	**ADON**	**10/25/10** **9/24/10** **10/26/10**

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	SERVICES (ASSSITANCE WITH INCONTINENCE-IN DINING ROOM) IN ACCORDANCE WITH CARE PLAN **R5 J** LACKED A COMPREHENSIVE BOWEL AND BALLD ASSESSMENT AT THE TIME OF THE FULL MDS WHICH LACKED ALL THE PERTINENT RISK FACTORS AND THREE DAY VOIDING PATTERN WAS INCOMPLETE **R18** WAS NOT TOILETED AS DIRECTED ON THE CARE PLAN		**R18 is toileted according to care plan.** **All residents at risk for bowel and bladder incontinence will be reassessed according to the RAI/MDS process and schedule.** **Policies/procedures have been reviewed to ensure comprehensive skin assessments are completed.** **Staff is receiving education re: comprehensive assessment policies and procedures.** **ADONs or designees will conduct random audits to ensure compliance. Audit recommendations will be referred to the Quality Council for review or recommendations.**	**ADON**	**9/24/10** **12/22/10**
TAG 2940 MN RULE 4658.0525 SUB 5.9	**SKILLED CARE REHAB-HYDRATION** **R32** LACKED AN ASSESSMENT OF THE ADEQUACY OF FLUID INTAKE **R11** LACKED AN ASSESSMENT OF THE ADEQUACY OF FLUID INTAKE **R10** LACKED AN ASSESSMENT OF THE ADEQUACY OF FLUID INTAKE	**21 DAYS**	Refer to Tag 2550	Dietary Director	
TAG 21665 MN RULE 4658.1400 SUB 4	**SKILLED CARE PLANT HOUSEKEEPING, OPERATIONS, AND MAINTENANCE** **STRONG ODOR DETECTED IN**	**30 DAYS**	**MVH will continue to ensure that resident rooms are free of odors.** **Resident R15 room was inspected to determine the cause of the odor. Based on the inspection, the room has been deep cleaned.**	Executive House Keeper	

RULE STATUE	CORRECTION ORDER	TIME FOR CORRECTION	PLAN of CORRECTION	RESPONSIBLE PERSON	COMPLETION DATE
	TWO ROOMS INCLUDING RESIDENT ROOM R15		**The room will be mopped daily with a product called "Consume" until the issue is resolved. Housekeeping staff will continue to monitor. For ongoing compliance, the Environmental check process will be as follows:** • **Rounds will be made on a scheduled basis to check resident rooms for odors.** • **When a room is identified as having odors an inspection to determine the cause, will be initiated. A 3 point (Standards of Work Practice will then be implemented) to address the issue.** **Executive Housekeeper/ designees will conduct a random audit to ensure compliance. Based on the findings, recommendations by housekeeping will be submitted to the Quality. Council for review.**		
TAG 21695 MN RULE 4658.1415 SUB 4	**SKILLED CARE PLANT HOUSEKEEPING, OPERATIONS, AND MAINTENANCE** 1ST AND 2ND FLOOR BUILDING 6 LOUNGES CARPET WAS IN POOR CONDITION \	**30 DAYS**	**MVH will continue to monitor facility carpeting for condition and cleanliness.** **Carpet Building 6 Lounges:** • **Bids have been obtained to replace the carpet in the affected lounge areas of building six. (Two bids have been obtained.** **The condition of the carpet has been added to the unit environmental rounds list for monitoring of condition and cleaning schedules.** **Executive Housekeeper/designee will be responsible to report the ongoing condition of the carpet in these areas.** **The Executive Housekeeper will report finding/recommendations to the Quality Council for review.**	**Executive Housekeeper**	

MINNESOTA VETERANS HOME
Minneapolis
Plan of Correction

MINNESOTA HEALTH DEPARTMENT SURVEY
PLAN OF CORRECTION-SURVEY 09/20-23/2010

RULE STATUE	CORRECTION ORDER	TIME FOR CORRECTION	PLAN of CORRECTION	RESPONSIBLE PERSON	COMPLETION DATE
TAG 21710 MN RULE 4658.1415 SUB 7	SKILLED CARE PLANT HOUSEKEEPING, OPERATIONS, AND MAINTENANCE RANDOM WATER TEMPERATURES IN BUILDING 6 MEASURED AT 93.2-103.9 AND BY REGULATION SHOULD BE 105-115	21 DAYS	MVH will continue to monitor facility water temperatures for compliance with required temps. Random Water Temps in Building 6 • A water temperature mixing valve was found to be defective and was replaced on 9/27/10. The plant services department will monitor water temperatures on a scheduled basis to insure temperatures are within in acceptable ranges. Monitoring has been added to the preventive maintenance rounding checklist. Maintenance Director/Designee will conduct periodic audit to ensure compliance. Findings and recommendations will be submitted to the Quality Council for review.	Physical Plant Director	
TAG 21805 MN STATUE 144.651 SUB 5	SKILLED CARE RESIDENTS OF HEALTH CARE FACILITY BILL OF RIGHTS R8 THOMAS JOHNSON DIGNITY WAS NOT PRESERVED IN DINING ROOM AS EVIDENCED BY EXPOSURE OF INCONTINENCE BRIEFS R41 WAS NOT TREATED IN A DIGNIFIED MANNER IN DINING ROOM R17 WAS NOT TREATED IN A DIGNIFIED MANNER SERVED ICE CREAM BY HOT FOOD R13 OBSERVED EATING ALONE APART FORM HIS PEERS R40 OBSERVED EATING IN	30 DAYS	Minneapolis Veterans Home will continue to ensure each resident receives dignified care. R8 incontinence brief is not exposed or is fixed when discovered exposed. Hand sanitizer removed from the wall where R41 is seated in the dining room. R17 Ice cream will be served in frozen form. R13 eats with other residents. R40 eats in first floor main dining room or per request at a table by himself. R12 and other residents will be fed dessert according to their preference.	ADON/Dietary Director	9/21/10 9/23/10 10/1/10 9/24/10 9/24/10 10/1/10

RULE STATUE	CORRECTION ORDER	TIME FOR CORRECTION	PLAN of CORRECTION	RESPONSIBLE PERSON	COMPLETION DATE
	HALLWAY APART FROM PEERS R12 AND OTHERS FED DESSERT BEFORE MEAL R45 EATING IN SMALL ROOM BY HIMSELF BUILDING 6 SOUTH DINING ROOM WASTE ITEMS OBSERVED ON TABLE WHILE RESIDENTS EATING R10 WAS DRINKING OUT OF PAPER CUP WHEN NON-DISPOSABLE CUPS WERE AVAILABLE		**R45 will continue to choose where to eat.** **Waste items will be removed from dining tables as needed.** **R10 will use either a paper cup or non-disposable cup to ensure adequate hydration is maintained.** **Standards of Work have been reviewed to ensure adequate and proper nursing care is given to each resident.** **Nursing Staff is receiving education re: Work Standards.** **ADONs/Dietary director or designees will conduct random audits to ensure compliance. Audit recommendations will be referred to the Quality Council for review or recommendations.**	**ADON**	**10/1/10** **10/1/10** **10/1/10** **11/30/10**
TAG 21815 MN STATUE 144.651 SUB 7	**SKILLED CARE RESIDENTS OF HEALTH CARE FACILITY BILL OF RIGHTS** R1 NOT NOTIFIED OF PHYSICIAN CHANGE WHEN ROOM CHANGED	**30 DAYS**	**Minneapolis Veterans Home will continue to ensure responsible party notification of change in medical provider.** **The Notice of Proposed Room or Bed Change has been revised to include identification of who the resident's Physician and Nurse Practitioner will be.** **Staff is receiving education re: responsible party notification via e-mail and staff meetings.** **Social Services Director or designee will conduct random audits to ensure compliance. Audit findings/recommendations will be submitted to the Quality Council for review.**	**DIRECTOR SOCIAL SERVICES**	
TAG 21990 MN STATUE	**SKILLED CARE REPORTING OF**	**14 DAYS**	**R42 is independent with mobility, walking with**	**ADON**	**7/2010**

RULE STATUE	CORRECTION ORDER	TIME FOR CORRECTION	PLAN of CORRECTION	RESPONSIBLE PERSON	COMPLETION DATE
626.557 SUB 4	MALTREATMENT VULNERABLE ADULTS R42 BRUISES OF UNKNOWN ORIGNE NOT REPORTED		a walker, having a tendency to bump into non-movable objects. R42 is on aspirin therapy and is at risk for bruising which is identified on his care plan. Incident reports list the bumping into objects as a potential cause of the bruising. R42 has ongoing episodes of behavioral altercations with other residents and staff which are also identified in his care plan. A documented behavior altercation occurred on July 6, 2010 between R42 and another resident of which staff intervened as both residents were reaching and grabbing at each other. Staff had to physically separate the 2 residents. Two hours later a bruise was identified on the forearm. The shape of the bruise was linear and demonstrated nothing suspicious such as finger prints, hand prints, or twisting striations. The position of the bruise on the body was not in an area that would have lead to any suspicion of maltreatment or abuse. R42 had been in an altercation with a resident two hours earlier that involved reaching out grabbing at each other. The linear bruise is attributable to the altercation and more than likely a result of reaching by the other resident with the inability to hold on causing a scratching-like motion. The incident was reported and investigated internally according to our P&P. The evidence points to the bruise as accidental as a result of the altercation. After discussing the altercation and since there was no evidence of maltreatment, abuse or neglect and the bruise did not have a suspicious cause, it was	ADON	

RULE STATUE	CORRECTION ORDER	TIME FOR CORRECTION	PLAN of CORRECTION	RESPONSIBLE PERSON	COMPLETION DATE
			decided the incident did not need reporting to CEP. **Minneapolis Veterans Home will continue to ensure maltreatment of vulnerable adults is reported.** **Resident incidents will be reviewed when they happen using the facility internal investigation process and reporting to CEP as needed** **ADONs or designees will conduct random audits to ensure compliance. Audit recommendations will be referred to the Quality Council for review or recommendations.**	**ADON**	
TAG 22000 MN STATUE 626.557 SUB 14	**SKILLED CARE REPORTING OF MALTREATMENT VULNERABLE ADULTS** **R42** BRUIE OF UNKN ONW ORIGEN WAS NOT FULLY INVESTIGATED	**14 DAYS**	See TAG 21990	**ADON**	
TAG 23240 MN RULE 4658.5405 SUB 14	**SKILLED CARE BUILDINGVENTILATION** VENTILATION UNITS IN BUYILDING 6 NOT FUNCITONING ON TWO NURSING UNITS EFFECTING APPROX 70 RESIDENTS	**21 DAYS**	**MVH will continue to monitor the facilities Ventilation to ensure there is air exchange. Ventilation building 6:** • **An air handling unit was found to have a defective drive belt. The belt was replaced on 9/23/10 and is operating properly.** **The Physical Plant Director has added this to the preventive maintenance checklist for ongoing monitoring. The Physical Plant Director report**	**Physical Plant Director**	

RULE STATUE	CORRECTION ORDER	TIME FOR CORRECTION	PLAN of CORRECTION	RESPONSIBLE PERSON	COMPLETION DATE
			findings/recommendations to the Quality Council for review.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
	MN VETERANS HOME MINNEAPOLIS

Type of Survey (select all that apply):

K					

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life safety Code
I Recertification
J Sanction/Hearing
K State License
L Chow

Extent of Survey (Select all that apply):

A					

A Routine/Standard (all providers/suppliers)
B Extended Survey (HHA or long term care facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's information number.

Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. Team Leader 15507	09-20-2010	09-23-2010	1.50	1.00	31.50	2.75	.25 0.00	16.00
2. 18623	09-22-2010	09-23-2010	0.00	1.75	8.75	0.00	0.50	1.75
3. 19200	09-20-2010	09-23-2010	0.00	1.00	32.50	2.50	.25 0.00	10.50
4. 19695	09-20-2010	09-23-2010	2.50	1.00	29.75	2.00	.25 0.00	4.50
5. 21242	09-20-2010	09-23-2010	1.00	0.00	31.00	2.50	.25 0.00	13.00
6. 28230	09-20-2010	09-23-2010	0.00	1.00	30.50	2.50	.25 0.00	23.25
7. 28589	09-20-2010	09-23-2010	1.00	1.50	31.75	2.50	.25 0.00	6.00
8.								
9.								
10.								

