00933 File

NH BCH

MINNESOTA
MDH
DEPARTMENT of HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7008 2810 0001 2258 1085

September 5, 2012

Mr. Dennis Decosta, Administrator
Minnesota Veterans Home - Minneapolis
5101 Minnehaha Avenue South
Minneapolis, Minnesota 55417

Re: Enclosed State Nursing Home Licensing Orders - Project Number SL00233023 and HL00233083

Dear Mr. Decosta:

The above facility was surveyed on August 13, 2012 through August 16, 2012 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number HL00233083 that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

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

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

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, P.O. Box 64900, St. Paul, Minnesota 55164-0900. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

Please feel free to call me with any questions.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

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 _____	08/16/2012

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

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2 000	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 August 13 through 16, 2012, 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	This Credible Allegation of Compliance has been prepared and timely submitted. Submission of this Credible Allegation of Compliance is not a legal admission that a deficiency exists or that the Statement of Deficiency were correctly cited, and is also not to be construed as an admission against interest of the Facility, its Administrator or any employees, agents or other individuals who draft or may be discussed in this Credible Allegation of Compliance. In addition, preparation and submission of this Credible Allegation of Compliance does not constitute an admission or agreement of any kind by Facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. Accordingly, we are submitting this Credible Allegation of Compliance. The submission of the Credible Allegation of Compliance within this time frame should in noway be considered or construed as agreement with the allegations of non-compliance or admissions by the facility.	

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
		9/26/2012

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2 000	Continued From page 1 Certification Program; Complaints; 85 East Seventh Place, Suite 220; P.O. Box 64900, St. Paul, Minnesota 55164-0900. Complaint #HL00233083 was investigated during the survey and was not substantiated.	2 000		
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 interview and document review, the facility failed to develop a comprehensive dialysis care plan for 2 of 2 residents (R8 and R9) that were reviewed who received dialysis services. Findings include: R8's clinical record lacked care plan development that accurately and comprehensively reflected the status of the resident for all relevant factors related to dialysis care. The