Total Supervisory Review Hours 22.75

Total Clerical/Data Entry Hours..... 3.25

Was Statement of Deficiencies given to the provider on-site at completion of the survey? ..... N

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

INFORMATIONAL MEMORANDUM

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

DATE OF SURVEY: September 20, 2010 through September 23, 2010

BEDS LICENSED:

HOSP: _____ NH: 341 BCH: 161 SLFA: _____ SLFB: _____

CENSUS:

HOSP: _____ NH: _____ BCH: _____ SLF: _____

BEDS CERTIFIED:

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

NAME(S) AND TITLE(S) OF PERSONS INTERVIEWED:

Interim Administrator: Pam Barrows
Assistant Administrator: Craig Barsness
Director of Nursing: Jill Smith
Director of Quality Affairs: Robin Gaustad
Assistant Directors of Nursing: VonMarie Goddard, Krista Gunter
Speech-Language Pathologist: Mary Russell
Registered Nurses: Brenda Charseston, Jung Chalce, Ann Marie Davidson, Jessica Nau, William Moore, Oakhee Kim, Judith Goldberg, Agnes Adams, Mary Kelvie, Ida Vishnyak, Pat Soulak, Cindy Morgan, Dawn Gross, Laurie Fitzloff, Judy Bakken, Moses Dukuly, Margaret Sookjai, Troy Holmstrom, Marilyn Micholic, Katherine Braeunig, Thomas Darly, Michelle Henkels, Laura Kelly,
Licensed Social Workers: Janet Gutzke, Linda Carey, Barbara Bradford
Clinical Nurse Specialist: Singh Rukhmin
Food Service Worker: Lelawattie Budhu
Recreation Therapy Program Supervisor: Shirlee Peterson
Building Maintenance Foreman: Richard Rice
Power Plant Chief Engineer: Richard Schaefer
Building Services Supervisor: Cherie Gunderson
Housekeeper: Manuel Ramos
Licensed Practical Nurses: Jabob Mabera, Kathleen Salseg, Steve Miller (HOTC), Linda Charland,

Majina Moolah, Tsegaye Wolde-Yesus, Susan Ambrosier, Stephanie Andrie, Charles Tiedeman, Catherine Steiner, Sussan McClune, Dooraga Hanuman, Stacy Traynoe, Denise Prybella
Human Services Technicians: Hodan Abdimaax, Thomas Kollie, Genet Habteyes, Amal Sheikh, Pierre Tanoe, Etenesh Badisso, Prince Dwumfour, Christina Gonzalez, Stephanie McGill, Jacob Liftka, Sara Toomy, Bobbie Bachan, Jeff Baker, Sara Toomey, Betty Outlaw, Anita Jackson, Trevina Jones, Curtis Lindman, Patrick McDonough, Mary Marty, Adzovi Vovor-Segbenya, Samuel Bettie,Tracy Alsaker, Merry Mortenson, Munaa Mohammed, Frances Hiama, Michael Botros, Glenda Wilson, Hope Ajayi,
Nurse Practitioner: Paula Opatmy
Occupational Therapists: Theodore Boal and Michael Swenson

SUBJECT: Annual Licensing Survey

ITEMS NOTED AND DISCUSSED:

An unannounced visit was made to determine compliance with state licensing regulations. The results of the survey were delineated during an exit conference. Refer to Exit Conference Attendance Sheet (HR116) for the names of the individuals attending the exit conference.

SL00233021

Minnesota Department of Health
Licensing and Certification Program

FACILITY MN VETERANS HOME MINNEAPOLIS DATE 9/23/10

Indicate the name and title for each surveyor/supervisor on site during the survey, even those not present at the exit.

Surveyors Names and Titles

NAME Please Print	TITLE
Gayle Lartho	Unit Supervisor/LSW
Sarah Greberg	HPR Sr. / RSW
Candace Bolduc, Vidya Tomar, Karen Beshar	HFE Nurse Aide II
Lisa Halvorson	HPR Sr. / RD
Gloria Desfosses, Unit Supervisor/RN	

Exit Conference Attendees

SIGNATURE	TITLE
Jay Smith AA/DON	
Pam Bowens	Interim Administrator
Gilbert Acevedo	Deputy Commissioner
Jeffrey Gordon	Director of Pharmacy
[illegible]	Recreation Therapy
Krista Geerdts RN	RN ADON

SL00233021

Minnesota Department of Health
Licensing and Certification Program

FACILITY MN VETERANS HOME MINNEAPOLIS DATE _____

Indicate the name and title for each surveyor/supervisor on site during the survey, even those not present at the exit.

Surveyors Names and Titles

NAME Please Print	TITLE

Exit Conference Attendees

SIGNATURE	TITLE
Chris Taylor	RN ADON
Karen Jamnicker	Rehab. Ther. Dir
Sara Dreyer	B.S.S.
Howard Berry	P.P.D.
Debra Zunker, NP	Medical Director
Dale Freeman	RN Infection Control.
B Bradley	Social Services Rep

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 _____	09/23/2010

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 9/20, 9/21, 9/22, and 9/23/10, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	RECEIVED NOV 16 2010 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION 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.	

Pamela K Bowers
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Interim Administrator

(X6) DATE: 11/15/10

ADMINISTRATOR: SEE MDH INSTRUCTIONAL BULLETIN 95-2

CENTERS FOR MEDICARE AND MEDICAID SERVICES
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER NUMBER (X2) MULTIPLE CONSTRUCTION

FORM APPROVED
OMB NO. 0938-0391

A. BUILDING _____ B. WING _____ (X3) DATE SURVEY COMPLETED

NAME OF PROVIDER OR SUPPLIER
STREET ADDRESS, CITY, STATE, ZIP CODE

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD 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) COMPLETION DATE

The enforcement processes mandate that policies and procedures be established to remedy deficient practices and to ensure that correction is lasting; specifically, that facilities take the initiative and responsibility for monitoring their own performance continuously to sustain compliance. Measures such as the requirements for a plan of correction emphasize the ability to achieve and maintain compliance leading to improved quality of care.

GUIDELINES TO ASSIST PROVIDER IN DEVELOPING AN ACCEPTABLE WRITTEN PLAN OF CORRECTION

Please Note:

Do not request an Informal Dispute Resolution (IDR) in the plan of correction

The Department's letter sent to the facility with the CMS-2567 specifies to whom to direct the IDR request.

1. The I.D. Prefix Tag of the deficiency to which you are responding will be printed in the middle column. Start the written plan of correction next to the Tag Number and, if necessary, complete on a separate sheet of paper.
2. In order for a plan of correction to be acceptable, it must:
   a. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
   b. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
   c. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
   d. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
   e. Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
   f. Include signature of provider and date.

The second expectation is that <u>all deficiencies will be addressed promptly</u>. The standard for program participation mandated by the regulation is substantial compliance. Deficiencies related to direct patient care, such as medication administration, repositioning, ambulation, etc., can and should be corrected immediately. Facilities should take note in preparing plans of correction that direct patient care issues should be corrected immediately, and noted as such in the plan.

3. Sign and date the CMS-2567. Return the Written Plan of Correction to the Unit Supervisor within <u>10 calendar days</u> from the date it was received in your facility.

F147	**EXAMPLE**			
	Deficiency	**F147**	**Plan of Correction**	**12/3/94**

THIS IS AN EXAMPLE: WRITE YOUR SIGNATURE ON PAGE 1 OF THE ORIGINAL STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	YOUR TITLE	DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) The findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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 _____	09/23/2010

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	Continued From page 1 Certification Programs; 85 East Seventh Place, Suite 220; P.O. Box 64900, St. Paul, Minnesota 55164-0900.	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.	
2 540	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive resident assessment. The results of the	2 540		

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 _____	09/23/2010

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2 540	Continued From page 2 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 interview and record review, the facility failed to ensure comprehensive assessments were completed for 1 of 3 residents in the sample (R29) who utilized a code alert system, 1 of 2 residents (R6) who developed wounds, 2 of 14 residents (R6 and R5) reviewed for incontinence, and for 2 of 3 residents (R32 and R11) who were at high risk of dehydration. Findings include: R29 was not comprehensively assessed related to the use of a personal alarm that restricted his access to areas off the unit. R29's Minimum Data Set (MDS) assessment indicated the resident had modified	2 540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 540	Continued From page 3 independence--some difficulty in new situations only. "Wandering (moved with no rational purpose, seemingly oblivious to needs or safety)" was not observed during the previous seven day assessment window. A mental status screen on 2/28/10 revealed the resident's memory was described as, "OK." A Behavioral Health Services Referral Request dated 5/2/10 indicated, "Resident refused code alert upon return to unit yelling 'NO' and backing away from writer. Code Alert placed on back left side of wheelchair this evening." The following day a behavioral assessment was completed. The assessment indicated the the primary concern was the resident leaving the facility and his cognitive and physical vulnerability. The information was provided to the resident in a "straightforward verbal reminder 'no pills, no pass, no pizza'...his primary nurse documented his indication that he was going to leave campus grounds...she informed him he could not set one foot off the curb and that she would need to report this if he did. This was sufficient redirection to keep him from leaving...Plan: at this time it is recommended by this writer that he continue to wear the TAS bracelet and be escorted when he leaves the unit until more information can be gathered though interviews...to better understand his behavior...." Self-preservation Elopement Risk Factors noted R29 did not have a designated decision maker, was not legally committed, and did not wander the floor aimlessly with non-goal directed behavior. The resident was identified as having a mood disorder, as well as a history of leaving the facility without notifying staff. "Resident has attempted to get off nursing unit to attend activities/get coffee redirected back to unit when	2 540		

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

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2 540	Continued From page 4 alarms sounded and escorted to/from activity/coffee." R29's care plan, effective 8/24/10 indicated the resident, "...likes independence in planning his day...I am self-directed/independent in structuring my leisure time. I enjoy spending my day attending programs, and going to the coffee shop for pizza and coffee. I will need an escort to and from programs off the unit I attend...." Added to the care plan (no date) was "I need assistance to go the vending machine for coffee @ 1100, 1400, & 1600" (at 11:00, 2:00, and 4:00)..."Major socialization is provided by interaction with staff, involvement in activities/programs and trips to the VA for pizza." The care plan noted the resident had impaired mobility and interventions included, "I have a TAS code alert #105 r/t (related to) elopement risk. I have a safety contract." A signed consent for the use of the alarm was not found in the resident's record. A registered nurse (RN-C) was interviewed on 9/23/10, at 9:15 a.m. The RN said the code alert was instituted for R29 after the resident left the grounds. The explained that the resident became angry when he was unable to be transported to the Veterans Administration Medical Center (VAMC) where he enjoyed volunteering. The RN said the bus was full or unavailable resulting in the resident's inability to be transported, he became frustrated. One day the resident "took off angrily" and was across the bridge in his wheelchair, heading toward the hospital. The staff was concerned because of the busy highway and light rail tracks. After the incident, the resident made an agreement with staff that he would not leave the campus on his own. On 5/2/10, the resident was found by Minnehaha Park (adjacent to the facility) and a park worker	2 540		

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	00233	A. BUILDING _____ B. WING _____	09/23/2010

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2 540	Continued From page 5 called the VAMC police, who escorted the resident to the VAMC for evaluation. The RN explained the resident was not angry, and was just sitting near the dog park. Because the resident had aphasia, staff was usually able to understand him, however, outsiders would have been unable to understand the resident. The RN said he was "just sitting there," watching the dogs and people in the park. The team then met and determined he was "at risk." The RN stated, "At this point, volunteers can't take residents out, because they aren't trained and they have left residents. They are talking about training them so some could take residents out." Nursing notes reflected the following: 1. On 9/4/10 the resident was found of the unit on the first floor going to get a soda. 2. On 9/6/10 the resident was seen on the elevator and was found near the chapel and wanting to go for coffee. The officer of the day and security was alerted. Later that day a note revealed the resident tried to leave the unit four times and when redirected back to the unit the resident threw up his hands and yelled, "'O shit' or 'No.' Resident brought down to vending machines by the chapel to get a coffee this shift. No further episodes afterwards." 3. 3. On 9/10/10 the resident was on the elevator and the alarms were sounding. The resident was brought back to the unit. 4. On 9/11/10, "This resident tired to leave the unit without escort around 1200, but was compliant with redirection. When asked as to where he was going, he shook his coffee mug. This writer informed this resident that he had	2 540		

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2 540	Continued From page 6 coffee in his cup from when the HST took this resident down for pizza and coffee at 1100." A registered nurse (RN-A) was interviewed on 9/23/10 at 2:20 p.m. She verified there was no consent signed for the use of the restriction. She was unaware of any follow-up to the psychologist's plan to obtain further interview information regarding the resident. She said when they had extra human services technicians (HST) on staff, they had taken the resident out of the building. She described the situation as a "tough one," since the resident was cognitively aware, but had physically declined. The RN described the code alert system as "pretty confining," and she added, "The system needs work." The facility CODE ALERT policy, revised 9/09 was reviewed. The policy included, "Objective: To provide optimal freedom in the least restrictive setting possible while ensuring safety through monitored movements...When a resident is assessed to demonstrate wandering behavior that causes the facility to restrict the resident's freedom of movement and the resident now requires monitoring of their whereabouts, they will have a CODE ALERT bracelet applied...Wandering is defined as purposeful movement with a discernible but unrealistic purpose. In these situations, a resident's judgement is significantly impaired, resulting in risks to their self-preservation by attempts to leave the building and/or grounds." R6 lacked a comprehensive skin assessment at the time of the full Minimum Data Set assessment. The assessment contained conflicting information, lacked co-morbid risk factors, analysis, and monitoring of leg ulcers.	2 540		

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2 540	Continued From page 7 R6 was admitted to the facility on 5/18/10 and re-admitted on 09/02/10 with diagnoses including End Stage Renal Disease, congestive heart failure (CHF), type II diabetes with neuropathy, Parkinson's disease, anemia, and depressive disorder. Hospice services were initiated on 9/4/10 for comfort cares. A skin risk factors checklist, dated 9/5/10 was lacking contributing factors related to skin breakdown and risk factors including diabetic neuropathy, anemia, depressive disorder, nutritional status, mobility, and the resident's expressed pain with movement. In addition, it lacked a comprehensive analysis summary. The tissue tolerance (TT) evaluations to determine R6's positioning needs were inaccurate. The TT dated 5/21/10, at 7:00 p.m. indicated the resident was lying on his back and tolerated this position well. At 9:00 p.m., the resident was lying on his right side, and also tolerated this well. No time was documented in the next column, however, it indicated R6 tolerated lying on his left side well. It was unclear as to what time the TT evaluation began and the time R6 was assisted to bed. In addition, the ending time was not noted to accurately reflect the resident's skin condition on the bony prominences to establish an appropriate repositioning plan. The evaluation indicated a two hour repositioning was appropriate. A re-admission TT evaluation was also completed inaccurately. The lying position tissue tolerance lacked a date, although a RN signed the form on 9/5/10. There were three steps listed on the form. The first step was to be completed,"2 hours after lying without interruption." That section indicated, "12	2 540		

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2 540	Continued From page 8 midnight, on back" and indicated the resident tolerated the position well. At 2:30 a.m. the resident position was not noted, however, indicated the resident tolerated it well. At 3:00 a.m. the assessment noted R6 was in a lying position and tolerated it well. It was unclear as to what time the observation began to evaluate how his skin responded to pressure. The assessment was not dated. The conclusion was made that an every three hour repositioning plan was appropriate. The nursing notes from 9/2/10 to 9/21/10 were reviewed. A note dated 9/6/10, indicated a skin abrasion was noted on right inner lower leg described as measuring 6 by 6 cm and round in shape. A skin inspection form completed on 9/7/10, however, noted the resident's skin was intact. The medical record lacked documentation of monitoring of the right inner, lower leg abrasion from 9/6/10 through 9/16/10 (10 days). A note on 9/16/10 revealed, "Rt (right) inner leg abrasion yesterday leg was weepy with lightly swollen, the hydrocolloid dressing was stuck on to the stocking the skin was peeling off, abrasion measured 11.5 x 11 cm long shape...." An interview was conducted with RN-C and RN-A on 9/21/10, at 2:45 p.m. after documentation was reviewed. The RNs verified R6's the skin assessment was lacking pertinent information, was inaccurate, and monitoring was not conducted in a timely manner. RN-C explained the facility had begun educating nurses how to conduct a comprehensive skin assessment. RN-A stated the future plan was to have the senior nurse complete all of the skin assessments to minimize inaccuracy. RN-A indicated, "Currently there are too many people involved in this process."	2 540		

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2 540	Continued From page 9 The facility policy and procedures for skin integrity management revised 6/09, revealed Braden Risk Assessment (used to determine risk of pressure sore development), Tissue Tolerance evaluation, and skin risk factors assessments needed to be completed with admission, re-admission, quarterly, and with any significant changes. Weekly wound rounds needed to be conducted by the RN manager or designee with nurse practitioner/physician if available. A daily wound assessment documentation was to be completed to include the following: evaluation of the ulcer if no dressing was present, evaluation of the status of the dressing if present, whether it was intact and/or drainage was present, etc., the status of the area surrounding the ulcer observed without removing the dressing, the presence of possible complications such as signs of increasing area of ulceration or soft tissue infection such as increased redness or swelling around the wound or increased draining from the wound, the presence of pain and whether it was being adequately controlled. R6 lacked a comprehensive bladder assessment at the time of the full MDS. A three-day voiding pattern was incomplete. A three-day voiding pattern form was incomplete for 9/5/10 on the day shift A "Comprehensive Bowel/Bladder Data Collect..." checklist, dated 9/21/10, indicated the resident had a change in continence. It revealed the resident was incontinent of bowel and bladder and the current plan was to check and change every two hours and as needed. On 9/23/10, at 11:40 a.m. RN-C reviewed the information and verified the voiding patterns for	2 540		

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2 540	Continued From page 10 the day shift was incomplete, but should have been completed. A HST recorded the information and it should have been checked for completion by the nurse on duty. RN-C indicated reported it was a Sunday morning shift, and she would check into the matter. R5 lacked a comprehensive bladder assessment at the time of the full MDS. The assessment lacked all of the pertinent risk factors and the three-day voiding pattern was incomplete. The resident was admitted to the facility on 3/4/10 with diagnosis including urinary incontinence and benign prostatic hypertrophy with urinary obstruction. R5's three-day voiding pattern dated 3/7/10 was incomplete for the day shift. The bladder assessment checklist dated 3/21/10 lacked co-morbid risk factors associated with benign prostatic hypertrophy (enlarged prostate gland) and urinary obstruction. The assessment plan indicated to toilet the resident every two hours and as needed. During an interview with RN-C on 9/23/10, at 11:10 a.m. the RN said after reviewing the information, it should have been completed and was not. She stated 3/7/10 was Sunday and the resident was present on the unit. RN-C verified the assessment checklist was not comprehensive and was lacking pertinent risk factors. The facility policy and procedure for bowel and bladder management dated revised 9/09, revealed a three-day voiding diary was to be completed with admission, significant changes, and annual MDS assessments. No further information was provided.	2 540		

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2 540	Continued From page 11 R32 and R11 lacked an assessment of the adequacy of fluid intake. R32 had a diagnosis of renal failure and received hemodialysis three times per week. The resident received a therapeutic pureed renal diet and was on a 1800 cc fluid restriction. R32's annual nutrition assessment was completed on 9/2/10. The assessment identified the resident had a stable weight for the past three months, had an 1800 cc fluid restriction, received protein powder three times per day (TID), two cans of Nepro supplement on dialysis days, 30 ccs of Prostat 63 TID, a snack TID on non-dialysis days, a can of Nepro supplement at bedtime, and Nepro was offered if intake fell below 50% of a meal. The assessment documented intake as, "Intake mostly 50-100% x 1, 25% x 1, 0-25% x 1, gets all the supplement Nepro intake is mostly 25-50%, Prostat mostly 100% and snack mostly 50-100%." Nutritional requirements were calculated to be 1819-2167 kilo calories (Kcal), 86-103 grams protein, 1800 cubic centimeters of fluids. The assessment indicated R32 was "provided" enough food to meet nutritional requirements. The assessment went on to explain the resident required assistance to eat, encouragement to eat more, and was at risk for skin breakdown. The goal for R32 was to consume at least 50% of meals and maintain good hydration. R32 was determined to be at high nutritional and dehydration risk and a summation of adequacy of fluid intake. An annual assessment completed on 8/12/10, indicated R11's diet order was modified to provide smaller portions to prevent R11 from becoming overwhelmed with the amount of food offered. R11 had pureed diet with thin liquids.	2 540		

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2 540	Continued From page 12 The assessment indicated R11 was receiving three cans of a supplement daily and three ounces of a different supplement daily and was taking at least half of the supplements. R11 was offered 8-12 ounces of fluids daily as a hydration plan, and was assessed to be at high risk for dehydration. The estimated needs for R11 were 1044-1253 kilo calories, 44-53 grams protein, and 1383-1660 cc of fluids daily. The assessment lacked a summation of the adequacy of R11's current intake for fluids. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could work with the appropriate department managers could review and revise policies and procedures as necessary. Training of staff could be provided, audits could determine the success of the plan, and the results could be reviewed by the quality committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 540		
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure reassessments were completed for 1 of 14 residents in the sample (R3) who were reviewed for incontinence, for 1 of 2 residents	2 550		

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2 550	Continued From page 13 (R14) who developed skin alterations, and 1 of 3 residents (R10) who were at high risk of dehydration. Findings include: R3 lacked an assessment and plan promoting bowel and bladder continence. R3's Comprehensive Bowel/Bladder Data Collect dated 7/25/10, indicated the resident had functional incontinence, was totally confused, was unable to communicate toileting needs, and was dependent on staff to use the toilet. Although 3-day voiding patterns were not collected, the assessment indicated R3 elimination showed "no pattern." Current interventions were identified as staff toileting the resident every two hours and as needed while awake, and changing the resident every two hours and as needed during the night. The summary of findings directed staff to, "continue to toilet" the resident every two hours and as needed while awake, and check and change the resident every two hours during the night. The RN completing the assessment indicated the documentation was added to the resident's care plan. The quarterly Minimum Data Set (MDS) dated 7/28/10 indicated the resident had multiple episodes of bladder incontinence daily, and bowel incontinence 2-3 times weekly. The resident had moderately impaired cognition skills, and was dependent on staff to transfer and use the toilet. The MDS indicated the resident was on a scheduled toileting plan. The registered nurse (RN-B) was interviewed on 9/21/10, at 3:40 p.m. The RN stated 3-day voiding data was collected upon a residents' admission, with a change in continence, and annually only if indicated. She said R3 was able	2 550		

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2 550	Continued From page 15 indicated the resident had three stage III pressure ulcers. A comprehensive assessment was not completed after the presence of pressure ulcers was identified. RN-D was interviewed on 9/22/10 at 10:00 a.m. The RN verified the skin assessment was not accurate, and a comprehensive assessment of all risk factors and appropriate plan was not completed. R10's quarterly assessment lacked a determination of the adequacy of fluid intake. R10 had diagnoses of Alzheimer's dementia with behavioral disturbance, head injury, and agitation. R10 received a diet of modified ground texture with nectar thick liquids and was determined to be at high risk for dehydration according to a quarterly assessment dated 9/3/10. The Resident Assessment Protocol (RAP) dated 12/10/09, indicated that R10 was on a therapeutic diet to meet diagnoses. The resident had a mechanically altered diet to minimize the risk of chewing and swallowing problems. The resident was known to leave 25% or more of meals uneaten, and was provided scheduled snacks and supplements to make up for missed calories. The quarterly assessment dated 9/3/10, indicated an intake of "mostly 75-100% x 1, 50-75% x 1, 0-50% x 1, gets magic cup 4 ounce at...2 cal med pass supplement 120 cc three times daily, offer 120 cc fluid with medication pass snack three times daily, health shake 120 cc three times daily." The assessment indicated R10 was on a dehydration risk list. The assessment lacked a determination of the adequacy of R10's actual fluid intake.	2 550		

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2 550	Continued From page 16 SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could work with the appropriate department managers could review and revise policies and procedures as necessary. Training of staff could be provided, audits could determine the success of the plan, and the results could be reviewed by the quality committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 550		
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 observation, interview, and record review, the facility failed to ensure 2 of 2 residents in the sample who received hospice benefits (R6 and R30) were provided care in a coordinated manner. Findings include: R30 had hospice services, however, the services were not coordinated so the provision of cares could be provided as outlined in the plan. R30's Minimum Data Set (MDS) assessment dated 6/28/10, indicated the resident was	2 560		

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2 560	Continued From page 17	2 560		

dependent on staff for activities of daily living, had severely impaired cognition, range of motion limitations, mild pain less than daily, "End-stage disease, 6 or fewer months to live," and overall the resident had deteriorated and required more support. R30 was identified as receiving hospice care. The MDS noted the resident had diagnoses of adult-onset diabetes, depressive disorder, hypothyroidism, and a B-complex deficiency.

R30's care plan effective 6/30/10 indicated, "I will be provided end of life care and comfort." Interventions included providing oral hygiene, offering fluids, assessing for pain and comfort, avoiding excessive verbal and environmental stimulation, providing passive range of motion as tolerated, pastoral care and behavioral services as needed, maintain contact with family and involve in decisions and allow resident and family to verbalize anger, denial, sadness, concerns, provide preferred food, and monitor intake. In addition the plan said, "Hospice interventions per individualized plan."

R30's record contained a Team Care Plan "as of 09-21-2010" from Hospice of the Twin Cities. The plan was to provide the resident and his family with support, music therapy, pet therapy, spiritual care, nursing, nursing aide care, and volunteer visits. The care plan indicated "projected visits," but was for the previous month. The plan did not specify when the resident, family, and staff could expect the various hospice visits. The record also did not contain information to show when the hospice staff actually provided services, nor reports of progress made toward goals.

R30 was observed on 9/22/10, at 2:35 p.m. The

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2 560	Continued From page 18	2 560		

resident was asleep in his bed. At 3:35 p.m. the human services technician (HST-J) responsible for his care was interviewed regarding the resident's hospice care. She stated, "I have never had the opportunity to meet them." She said she often cared for the resident, but had never seen anyone from hospice visit the resident on her shift.

The following day at 8:00 a.m. the resident was at breakfast. The HST responsible for his care (HST-K) was interviewed at 8:15 a.m. She stated the hospice aide came about two times a week. She said the aide sometimes came at 8:00 and sometimes at about 10:00. The HST stated, "I care for him regardless, because I don't have the schedule to know when they are coming. If I already completed cares, they do a little more washing up. If I'm in the middle of cares, they finish." She said the resident's scheduled bath was in the evening, "so I wouldn't think they do that."

HST-I was interviewed at 9:05 a.m. after R30 was fed breakfast by a facility HST. He was asked whether the hospice aide ever fed the resident. He stated, "Sometimes they do come. I don't know their schedule though. If here, they do feed him."

The registered nurse (RN-C) was interviewed on 9/23/10, at 9:10 a.m. She stated, "They come. I'm not sure what their days are." She reported "someone" from hospice was there yesterday. When asked about whether nursing care was provided by hospice, the RN explained they looked at the resident's pain level and other needs, and the facility nurses could call hospice if they needed medication or updates. She said the communication was verbal. When asked how

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2 560	Continued From page 19 the aides were informed when to expect the hospice aide to provide care for the resident she replied, "I don't know...I don't know their schedule though." The RN then said a hospice licensed practical nurse (LPN) helped feed the resident, monitored his swallowing because of a swallowing problem, asked the resident how he was feeling, touched base with the family, kept track of his intake and pain level. She added that it was not necessary, however, since the resident did not experience pain. The nurse added, "They have more time to talk to him than we do." R30's wife was interviewed via telephone on 9/23/10, at 10:50 a.m. When asked about the provision of hospice services she stated, "I have the folder." She explained they also updated her as to whether there were any changes in the resident and explained the dying process. She said she spoke to the chaplain. R30's wife then said she hoped the resident could continue on hospice. The facility and contracted hospice agency failed to demonstrate coordination of services for R6, whom elected the Medicare hospice benefit. R6 was admitted to the facility on 5/18/20 and re-admitted on 9/2/10 with diagnosis including End Stage Renal Disease, congestive heart failure (CHF), Parkinson's disease and depressive disorder. The hospice services was initiated on 9/4/10 for comfort cares with the resident's and family's approval. R6's significant change Minimum Data Set (MDS) assessment dated 9/2/10, indicated the resident exhibited modified independence in cognitive skills, and required extensive assistance from staff for transferring, bed mobility and personal hygiene. The resident was totally dependent on	2 560		

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2 560	Continued From page 20 staff for locomotion on unit, toileting and was incontinent of bowel and bladder. The physician's order dated 9/2/10 indicated, DNR/DNI (do not resuscitate/intubate) with no hospitalization, hospice to evaluate and provide treatment. The terminal diagnosis was documented as end-stage CHF and end-stage renal disease. During reviews of R6's record on 9/21/10, the record lacked hospice care plan which included directives for managing pain, edema, and impaired skin integrity. R6's cares were observed on several occasions during the survey. The resident had open wounds and cried out in excruciating pain during wound care. The record included the hospice staff names who visited the resident and their anticipated future visit dates, however, it was unclear as to how the hospice and nursing home staff communicated and established the plan of care for the resident to manage uncomfortable symptoms and provide palliative care. During an interview with a hospice licensed practical nurse (LPN-C) on 9/21/10, at 4:00 p.m. he explained he visited the resident at least once weekly and sometimes more frequently. He said he discussed pain management interventions. The information regarding the resident was documented in his laptop computer, and was not yet filed in the resident's medical record. When asked about the coordination between services, the LPN said information was communicated "verbally," and he was unable to provide any written documentation regarding the coordination of care with nursing home staff.	2 560		

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2 560	Continued From page 21 During an interview with a hospice registered nurse (RN-P) on 9/22/10 at 10:45 a.m., the RN stated they coordinated R6's plan of care verbally with nursing home staff. When asked whether there was a written plan for skin and pain issues, the RN said it was documented on their laptop computers, and then was printed and placed in the resident's record. She stated she had just filed it in the resident's record. When asked if it was a common practice to file a hospice plan of care 18 days after hospice was initiated, RN-P stated, "I just got these papers today and filed them in his record today. I don't know, you would have to ask my supervisor." On 9/22/10, at 3:40 p.m. a human service technician (HST-L) was interviewed and explained that she regularly and consistently provided care for R6. She stated she had not seen the hospice staff, and did not know when they came or what they did for the resident. On 9/23/10, at 9:00 a.m. HST-M said he floated between different units, but had provided care for R6, and was familiar with his routine. He said he had not seen hospice staff for R6, and did not know when they came, or what services they provided for the resident. During an interview on 9/23/10, at 9:45 a.m. R6's family member indicated he visited the resident and was present when hospice services were initiated. He said he was informed hospice would coordinate services and inform him of the resident's health condition on a regular basis. Although hospice was initiated on 9/4/10, as of 9/23/10 he said the hospice staff had not contacted him. He believed coordination of care was lacking for the resident.	2 560		

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2 560	Continued From page 22 During an interview, on 09/23/10 at 12:00 p.m., RN-C, stated that they coordinated cares by verbal communication, was unsure as to when hospice staff came or what they did. She was not aware that the hospice care plan for pain and skin were not available and were just filed in the resident's record as of yesterday. RN-C acknowledged that the coordination of care with hospice staff needed to improve to establish the comfort care goals for the resident. No additional information was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing with the hospice agencies could ensure the process for coordination of services was in place. Agency services and when those services would be delivered could be clearly communitated to the resident, representative, and the facility staff. Interviews to determine success of coordination could be conducted, and results could be reviewed by the quality committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	2 565		

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2 565	Continued From page 23	2 565		

review, the facility failed to ensure the care plan was followed for 1 of 2 residents in the sample (R2) who utilized a splint, 1 of 1 resident (R8) whose orthostatic blood pressures were not recorded, 1 of 3 residents (R8) who utilized a scoop plate, for 1 of 1 resident (R32) reviewed for dialysis, and for 1 of 14 residents reviewed for incontinence. Findings include:

R2 did not have interventions as outlined in the care plan to maintain and/or minimize the risk of further decrease in range of motion (ROM).

R2 was observed during the evening of 9/20, during the day on 9/21, and at breakfast on 9/22/10. Although the resident was to wear a splint in his hand, during the observations, the splint was not in place.

The resident's Minimum Data Set (MDS) dated 8/27/10 indicated the resident had bilateral limitations in range of motion in his neck, hand, leg, foot, and other, as well as limitations on one side in his hand.

R2's 9/10 physician's orders directed staff to place a hand splint on right hand, "on in a.m. off in p.m." The care plan (effective 9/2/10) indicated the resident had chronic pain in his hand, and staff were to cleanse the resident's right hand/palm well, and "place splint" per occupational therapy recommendations. The nursing assistant assignment sheet (updated 9/16/10) directed the human service technicians (HSTs) to don the splint in the morning and take off at bedtime, removing it for cares as needed.

The registered nurse (RN-B) was interviewed on 9/22/10, at 9:10 a.m. She was informed the splint had not been in the resident's hand during the

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2 565	Continued From page 24 observations on 9/20 to 9/22/10. The RN verified he was supposed to utilize a splint, and said she thought the resident had the splint in place. Upon checking the resident, however, the splint was not in place. The RN found the splint on the resident's dresser and placed it in the resident's hand. R8's care plan was not followed for orthostatic blood pressures or for the use of a scoop plate at meals. During an observation of the evening meal on 9/20/10, at 5:30 p.m. R8 was not provided a scoop plate for his evening meal. The human service technician (HST-C) fed R8 for the entire meal. Observations of breakfast on 9/21/10, at 9:45 a.m. R8 again did not have a scoop plate. HST-E brought R8 his breakfast on a bedside table in the activity dayroom consisting of hot cereal in a bowl, a snack pack vanilla pudding, thickened cranberry juice, 2% milk in a carton, and applesauce in a disposable plastic container. An interview with HST-E on 9/21/10, at 9:30 a.m. revealed R8 usually slept in mornings and the staff made his breakfast. HST-E verified that a scoop plate was not used. HST-E stated the scoop plate was supposed to be sent up from the kitchen. An interview with a registered nurse (RN-L) on 9/23/10, at 3:00 p.m. verified the scoop plate was an intervention on R8's care plan and on the meal ticket. RN-L relayed R8 did not always feed himself, and the plate was sometimes used. Multidisciplinary progress note for occupational therapy dated 1/29/10, indicated, "Has been using the scoop plate and standard utensils for all meals." The care plan dated 1/24/10 indicated, "Scoop plate with standard utensils."	2 565		

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2 565	Continued From page 25 R8 received psychotropic medications for dementia with behavioral disturbances, psychosis, and depression. The physician's orders dated 9/10/10, included Venlafaxine, Risperidone (anti-psychotic), Divalproex, and Alprazolam. Potential adverse side effects included but were not limited to dizziness, hypertension (high blood pressure) hypotension (low blood pressure), tachycardia, vasodilation, orthostatic hypotension (sudden drop in blood pressure), lightheadedness, impaired coordination, and syncope (fainting). The orders directed staff to take orthostatic blood pressures (lying/sitting/standing) monthly. A review of the Medication Administration Record (MAR) indicated orthostatic blood pressures were taken in 5/10, in 6/10 it was noted the resident refused, in 7/10, lying and sitting were taken, but the resident refused standing, and then in 8/10 and 9/10, the MAR was initialed by nurses, but the actual blood pressure readings were not recorded. The care plan (dated 7/21/10) related to psychotropic drug use directed staff to monitor side effects of medication. An interview with the registered nurse (RN-L) on 9/21/10, at 3:30 p.m. verified orthostatic blood pressure readings were not recorded in the MAR for 8/10 and 9/10. R32's fistula site was not checked as directed on the care plan. R32 received hemodialysis through a shunt in the arm. The care plan for R32 indicated the shunt was to be checked every shift for thrill and bruit (to show the shunt was operational) and to report any signs of infection at the shunt site. A review of the treatment sheet for R32, however, lacked evidence the site was being monitored and	2 565		

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2 565	Continued From page 26 observed every shift according to the resident's care plan. RN-J verified there were no physician orders to check the shunt site, although the care plan directed staff to do so. The RN said it was a facility standard of practice to check the site every shift. R18 was not toileted as directed on the care plan. R18 was observed in the dining room on 9/20/10, at 5:15 p.m. After dinner the resident was assisted back to his room at 6:25 p.m. R18 was brought to an activity at 7:05 p.m. and assisted back to his room at 7:38 p.m. At 7:45 p.m. the surveyor intervened and asked registered nurse (RN-H) about R18's care. RN-H asked license practical nurse (LPN-A) when R18 was last toileted. LPN-A stated R18 was repositioned at 6:45 p.m. but was not toilet R18 at that time. RN-H and RN-I assisted R18 to the bathroom and had been incontinent. R18 had diagnoses including dementia and urinary retention. The annual Minimum Data Set (MDS), dated 2/1/10, indicated R18 had moderately impaired decision making skills and required extensive assistance for all activities of daily living, including toileting. The resident was incontinent of bowel and bladder. The bowel and bladder assessment, dated 8/7/10, indicated R18 was on a scheduled toileting plan to be checked and changed every two hours and as needed. The care plan dated 5/20/10, identified R18 as being incontinent of bowel and bladder and unaware of incontinence. The plan noted the resident required total assistance with care, and directed staff to check and change the resident every two hours and as	2 565		

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2 565	Continued From page 27 needed. The nursing assistant team worksheet was consistent with the care plan. On 9/20/10, at 8:10 p.m. a registered nurse (RN-H) and assistant director of nursing (ADON-A) verified that according to R18's nursing assistant assignment sheet, R18 should have been toileted every two hours. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee together with the appropriate department managers could ensure care plan approaches are being followed. Training and audits could be conducted. Results of the audits could be reviewed by the quality committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 565		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	2 570		

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2 570	Continued From page 28 review, the facility failed to revise the care plan for 1 of 1 resident (8) who required a revision. Findings include: Resident 8's care plan was not reviewed/revised related to pacemaker checks and shin guards. R8 was not wearing shin guards on 9/20/10, from 5:30 p.m. until bedtime at 7:15 p.m. During observations of morning cares on 9/21/10, from 7:00 a.m. until 10:00 a.m. R8 was again not wearing any shin guards. An interview with a human services technician (HST-E) on 9/21/10, at 10:00 a.m. revealed the shin guards were not applied because they were unavailable. A physician's order dated 5/17/10, indicated "Shin guards on when out of bed." The care plan dated 7/24/10, indicated "Skin very fragile. Prone to skin tears and bruises." The care plan did not indicate the need for shin guards. The care plan directed staff to perform pacemaker checks for R8. A physician's order dated 7/28/10, directed staff, however, to discontinue "all pacemaker checks per family request." An interview with the registered nurse (RN-L) on 9/23/10, at 3:00 p.m. verified the pacemaker checks were not removed from the care plan and the shin guard order was not transcribed onto the care plan. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee together with the appropriate department managers could ensure individualized care plans are reviewed	2 570		

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2 570	Continued From page 29 and revised as necessary, and are an accurate reflection of the residents. Training and audits could be conducted. Results of the audits could be reviewed by the quality committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 570		
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 provide services for 1 of 1 resident (R6) who expressed severe pain during care observations, to maintain comfort and minimize the risk of skin breakdown for 2 of 2 residents whose personal alarms were improperly bracketed to the top of their wheelchairs (R12 and R44), and to ensure 1 of 1 resident with unclean orthotics/splints (R29) was provided assistance to ensure a clean appearance. Findings include:	2 830		

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2 830	Continued From page 30 R6 was not provided with appropriate education regarding pain medications in order to make an informed decision regarding pain medication available to alleviate excruciating pain. R6 was admitted to the facility on 5/18/10 and re-admitted on 9/2/10 with diagnoses including End Stage Renal Disease, congestive heart failure (CHF), type II diabetes with neuropathy, Parkinson's disease, anemia, and depressive disorder. Hospice services were initiated on 9/4/10 for comfort cares. During observations on 9/20/10, at 6:40 p.m. the resident was interviewed in his room and stated he experienced pain all over his body when staff attempted to move him. His lower extremities were very painful and he wished the pain would subside. When asked if pain medication was offered and was helpful, R6 stated that he didn't like taking pills, they made him nauseated and made him feel like he was going to choke. During observations on 9/20/10, at 7:50 p.m. two human service technicians (HST-G and HST-H) entered R6's room to provide evening cares for the resident. The resident's bilateral lower extremities had 4 plus pitting edema. Two large hydrocolloid wound dressings were on the resident's right lower leg and were dated 9/19/10 "7-3." The dressings were saturated with large amount of purulent drainage. In addition, there were several large wet and dry areas of purulent drainage on the top and bottom sheets, as well as on a towel underneath the resident's right lower leg. Resigered nurses (RN-C and RN-N) changed R6's dressings. The resident screamed in pain each time RN-N attempted to peel off the dressing, the resident yelled, "It hurts, it hurts! Stop! It hurts so bad." RN-N asked the resident	2 830		

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2 830	Continued From page 31 if he wanted some pain medication. The resident declined stating it was too late now and he would rather have the procedure over with. The registered nurses did not explain the quick absorption mechanism of elixir morphine sulfate medication to the resident to help relieve his pain and continued with the dressing change. The facility policy and procedures for skin integrity management revised 6/09, revealed the need to assess residents for the presence of pain related to skin issues, and whether the pain was being adequately controlled. During an interview on 9/20/10, at 8:20 p.m. RN-C, reviewed the 9/10 Medication Administration Record for R6 and stated the resident had an order for morphine-sulfate elixir as needed for pain control, but the resident refused to take it. When queried the reason for refusal, or if it was explained to the resident that the morphine was liquid medicine and worked at a much faster rate to control pain, RN-C made no comment. During observations of morning cares for R6 on 9/21/10, at 9:05 a.m. the resident again screamed out in pain during perineal care, yelling, "Ouch! Oh God!" When asked if needed pain medicine, the resident replied, "I am afraid that pain medicine will make me sick--nausea and it has happened in the past." The resident added that was the reason he did not wish to take pain medicine. The resident verified the staff had not discussed nor explained medications could have been used to help with the nausea. The resident then stated his "journey would be much smoother" if he received pain medication that did not cause nausea and an upset stomach.	2 830		

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2 830	Continued From page 32	2 830		

During observations on 9/21/10, at 9:30 a.m. during dressing changes, R6 again yelled out in pain stating, "Ouch! Ouch!" when RN-C attempted to peel off the hydrocolloid dressing from the resident's lower leg. RN-A asked if the resident wanted pain medication, and the resident asked, "What?" RN-A asked the resident if he wanted some Tylenol or Morphine, and the resident said he would take Tylenol. The Tylenol was administered and RN-C stated that she would return later to change the dressings. No explanation nor education was provided to inform the resident regarding quick-acting Morphine Sulfate for pain control and medication available medication to manage the nausea, should that occur.

On 9/21/10, at 10:45 a.m. RN-C and RN-O entered the resident's room to change the dressing, the resident again yelled out in pain when RN-C attempted to peel off the hydrocolloid dressing. The dressing was completely stuck to the wound bed and was peeling off the tissue. The resident yelled out, "Take it easy! Ah--Ah--Ouch!" RN-C stopped attempting to peel off the dressing and explained to the resident the Morphine worked at a much faster rate to control pain, and would not make him gag. The resident quickly agreed to take the medication stating, "Okay." The treatment was stopped and Morphine 5 mg/2.5 milliliter (ml) was administered. The resident took the medication without difficulty. At 11:25 a.m. RN-C and RN-A changed the resident's dressing. The resident stated he was doing much better, and he did not cry out in pain.

An interview was conducted with RN-C and RN-A on 9/21/10, at 2:45 p.m. After reviewing the documentation, RN-C verified that the resident's

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2 830	Continued From page 33 pain symptoms were not monitored adequately. In addition, the RN said important information was not provided to the resident so he could make an informed decision regarding his pain management regimen. The RN stated, "It wasn't documented, therefore, it wasn't done." No additional information was provided. R12 was observed on 9/21/10, at 8:45 a.m. to be leaning on the metal prongs of an alarm bracket that was attached to the back of the wheelchair. A registered nurse (RN-M) verified upon observation that R12's skin was reddened and there were indentations in the skin where the resident had been leaning back on the prongs. R44 was observed on 9/22/10, at 12:20 p.m. to be leaning on prongs from the alarm bracket attached to the back the wheelchair. R44 stated he could feel the prongs and it was "uncomfortable." Indentations were palpable on the back of R44 where in the area where the prongs were pressing into the resident's skin. R29's splint and clothing was unclean. During observations on 9/20 to 2/23/10, R29's arm and leg splint were visibly soiled with spills. In addition, on 9/22/10, at 2:40 p.m. the resident's shorts had a large spot of what appeared to be spilled, dried coffee. R29's Minimum Data Set (MDS) assessment dated 8/16/10, indicated the resident required assistance to dress and groom, and utilized splints daily. It was also noted the resident sometimes resisted care. The care plan effective 8/24/10 indicated R29 had a self-care deficit and required assistance with activities of daily living. Interventions directed staff to allow the resident to select his	2 830		

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2 830	Continued From page 34 own clothing and then assist the resident to dress. The resident was to wear an orthotic on the right lower extremity, as well as a splint to the right hand/arm. "May use protective sleeve under splint. Handwash geri-sleeve weekly--Q (every) Friday--at HS (bedtime)." RN-C was interviewed on 9/23/10, at 10:00 a.m. She explained the HST got the resident coffee, "and he spilled it." She said although they tried to keep the resident well groomed, he did refuse to allow some cares, and it "takes a certain persuasion." The RN verified the splint/geri-sleeve should have been washed when it was soiled. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could work with the appropriate department managers could review and revise policies and procedures as necessary. Training of staff could be provided, audits could determine the success of the plan, and the results could be reviewed by the quality committee. TIME PERIOD FOR CORRECTION: 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:	2 895		

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2 895	Continued From page 35 B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure 1 of 2 in the sample utilized a splint (R2). Findings include: R2 did not have interventions to maintain and/or minimize the risk of further decrease in range of motion (ROM). R2 was observed during the evening of 9/20, during the day on 9/21, and at breakfast on 9/22/10. Although the resident was to wear a splint in his hand, during the observations, the splint was not in place. The resident's Minimum Data Set (MDS) dated 8/27/10 indicated the resident had bilateral limitations in range of motion in his neck, hand, leg, foot, and other, as well as limitations on one side in his hand. The MDS noted the resident received daily ROM, however, splint use was not noted. R2's 9/10 physician's orders directed staff to place a hand splint on right hand, "on in a.m. off in p.m." The care plan (effective 9/2/10) indicated the resident had chronic pain in his hand, and staff were to cleanse the resident's right hand/palm well, and "place splint" per occupational therapy recommendations. The nursing assistant assignment sheet (updated 9/16/10) directed the human service technicians (HSTs) to don the splint in the morning and take	2 895		

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2 895	Continued From page 36 off at bedtime, removing it for cares as needed. The registered nurse (RN-B) was interviewed on 9/22/10, at 9:10 a.m. She was informed the splint had not been in the resident's hand during the observations on 9/20 to 9/22/10. The RN verified he was supposed to utilize a splint, and said she thought the resident had the splint in place. Upon checking the resident, however, the splint was not in place. The RN found the splint on the resident's dresser and placed it in the resident's hand. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could work with physical and occupational therapies as appropriate. Training could be provided to persons responsible. Audits could determine the success of the plan, and the results could be reviewed by the quality committee. 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	2 900		

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2 900	Continued From page 37 receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure necessary care and services were provided to minimize the risk of pressure ulcer development for 2 of 2 residents in the sample (R13 and R14) who developed pressure ulcers. Findings include: R13 was not provided with appropriate care and services to prevent the development of pressure ulcers. The resident was identified at risk for pressure ulcers and an every two turning schedule was instituted, but was not followed. The resident developed a stage III pressure ulcer on his ear on 3/30/10, which had since healed. On 4/9/10, a stage II pressure ulcer developed on the resident's right foot. The most recent wound documentation on 9/21/10 indicated the length as .3 cm width 1 cm. It was described as dry scales with a pin point open area in the center with 98% wound base granulation. There was a small amount of serous drainage. Below the pressure ulcer a 1.4 cm x .8 cm reddened area developed. R13's most recent skin assessment was completed on 9/8/10 and the Braden was completed on 9/3/10. The Braden indicated the resident was at high risk for the development of pressure ulcers. The skin risk factors dated 9/8/10 indicated no actual open wounds but the conclusion indicated the resident had a wound on his right foot which was healing slowly. It further stated he was not always compliant with turning.	2 900		

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2 900	Continued From page 38 The plan was to continue to turn and reposition every two hours. R13's care plan developed on 12/09 and updated 9/16/10 indicated the resident was at risk for skin breakdown due to diabetes, incontinence and decreased mobility. The plan was to reposition every two hours. It indicated the resident refused to wear the pressure relief boots and had a pressure ulcer on the right foot lateral aspect at the 5th metatarsal head (stage II). The resident was in bed the entire evening of 9/20/10 when observations were done between 5:10 and 8:00 p.m. The resident remained on his back with the lateral aspect of the right foot lying directly on the bed. The resident was not wearing any type of foot protectors which were observed lying on the chair in the room. The HST (HST-F) when interviewed on 9/20/10 at 7:45 PM did not indicate he had turned the resident off his back. There was no documentation on the HST repositioning and flow record for 9/20/10 on the evening shift to indicate that had been done. When interviewed on 9/21/10 at 3:30 p.m. RN-A stated if not turned and repositioned and not documented that was unacceptable. If the resident were to refuse to be turned and repositioned the HST was to inform the nurse so the nurse could go in and try to get the resident to cooperate. She stated without documentation that probably was not done. R14 was not provided with appropriate care and services to minimize the development of pressure ulcers. During an initial tour on 9/20/10, R14 was identified by RN-D as a resident who had	2 900		

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2 900	Continued From page 39 pressure ulcers. The RN stated they were hospital-acquired. Resident was observed on 9/20/10 in bed at 5:15 p.m. and was up in the wheelchair at 5:25 p.m. At 6:55 p.m., the resident stated he needed to get back into bed, as he had sat up too long. He required the use of a mechanical lift and four staff members. He was placed in bed at 7:20 p.m. The resident was observed to have three areas on his buttocks that were covered with a colloid dressing. RN-D explained the dressings were to cover an unstagable deep tissue injury. The resident had one stage II pressure ulcer on his buttocks. When asked how the ulcers occurred, the RN said she did not know, but the resident returned from the hospital with the problem. Wound care was observed on 9/21/10, at 3:55 p.m. The RN stated the wound dressings would include the heel and the pannus (left groin). She did not plan to remove the colloidal dressings on the buttocks. The heel wound began as a blister on 6/9 that developed into a stage III ulcer by 6/15 that measured 0.6 centimeters (cm) by 1.5 cm with no depth. When observed on 9/21/10, the wound measured approximately 1.3 by 2.1 by 0.2 cm (depth). Under the abdominal folds, a left groin wound was identified as "redness" during a head to toe body check after a hospital return on 8/14/10. The full body check on 8/16/10 identified no problems other than the areas on the buttocks. The resident was hospitalized again from 8/16/10 to 8/21/10. Upon returning, R14's body check revealed superficial open areas in the groin. The resident was sent back to the hospital from 8/22/10 to 8/27/10. The hospital discharge record on 8/27/10 identified a pannus wound under the abdominal folds that appeared worse on the day of discharge. A treatment of dry	2 900		

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2 900	Continued From page 40	2 900		

dressing changes was ordered. Upon returning, the complete body check on 8/27/10 noted the area underneath the abdominal folds was again reddened. The first documented nursing note was dated 8/29/10. The note indicated the nurse investigated the wound to the left pannus that was noted on the hospital discharge summary. The nurse noted the left side under the abdominal folds were red, raw, and bleeding. The abdominal pad which was in the wound was saturated with drainage. The nurse lifted the abdomen so the fold could be examined and discovered an area 10 by 4.6 cm. The wound bed was 90% covered in thick yellow/tan slough with a foul odor. The nurse attempted to unsuccessfully remove some of the slough, but it was adhered to the wound bed. Foam was placed over the wound and a consultation with the wound nurse was planned for the following day.

An examination of R14 by the registered nurse practitioner (RNP) on 8/30/10 revealed the resident was diagnosed with Methellin-resistant staphylococcus aureus (MRSA) in the wound, and antibiotic medication was started and was to continue through 9/5/10. A wound treatment was also ordered.

Weekly wound documentation was completed on 8/31/10. The nurse noted the presence of an unstagable left-sided wound under the abdominal folds that measured 10 by 4.6 cm. The nurse noted the wound was acquired during hospitalization. On 9/13/10 the wound measured 12.5 by 5.1 by 1.0 cm in depth, and was identified as a stage III ulcer. The slough was mostly removed, however, there was a copious amount of serosanguinous drainage with redness surrounding the wound bed. Although the wound

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2 900	Continued From page 41 was identified as larger in size, the nurse documented the wound as improved. Weekly wound documentation of 9/21/10 noted the wound was at stage IV, and measured 12 by 4.2 cm (no depth was recorded). Adipose tissue and muscle were present in the wound bed, with no slough remaining. A moderate amount of serosanguinous drainage was noted, with redness surrounding the wound. Improvement was again noted by the RN. Pressure ulcers were not identified on R14's quarterly Minimum Data Set (MDS) dated 4/21/10. Although the resident was not hospitalized since his admission on 1/12/10, the quarterly MDS dated 7/26/10 (with a look back period of seven days) noted the resident had three stage III pressure ulcers. A comprehensive skin assessment was not completed at the time. On 7/20/10 it was noted the resident had no open areas when his skin was assessed, and the Braden Scale for predicting pressure ulcer risk was 17, placing the resident at mild risk. Wounds to the right heel and left thigh were identified, with a plan to reposition every two hours. The heel ulcer and treatment was added to the care plan on 6/9/10. The left groin wound was added 8/30/10 with plan to keep area dry and clean and treat as ordered. The treatment record for 8/10 indicated the dry dressings ordered from the hospital was not added, and the first treatment noted for the left pannus (groin) was 8/30/10. RN-D was interviewed on 9/22/10 at 10:00 a.m. The RN verified the skin assessment did appeared inaccurate and a comprehensive assessment was lacking. Further hospital records regarding the pannus wound were requested from RN-D on 9/23/10, but were not provided. The RN stated the wound treatment as	2 900		

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2 900	Continued From page 42 ordered by the hospital was not completed, and it appeared the wound was not examined at the time the resident was readmitted to the facility. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could ensure policies and procedures were current. Individualized programs for minimizing the risk of skin breakdown could be insituted. Training could be provided to persons responsible. Audits could determine the success of the plan, and the results could be reviewed by the quality committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 900		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and 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:	2 910		

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2 910	Continued From page 43 Based on observation, interview, and record review, the facility failed to ensure 6 of 14 residents in the sample (R3, R8, R13, R6, R5, and 18) who were reviewed for incontinence received care and services to promote continence. Findings include: R3 lacked an assessment and plan promoting bowel and bladder continence. R3 was observed on 9/20/10 at 6:37 p.m. A human services technician (HST-A) assisted the resident to use the toilet using the E-Z stand. At 8:00 p.m. the resident was again assisted to use the toilet. The following day on 9/21/10, at 4:25 p.m. R3 was observed just after having used the toilet. HST-A was then interviewed, and said he assisted the resident to the toilet just as the resident needed to have a bowel movement. He explained the resident was sometimes both continent and incontinent, but if assisted in time, he could successfully use the toilet to both void and have bowel movements. The HST said the resident was toileted "about every two hours." R3's Comprehensive Bowel/Bladder Data Collect Mpls V05 dated 7/25/10, indicated the resident had functional incontinence, was totally confused, was unable to communicate toileting needs, and was dependent on staff to use the toilet. Although 3-day voiding patterns were not collected, the assessment indicated R3 elimination showed "no pattern." Current interventions were identified as staff toileting the resident every two hours and as needed while awake, and changing the resident every two hours and as needed during the night. The summary of findings directed staff to, "continue to toilet" the resident every two hours and as needed while awake, and check and change the	2 910		

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

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2 910	Continued From page 44 resident every two hours during the night. The RN completing the assessment indicated the documentation was added to the resident's care plan. The quarterly Minimum Data Set (MDS) dated 7/28/10 indicated the resident had multiple episodes of bladder incontinence daily, and bowel incontinence 2-3 times weekly. The resident had moderately impaired cognition skills, and was dependent on staff to transfer and use the toilet. The MDS indicated the resident was on a scheduled toileting plan. The registered nurse (RN-B) was interviewed on 9/21/10, at 3:40 p.m. The RN stated 3-day voiding data was collected upon a residents' admission, with a change in continence, and annually only if indicated. She said R3 was able to sometimes successfully use the toilet, and verified the resident's plan was to check and change every two hours and at night, and to assist to use the toilet before meals and at bedtime. The RN said she thought the plan had changed from every three hours to every two hours. Orders on R3's physician order sheet dated 2/7/07 instructed staff to toilet the resident before meals and at bedtime, and during the night and/or if resistive, he was to be checked and changed every three hours. On 9/21/10, RN-B wrote a nursing order to discontinue toileting as above and instead, "start toileting program: toilet upon rising in a.m., before and after meals, before bedtime," and check and change every three hours during the night. R3's HST assignment sheet (updated 9/16/10) was consistent with the care plan after updates	2 910		

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2 910	Continued From page 45 were made on 9/22/10 after an interview with the RN. The care plan noted, "I am incontinent of bowel and bladder and use incontinent briefs...I depend on staff for use of bathroom. I require a scheduled toileting program. Take me to the bathroom upon rising, before and after meals and at bedtime." The resident was to be checked and changed every three hours and as needed during the night. R13 was not provided services in accordance with the care plan. The resident was observed in bed the the evening of 9/20/10 from 5:10 to 8:00 p.m. The resident was not assisted with incontinence care during that time. The annual MDS and Resident Assessment Protocol Summary (RAPS) dated 6/13/10 and care plan for R13 indicated the resident was totally incontinent and the resident was to be checked and changed every two hours. The plan to minimize the risk of skin breakdown and urinary tract infections. It was noted certain staff were more successful in assisting the resident when cares were refused. HST-F informed the surveyor R13 was changed around 5:30 p.m. When the surveyor told the HST the cares had not been observed since observations began at 5:10 p.m., the HST then stated he cared for the resident sometime around 5:00 p.m. The HST also said he asked the resident around 7:00 p.m. but the resident refused care. He did not State he checked the resident for incontinence. Documentation was lacking on the HST activities of daily living flow record for 9/20/10 during the evening shift to support care as outlined on the care plan.	2 910		

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2 910	Continued From page 46 RN-D was interviewed on 9/21/10, at 3:30 p.m. The RN stated it was unacceptable if R13 was not toileted or checked and changed as indicated on the plan of care and it was not documented. R8 did not receive assistance to the bathroom when he asked on 9/20/10, at 5:55 p.m. while in the dining room for supper. R8 was observed in the dining room being assisted to eat by a human services technician (HST-C) when R8 stated, "I gotta pee right now." R8 pushed himself away from the table and HST-C stated, "I can't do it alone I can't do it by myself." HST-C placed the call light on in the dining room and stated, "I'm waiting for someone to come, I can't leave the room dear." HST-Cmoved R8 back to the table and stated, "Can you eat a little more (resident's name), I don't think anyone's going to get here soon." R8 crossed his legs and again moved away from the table. HST-C continued to offer bites of food to R8 and stated, "I'm sorry (resident's name)." At 6:00 p.m. HST-C looked out the door of the dining room and down the hall but did not get any help. Still no one had answered the call light. Another HST-D walked past the dining room and the HST-C did not try to get HST-D's attention to assist R8 and offered another bite of food to R8. At 6:18 p.m. HST-C headed off another resident in the dining room who was trying to stand up and stated, "I need to take you down where there's more people. I'll be right back." HST-C wheeled the other resident down to the activity day room at the other end of the hall from the dining. No observations of HST-C asking for any assistance for R8 related to his request to go to the bathroom and no one had answered the call light. At 6:19 p.m. on the way back into the dining room HST-C prevented a resident to resident altercation in the doorway of the dining room and	2 910		

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2 910	Continued From page 47	2 910		

gently separated the two residents. R8 had moved himself away from the table again and HST-C wheeled R8 back to the table and continued to offer bites of food and sips of milk. R8 hollered out, "No!" At 6:25 p.m. HST-C wheeled R8 down to the nursing station while R8 called out, "I have to pee." HST-C passed HST-D in the hall while R8 called out and no one helped R8 to the bathroom. At 6:50 p.m. R8 was dozing in the wheelchair still sitting outside the nursing station when registered nurse (RN-K) asked the resident if he was sleepy and R 8 stated, "Yes." RN-K wheeled R8 to his room and waited with the R8 for help. At 6:57 p.m. HST-D was passing R8's room and RN-K called to him to help assist R8. By this time R8's agitation had increased and escalated throughout the time it took HST-D and RN-K to walk R8 into the bathroom and help the resident onto the toilet. R8's incontinence pad was wet according to the RN-K and R8 had a very large bowel movement while sitting on the toilet almost immediately after sitting down.

The quarterly minimum data set (MDS) dated 7/21/0, indicated R8 had short term/long term memory loss with severely impaired decision makning abilities, sometimes understands/sometimes understood others and was frequently incontinent of bowel/bladder and required extensive assistance of two staff. The comprehensive bowel/bladder data collection tool dated 7/18/10, indicated R8 had functional incontinence and required two person physical assist for toileting if resistive. The care plan dated 7/21/10, "When I am resistive I need two assist for toileting."

Despite R8's cognitive and communication limitations an interview with RN-K on 9/20/10, at

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2 910	Continued From page 48 7:30 p.m. revealed the expectation of the HST to get assistance for R8 when the resident had asked to go to the bathroom during the evening meal after ensuring no residents were choking. An interview with RN-L at 7:33 p.m. related to what was the expectation of a staff member left alone in the dining room with residents during a meal and someone needed help. RN-L stated staff should put on the call light and if no one answered it, the staff member should make sure no residents were choking and quickly go down the hall to get some help or if an emergency call out down the hall. RN-L checked the call light in the dining room and verified it worked and that the call light could be heard in the main dining room across from the nursing station. R6 lacked a comprehensive bladder assessment at the time of the full MDS. A three-day voiding pattern was incomplete. During observations on 9/20/10 at 7:50 p.m., human service technicians (HST-G) and (HST-H) entered room to provide evening cares to the resident. The resident's incontinence brief was saturated with urine and had a small loose bowel movement. The HSTs provided perineal care and placed a clean incontinence brief on the resident. A three-day voiding pattern form was incomplete for 9/5/10 on the day shift A "Comprehensive Bowel/Bladder Data Collect..." checklist, dated 9/21/10, indicated the resident had a change in continence. It revealed the resident was incontinent of bowel and bladder and the current plan was to check and change every two hours and as needed. On 9/23/10, at 11:40 a.m. RN-C reviewed the information and verified the voiding patterns for	2 910		

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2 910	Continued From page 49 the day shift was incomplete, but should have been completed. A HST recorded the information and it should have been checked for completion by the nurse on duty. RN-C indicated reported it was a Sunday morning shift, and she would check into the matter. R5 lacked a comprehensive bladder assessment at the time of the full MDS. The assessment lacked all of the pertinent risk factors and the three-day voiding pattern was incomplete. The resident was admitted to the facility on 3/4/10 with diagnosis including urinary incontinence and benign prostatic hypertrophy with urinary obstruction. R5's three-day voiding pattern dated 3/7/10 was incomplete for the day shift. The bladder assessment checklist dated 3/21/10 lacked co-morbid risk factors associated with benign prostatic hypertrophy (enlarged prostate gland) and urinary obstruction. The assessment plan indicated to toilet the resident every two hours and as needed. During an interview with RN-C on 9/23/10, at 11:10 a.m. the RN said after reviewing the information, it should have been completed and was not. She stated 3/7/10 was Sunday and the resident was present on the unit. RN-C verified the assessment checklist was not comprehensive and was lacking pertinent risk factors. The facility policy and procedure for bowel and bladder management dated revised 9/09, revealed a three-day voiding diary was to be completed with admission, significant changes, and annual MDS assessments. No further information was provided.	2 910		

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2 910	Continued From page 50	2 910		

R18) was not toileted as directed on the care plan.

R18 was observed in the dining room on 9/20/10, at 5:15 p.m. R18 was returned to his room after dinner at 6:25 p.m. R18 was brought to an activity at 7:05 p.m. Staff brought R18 out of the activity at 7:38 p.m. and back to his room. At 7:45 p.m. the surveyor intervened and asked registered nurse manager (RN-H) about R18's care. RN-H asked license practical nurse (LPN-A) when R18 was last toileted. LPN-A stated R18 was repositioned at 6:45 p.m. but was not toilet R18 at that time. RN-H and RN-I assisted R18 to the bathroom. When R18 was toileted, he was incontinent.

R18 had diagnoses that included dementia with behavioral disturbances, urine retention and left sided hemiplegia related to cerebrovascular accident (CVA). The annual Minimum Data Set (MDS), dated 2/1/10, indicated R18 had moderately impaired decision making skills and was extensive assist to totally dependent on others for all activities of daily living, including toileting. The resident was identified as incontinent of bowel and bladder.

The bowel and bladder assessment, dated 8/7/10, indicated R18 was on a scheduled toileting plan to be checked and changed every 2 hours and as needed.

The care plan dated 5/20/10, identified R18 to be incontinent of bowel and bladder and R18 would not be aware when he was incontinent. Approaches included staff to check and change R18 every 2 hours and as needed. R18 was identified on the care plan as total care. The

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2 910	Continued From page 51 nursing assistant team worksheet was consistent with the care plan. On 9/20/10, at 8:10 p.m. RN-H and assistant director of nursing (ADON-A) verified that according to R18's nursing assistant assignment sheet, R18 should have been toileted every two hours. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could ensure policies and procedures were current. Complete and accurate data collection and assessments with analysis and an appropriate individualized plan could be instituted. Training could be provided to persons responsible. Audits could determine the success of the plan, and the results could be reviewed by the quality committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 910		
2 940	MN Rule 4658.0525 Subp. 9 Rehab - Hydration Subp. 9. Hydration. Residents must be offered and receive adequate water and other fluids to maintain proper hydration and health, unless fluids are restricted. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to determine fluid adequacy for 3 of 3 residents in the sample who were identified at high risk of dehydration. Findings include: R32 lacked an assessment of the adequacy of	2 940		

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2 940	Continued From page 52 fluid intake. R32 had a diagnosis of renal failure and received hemodialysis three times per week. The resident received a therapeutic pureed renal diet and was on a 1800 cc fluid restriction. The care plan for R32 indicated the resident was at high risk related to nutrition and dehydration, had chewing and swallowing problems, was on a fluid restriction, had mouth pain at times, left greater that 25% of food uneaten at most meals, and had a history of skin alterations. Interventions for R32 included to offer fluid between meals, encourage intake of fluids, record the fluids given with medication pass, and provide supplements. R32's Medical Administration Record (MAR) revealed ten separate areas for recording fluid intake for various snacks, supplements, and fluids given with medication pass. The fluids consumed with each shift were recorded on the computer, not on the MAR, and the fluids consumed per day were not totaled. R32's annual nutrition assessment was completed on 9/2/10. The assessment identified the resident had a stable weight for the past three months, had an 1800 cc fluid restriction, received protein powder three times per day (TID), two cans of Nepro supplement on dialysis days, 30 ccs of Prostat 63 TID, a snack TID on non-dialysis days, a can of Nepro supplement at bedtime, and Nepro was offered if intake fell below 50% of a meal. The assessment documented intake as, "Intake mostly 50-100% x 1, 25% x 1, 0-25% x 1, gets all the supplement Nepro intake is mostly 25-50%, Prostat mostly 100% and snack mostly 50-100%." Nutritional requirements were calculated to be 1819-2167 kilo calories (Kcal), 86-103 grams protein, 1800	2 940		

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2 940	Continued From page 53 cubic centimeters of fluids. The assessment indicated R32 was "provided" enough food to meet nutritional requirements. The assessment went on to explain the resident required assistance to eat, encouragement to eat more, and was at risk for skin breakdown. The goal for R32 was to consume at least 50% of meals and maintain good hydration. R32 was determined to be at high nutritional and dehydration risk. The medical record lacked evidence that totals of all fluids consumed were calculated and assessed to determine if R32 was meeting or exceeding his fluid needs. The director of dietary verified on 9/23/10, at 10:00 a.m. that a calculation of the adequacy of intake would be expected. R11 lacked an assessment of the adequacy of fluid intake. R11 had diagnoses including organic brain syndrome, dysphagia (swallowing disorder), depressive disorder. The nutrition care plan indicated that R11 was at risk for dehydration. R11 could become irritated with eating and lose interest in eating. R11 left 25% or more food uneaten and had chewing and swallowing problems. The goal for R11 was to maintain adequate nutrition and hydration on the least restrictive diet without evidence of aspiration. Interventions included: encourage to eat and drink 75% and to attend meals, provide assistance with eating and drinking, monitor for swallowing problems, provide supplements, encourage intake of high protein foods and supplements, encourage fluids 8-12 ounces with medication pass, offer fluids between meals, and encourage fluid intake.	2 940		

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2 940	Continued From page 54 The MAR for R11 had four separate sections for recording fluid intake, one for fluids with medication pass, one for fluids between meals, and two for supplements given. The MAR did not indicate a total of fluids for the day. Intakes per meals were recorded on the computer program. An annual assessment completed on 8/12/10, indicated R11's diet order was modified to provide smaller portions to prevent R11 from becoming overwhelmed with the amount of food offered. R11 had pureed diet with thin liquids. The assessment indicated R11 was receiving three cans of a supplement daily and three ounces of a different supplement daily and was taking at least half of the supplements. R11 was offered 8-12 ounces of fluids daily as a hydration plan, and was assessed to be at high risk for dehydration. The estimated needs for R11 were 1044-1253 kilo calories, 44-53 grams protein, and 1383-1660 cc of fluids daily. The assessment lacked a summation of the adequacy of R11's current intake for fluids. R10 lacked an assessment and determination of fluid adequacy. On 9/20/10, at 5:30 p.m. R10 was observed wandering the halls in a wheelchair and resisting encouragement to eat. On 9/23/10, at 8:30 a.m. R10 was encouraged to eat and drink. R10 was resistive to the encouragement and became restless. R10 had diagnoses of Alzheimer's dementia with behavioral disturbance, head injury, and agitation. R10 received a diet of modified ground texture with nectar thick liquids and was determined to be at high risk for dehydration according to a quarterly assessment dated 9/3/10.	2 940		

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2 940	Continued From page 55 The care plan for R10 indicated the resident was at nutritional risk due to refusals of eating and drinking and requiring assistance to eat. Interventions were to provide physical assistance with eating, encourage self-feeding as able, provide finger foods, provide cues to drink, offer fluids between meals, often would eat well when sitting in the recliner, provide between meal snacks, use a nosey cup and plastic coated spoon, and provide supplements of 120 cubic centimeters (cc) 2 Cal HN (supplementation) with medication pass, 120 cc health shake three times daily, Magic Cup with meals, and offer 120 cc fluids with medication pass and extra fluids with meals. The Resident Assessment Protocol (RAP) dated 12/10/09, indicated that R10 was on a therapeutic diet to meet diagnoses. The resident had a mechanically altered diet to minimize the risk of chewing and swallowing problems. The resident was known to leave 25% or more of meals uneaten, and was provided scheduled snacks and supplements to make up for missed calories. The quarterly assessment dated 9/3/10, indicated an intake of "mostly 75-100% x 1, 50-75% x 1, 0-50% x 1, gets magic cup 4 ounce at...2 cal med pass supplement 120 cc three times daily, offer 120 cc fluid with medication pass snack three times daily, health shake 120 cc three times daily." The assessment indicated R10 was on a dehydration risk list. The assessment lacked a determination of the adequacy of R10's actual fluid intake. SUGGESTED METHOD OF CORRECTION: The registered dietitian with the director of nursing could ensure policies and procedures	2 940		

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2 940	Continued From page 56 were current. The process for ensuring residents at risk of dehydration are assessed, and a system to ensure adequacy of hydration could be determined. The data collection system could be streamlined to ensure appropriate hydration. Training could be provided to persons responsible. Audits could determine the success of the plan, and the results could be reviewed by the quality committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 940		
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, interview, and record review, the facility failed to ensure odors were kept to a minimum for 1 of 1 in the sample (R15) whose room was odorous. Findings include: During the initial tour of the facility on 9/20/10, at 12:30 p.m. a strong odor was detected in two rooms, including R15's room. The odors in the resident's room were offensive and of stale urine. The odor in the room lingered throughout the survey and was noted at various times throughout the day. When interviewed on 9/20/10, R15 said he did not notice odors in the facility. The resident's roommate was interviewed on 9/22/10 and said he did not detect odors, but said, "My nose isn't	21665		

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

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21665	Continued From page 57 too good." Two registered nurses (RN-D and RN-E) both verified in interviews on 9/21/10 and 9/23/10 the presence of lasting odors in R15's room that they were unable to eliminate. The room was routinely cleaned and deep cleaned periodically. The mattress and the wastebasket were disposed of in efforts to eliminate the odor, however, the odor remained. The director of housekeeping was interviewed on 9/23/10, at 10:45 a.m. The director said the last time the floors were cleaned (completed every 8-12 months) in the room was 7/28/10 and the last total monthly room cleaning was completed was on 9/9/10. Daily cleaning included spot cleaning everything and sweeping and mopping of the floor. Total monthly cleaning included ceiling vents, lights, wall hangings, vents, baseboards, bed frame, mattress, furniture, windows, drapes, and privacy curtains as needed. When the floors were cleaned, furniture was removed and everything else in the room cleaned. The director was aware of the odor, but was unable to identify other solutions to the problem. SUGGESTED METHOD FOR CORRECTION: The administrator together with the director of maintenance and housekeeping could monitor the status of physical plant conditions periodically using a routine inspection plan. Appropriate staff could be trained, and audits conducted. The results could be communicated to the quality committee. TIME PERIOD FOR CORRECTION: Thirty (30) days.	21665		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance	21695		

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21695	Continued From page 58	21695		

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, interview, and record review, the facility failed to ensure carpeting was maintained in a clean and well-repaired manner in two lounges in Building 6, potentially affecting approximately 70 residents. Findings include:

During an initial tour of the facility on 9/20/10, as well as during an environmental tour on 9/22/10, at 2:35 p.m. two lounges on the 1st and 2nd floor in Building 6 had carpeting in poor repair. The carpeting appeared heavily soiled, with large, dark stains throughout. The lounges were used most of the residents residing on the two units.

A cleaning schedule showed the carpeting was completely shampooed every 6-8 months and in Building 6. On 8/12/10 records showed the carpeting was cleaned in both 1st and 2nd floor day rooms.

The director of housekeeping was interviewed on 9/23/10, at 10:45 p.m. The supervisor verified the stains were permanent and unsightly. She said replacement of the carpet was in the budget for replacement, however, she did not know when the replacement was to occur.

SUGGESTED METHOD FOR CORRECTION:
The administrator together with the director of

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21695	Continued From page 59 maintenance and housekeeping could monitor the status of physical plant conditions periodically using a routine inspection plan. Appropriate staff could be trained, and audits conducted. The results could be communicated to the quality committee. TIME PERIOD FOR CORRECTION: Thirty (30) days.	21695		
21710	MN Rule 4658.1415 Subp. 7 Plant Housekeeping, Operation, & Maintenance Subp. 7. Hot water temperature. Hot water supplied to sinks and bathing fixtures must be maintained within a temperature range of 105 degrees Fahrenheit to115 degrees Fahrenheit at the fixtures. This MN Requirement is not met as evidenced by: Based on observations, interview, and record review, the facility did not maintain hot water temperatures within required ranges (105-115 degrees Farenheit) throughout Building 6. Findings include: Random water temperatures were taken during an environmental tour on 9/22/10, at 2:35 p.m. in Building 6. The temperatures ranged from 93.2 to 103.9 degrees. Water temperature logs were reviewed for the months of June through August 2010. In 6/10, 7 of 9 water temperatures measured were between 91.4 and 102.3 degrees. In 7/10, all nine water temperatures measured were between 102 and 104.1 degrees. No low temperatures were recorded in 8/10.	21710		

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21710	Continued From page 60 When interviewed on 9/23/10, at 8:30 a.m. the chief engineer stated he was unaware of the temperature requirements of 105-115 degrees. He then verified the water was set too low. SUGGESTED METHOD FOR CORRECTION: The administrator together with the director of maintenance could periodically monitor the water temperatures using a routine inspection plan. The results could be communicated to the quality committee. TIME PERIOD FOR CORRECTION: Twenty (21) days.	21710		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the dignity of all residents was maintained during the dining experience (including R8, R41, R17, R13, R40, R12, R45, and R10) Findings include: R8's dignity was not preserved when in the dining room on 9/20/10, at 5:45 p.m. as evidenced by exposure of the incontinence brief he was wearing along the side of his wheelchair. During observations of the evening meal on 9/20/10, at 5:45 p.m. R8 was observed seated in	21805		

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21805	Continued From page 61 a wheelchair at the dining room table while assisted to eat by a human service technician (HST-C). His sweat pants were pulled down below his hips and were bunched up in the front, partially exposing the resident's lower half (hips/thighs), as well as an incontinence brief. R8 remained that way until approximately 7:00 p.m. when a registered nurse (RN-K) observed the situation and assisted the resident to the bathroom. The RN said it was "not okay," despite the resident's resistiveness to care. The RN further said if the staff could stand him up to transfer him into a wheelchair, they could also pull up his pants and ensure his hips and thighs were properly covered. R8's quarterly Minimum Data Set (MDS) dated 7/21/0, indicated R8 had short and long term memory loss with severely impaired decision making abilities, and he required extensive assistance with all activities of daily living. The care plan dated 4/22/10, indicated "I have memory problems, remind me of who you are, interpret my non-verbal communication (facial expressions, behaviors, gait) to anticipate my needs...I will be dressed in seasonally appropriate clothing, receive hygiene, and be groomed daily." R41 was not treated in a dignified manner. On 9/23/10, at 7:55 a.m. R41 was observed in the dining room at his table. Foam hand sanitizer dispenser was located above R41's table. Staff were observed to frequently reach behind and/or in front of the resident to dispense hand sanitizer. HST-B reached across the resident to dispense hand sanitizer, and then commented to the resident that the dispenser did not seem to be placed in the "best" place. R41 agreed with the HST and said he thought it could be moved. The	21805		

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21805	Continued From page 62 resident then told the surveyor the location of the hand sanitizer bothered him and stated, "They should move it." R17 was not treated in a dignified manner. On 9/21/10, at 9:25 a.m. R17 was interviewed. R17 stated that ice cream was served "a lot" at the facility. R17 explained that he sometimes had staff save his tray and he ate at a later time. However, when ice cream was served, the ice cream was on the plate with the hot food and was melted. R17 said it seemed "strange" to serve ice cream on the same plate as hot food. During dining observations on 9/23/10, at 8:00 a.m. many residents were drinking out of disposable cups. One resident was served liquids in four disposable cups. HST-B was interviewed on 9/23/10, at 8:15 a.m. The HST explained staff gave water to residents in disposable cups because the residents often did not drink the water. The staff preferred to serve juice and milk in non-disposable glasses so the residents would not squeeze the cups and spill the liquid. HST-B stated they were not provided with an adequate supply of non-disposable cups to serve all fluids without utilizing disposable cups. R13 was observed eating alone, away from his peers. Observation of R13 at the evening meal on 9/21/10 revealed the resident ate alone at a tray table in the hallway at least 15 feet away from four other residents who sat together at a table. The dining room was full and did not have extra seating. R13's care plan for nutrition dated 9/16/10	21805		

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indicated the resident was served meals in the hall outside of the dining room. It further indicated the resident was at high risk for choking. It did not address the resident's need to eat away from peers, however, it was noted the resident had anger issues, but enjoyed visiting. Attempts to interview the resident regarding his wishes were unsuccessful.

A registered nurse (RN-E) was interviewed on 9/23/10, at 2:40 p.m. The RN explained the reason the resident ate alone was because of aggressive behavior in the dining room approximately one year prior. She said they tried to allow the resident to eat in the dining room since that time, but it was unsuccessful. She verified they had not tried to allow him to eat with fewer peers, such as in the hallway with where the four other residents ate. The RN agreed they it could be attempted to promote socialization, since the resident resided in a room without a roommate.
R40 ate alone in the hallway, away from others.

During supper observations on 9/20/10, at 6:00 p.m. R40 was sitting in his wheelchair outside of his room, against the wall and away from the dining room and from all other residents.

During breakfast observations on 9/21/10, at 8:40 a.m. R40 was again seated in his wheelchair outside his room, facing the wall and eating all alone. The following morning on 9/22/10, at 9:06 a.m. the resident was again eating breakfast alone. When asked if he preferred eating alone the resident replied, "It would be nice to eat meals with others. It gets lonely here."

During an interview on 9/23/10, at 12:00 p.m. RN-C explained that R40's electric wheelchair

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21805	Continued From page 64 was broken, which he used to get to the main dining room for meals. She stated the 2 north dining room was too congested, therefore the resident ate in the hallway for meals. RN-C verified the resident should not have been eating alone and said a place would be made for him to eat with his peers. The dignity of residents was not preserved during the dining service. R12 and other anonymous residents in the dining room were fed their dessert of a fudge bar first before the meal, during the supper meal on 9/20/10, at 5:30 p.m. in the second floor north dining room of building 6. The staff helping R12 to eat the fudge was standing while assisting and was holding paper and plastic waste. The staff eventually placed the paper and plastic waste on the table next to R12's place setting in order to have free hands while assisting. After R12 finished the fudge, the staff picked up the waste and disposed of it. At 6:00 p.m. in the south dining room of second floor building 6, 17 beverages were observed being served in disposable cups. RN-E stated that they ran out of regular cups. Supper observations were conducted in the 3 south dining room 9/20/10, at 5:15 p.m. The human services technicians (HSTs) placed clothing protectors on each table. Without asking the residents if they wished to utilize a clothing protector they were automatically placed on each resident. Many of the HSTs reached around the residents from behind and without an explanation, placed the clothing protectors on the residents. Food was served beginning at 5:30 p.m. A plate of hot food, including a hamburger and french fries, was served to each resident. At the same time, a fudge bar was also placed on	21805		

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the same plate. Several of the residents ate the fudge bar before the meal. At 6:00 p.m. a HST requested bowls for two residents' fudge bars, stating to the staff person serving the food, "They're all melted." The staff person responded, "Yeah, they're all like that. I tried to put them on ice." On 9/23/10, at 9:25 a.m. RN-B stated the freezer in the 3 south kitchenette was not working the evening of 9/20/10.

The following day on 9/21/10, at breakfast at 8:40 a.m. R45 was in the small dining room on third floor. A staff person entered the room wheeling blood pressure equipment stating, "There he is," and proceeded to take the resident's blood pressure while several residents were eating breakfast.

At breakfast in the 3 south dining room on 9/21/10, at 8:45 a.m. all residents were wearing clothing protectors. The residents were served food including hot or cold cereal, scrambled eggs, sausage, bananas, and multiple different liquids. Several residents were served the cold cereal from the disposable plastic bowls and liquids from the plastic containers in which the products came. Waxed paper cups were also utilized for several residents' drinks. The garbage from the various containers and food (plastics, covers, cartons, banana peels, etc.) was left on the tables while the resident ate.

On 9/21/10, at 8:45 a.m. R10 was observed drinking juice and other beverages out of paper cups. Clean, non-disposable cups were available on top of the food cart.

The dietary director (DD-A) stated on 9/22/10, at 11:15 that regular bowls were available for the oatmeal, but it was the facility practice to serve

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the cold cereal in the plastic single portion bowls. It was also the facility practice to serve juice in disposable portion control cups. The residents on the second floor of building 6 had varying degrees of dementia and could not always make their preferences known.

On 9/23/10, at 8:15 a.m. in the south dining room of second floor building 6, meal service waste items were observed on the tables while the residents were eating. Observed were foil tops from the plastic juice cups, banana peels, and plastic cups. Residents were also observed eating cold cereal out of disposable single service bowls.
The licensed social worker (LSW-A) was interviewed on 9/23/10, at 9:30 a.m. regarding whether the facility was considering culture changes, such as alternatives to clothing protectors. She replied, "Not that I'm aware of...resident-centered care--that has been talked about, and some residents have individualized care plans." She said they were piloting what she referred to as "resident-centered care" in Building 6 on the third floor.

On 9/23/10, at 10:35 a.m. staff on the 2 north unit were observed automatically placing clothing protectors on each of the residents without asking their preferences or offering alternatives.

The director of nursing was interviewed during the afternoon of 9/23/10 regarding the facility's progress toward making culture changes. She said they were piloting a project on the dementia unit on the third floor in building 6. She explained it just needed a little more "tweaking" and it would be rolled out throughout the facility. Details regarding the plan were not delineated.

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21805	Continued From page 67 SUGGESTED METHOD OF CORRECTION: The administrator with the other department managers could review the dining room service for all residents to ensure a dignified experience. The facility could look at approaches to move toward changing insititutional practices. Education could be provided and audits conducted to ensure compliance. The results could be reviewed by the quality committee TIME PERIOD FOR CORRECTION: Thirty (30) days.	21805		
21815	MN St. Statute 144.651 Subd. 7 Patients & Residents of HC Fac.Bill of Rights Subd. 7. Physician's identity. Patients and residents shall have or be given, in writing, the name, business address, telephone number, and specialty, if any, of the physician responsible for coordination of their care. In cases where it is medically inadvisable, as documented by the attending physician in a patient's or resident's care record, the information shall be given to the patient's or resident's guardian or other person designated by the patient or resident as a representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to provide notice as required to 1 of 2 residents and/or resident representatives in the sample (R1) who was assigned a new physician. Findings include: R1's wife was interviewed via telephone on 9/21/10 at 3:20 p.m. R1's wife stated the resident was moved a few months ago from one unit to	21815		

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another. When asked if the move resulted in a change in physician and nurse practitioner she stated, "I believe he has the same doctor, but a different nurse practioner--as far as I know."

The registered nurse (RN-B) was interviewed on 9/21/10, at 9:25 a.m. She verified the resident transferred from one unit to another on 6/30/10, resulting in a change in nurse practitioner (NP) and physician assignments. The RN was asked whether residents were informed of the changes and/or were given a choice of physicians she replied, "I believe they do. They have a choice." The RN was informed that although R1's wife was aware the NP changed, she was under the impression he had the same physician. The RN then asked the licensed social worker (LSW-B) if she was responsible for informing residents and/or their representatives of the changes. The LSW said she was unsure who communicated "that they don't really have a choice--I don't tell them. I think if they object we maybe make that happen." The RN and LSW then asked NP-A whether residents could maintain their physician if they changed units. The NP stated, "They can't." The RN asked how that information was communicated to the resident and/or representative she stated, "I have no idea. To my knowledge there's no process addressing it. Again, how that's conveyed to family, I don't know. Several years ago there was talk of changing this, but that got nixed." She said the reason was that several physicians refused to see residents on different units, and thought it would cause confusion among the staff as to who should be called. The NPs were employed by the facility and strictly saw residents on their assigned unit.

The facility provided a form titled, Identity of

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21815	Continued From page 69 Resident's Attending Physician and Facility's Allied Health Services. The form said, "The attending physician at the Minnesota Veteran's Home--Minneapolis, responsible for your care is: _____" Physician names were then listed and the appropriate physician checked. In addition, a letter dated 4/28/10 was provided by the facility informing residents on that unit (where R1 was residing), a new physician was being assigned as the units' primary physician. However, R1 did not move to the unit until 6/30/10. SUGGESTED METHOD FOR CORRECTION: The director of social services could work with the administrator to ensure residents and/or their representatives are provided with information related to physician changes. The facility could determine an appropriate policy and procedure. The quality committe could monitor for compliance. TIME PERIOD FOR CORRECTION: Thirty (30) days.	21815		
21990	MN St. Statute 626.557 Subd. 4 Reporting - Maltreatment of Vulnerable Adults Subd. 4. Reporting. A mandated reporter shall immediately make an oral report to the common entry point. Use of a telecommunications device for the deaf or other similar device shall be considered an oral report. The common entry point may not require written reports. To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment, any evidence of previous maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the	21990		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21990	Continued From page 70 reporter believes might be helpful in investigating the suspected maltreatment. A mandated reporter may disclose not public data, as defined in section 13.02, and medical records under section 144.335, to the extent necessary to comply with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, bruises of unknown origin were not called to the designated State agency for 1 of 4 (R42) whose bruises of unknown origin reviewed. Findings include: R42's incident report was reviewed, which indicated the resident had a bruise described as bluish in color and measuring 8.0 x 3.5 cm on the lateral right forearm on 7/6/10. The report noted the cause of the bruise was unknown, and the resident was unable to explain what happened. A registered nurse manager (RN-J) reviewed incident. Report identified cause was unknown etiology, and R42 potentially bumped into an object. R42 was identified to be on aspirin therapy and was at increased risk for bruising. The assistant director of nursing (ADON-A) reviewed incident report and did not feel it met the criteria to be reported to the State agency. RN-J was interviewed on 9/23/10, at 10:45 a.m. RN-J stated when an incident report was received, she looked at the whole picture, including looking back to see whether a resident bruised easily and at medication use. RN-J explained the resident did not have frequent bruising. The resident ambulated independently and had a history striking out at staff and other residents. The RN said a suspicious bruise that required more in depth investigation would depend on the size and the location. The bruise	21990		

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21990	Continued From page 71 would then be discussed with the interdisciplinary team, as to whether it warranted reporting to the designated State agency. RN-J verified there was no documentation of conversations with staff regarding investigation into the source of the bruise. Vulnerable Adult Reporting policy with revision date of 8/09 indicated: "An injury of unknown origin was considered when no one observed the source of injury that could not be explained by the resident. This must be reported to the Office of Health Facility Complaints by the facility if, after investigation, the injury is not explainable as to actual location or cause, if suspicious because of the nature of the injury, size or recurrence...Resident is resistive to care is not an adequate reason for recurrence...." The interim administrator was interviewed on 9/23/10, at 11:10 a.m. The administrator explained it was a standard of practice to investigate, and she would want injuries an unknown sources to be looked at and investigated to determine whether they required reporting to the designated State agency. SUGGESTED METHOD FOR CORRECTION: The administrator, director of nursing, and licensed social worker could review and revise as necessary the policies and procedures regarding the internal process of reporting/investigating the process of abuse or maltreatment. Training could be provided as necessary. The appropriate staff could monitor to ensure reporting requirements are met. Results could be reviewed by the quality committee. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21990		

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22000	MN St. Statute 626.557 Subd. 14 (a)-(c) Reporting - Maltreatment of Vulnerable Adults Subd. 14. Abuse prevention plans. (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency. (b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse. (c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal	22000		

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22000	Continued From page 73 misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult. This MN Requirement is not met as evidenced by: Based on interview and record review bruises of unknown origin were not thoroughly investigated for 1 of 4 residents (R42) whose bruising of unknown origin were reviewed. Findings include: R42's incident report was reviewed, which indicated the resident had a bruise described as bluish in color and measuring 8.0 x 3.5 cm on the lateral right forearm on 7/6/10. The report noted the cause of the bruise was unknown, and the resident was unable to explain what happened. A registered nurse manager (RN-J) reviewed incident. The report identified cause was unknown etiology, and R42 potentially bumped into an object. R42 was identified to be on aspirin therapy and was at increased risk for bruising. The assistant director of nursing (ADON-A) reviewed incident report and did not feel it met the criteria to be reported to the state agency. R42 had diagnoses including dementia with behavioral disturbances. The Minimum Data Set (MDS) dated 8/31/10, identified R42 as having poor decision making skills. The resident was independent with ambulation and transfers, and resisted care daily.	22000		

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22000	Continued From page 74 Nursing notes dated 7/6/10, identified R42 had a bruise on right forearm measuring 8.0 x 3.5 centimeters (cm). The next nursing note for R42's bruise was dated 7/7/10, and R42 refused to have staff look at bruise on the arm. Nursing note 7/12/10, indicated staff updated the doctor about bruise on right arm that was of an unknown origin. There were no further nursing notes addressing R42's bruise on right arm. The incident report was reviewed with ADON-A on 9/22/10, at 9:30 a.m. and she verified there were no further nursing notes or investigative notes regarding the bruise. The ADON stated R42 received aspirin daily (known to potentiate bruising), was independent with ambulation and had a history of being resistive to cares. RN-J was interviewed on 9/23/10, at 10:45 a.m. RN-J stated when an incident report was received, she looked at the whole picture, including looking back to see whether a resident bruised easily and at medication use. RN-J explained the resident did not have frequent bruising. The resident ambulated independently and had a history striking out at staff and other residents. The RN said a suspicious bruise that required more in depth investigation would depend on the size and the location. RN-J verified there was no documentation of conversations with staff regarding investigation into the source of the bruise. Vulnerable Adult Reporting policy with revision date of 8/09 indicated: "An injury of unknown origin was considered when no one observed the source of injury that could not be explained by the resident...Resident is resistive to care is not an adequate reason for recurrence...."	22000		

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22000	Continued From page 75 The interim administrator was interviewed on 9/23/10, at 11:10 a.m. The administrator explained it was a standard of practice to investigate, and she would want injuries an unknown sources to be looked at and investigated. SUGGESTED METHOD FOR CORRECTION: The administrator, director of nursing, and licensed social worker could review and revise as necessary the policies and procedures regarding investigations into injuries of unknown origin. Training could be provided as necessary. The appropriate staff could monitor to ensure reporting requirements are met. Results could be reviewed by the quality committee. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	22000		
23240	MN Rule 4658.5405 Ventilation Requirements; Existing Constructn Existing facilities must have mechanical exhaust ventilation in the kitchen, laundry, soiled linen collection room, soiled utility rooms, and toilet areas, except if the toilet area is private or semiprivate, and is provided with window ventilation. Ventilation must be provided according to part 4658.4520. This MN Requirement is not met as evidenced by: Based on observation and interview the facility did not have functioning ventilation units on two units in building 6, potentially affecting the approximate 70 residents on those units. Findings include:	23240		

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23240	Continued From page 76 An environmental tour was conducted on 9/22/10, at 2:35 p.m. on the 1st and 2nd floor units in building 6. The ventilation was checked in randomly selected rooms, and the ventilation on the units was determined to be non-functioning. The lack of proper ventilation was not apparent as evidenced by lack of air movement or odors. When interviewed during the tour, the chief engineer agreed the ventilation units were not properly functioning. The engineer also noted the ventilation system was not part of routine maintenance checks. SUGGESTED METHOD FOR CORRECTION: The administrator together with the director of maintenance could periodically monitor the ventilation system to ensure it is working properly. The results could be communicated to the quality committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	23240		

MDH L & C 3201

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Ms. Pam Barrows, Administrator
Minnesota Veterans Home Minneapolis
5101 Minnehaha Avenue South
Minneapolis, Minnesota 55417

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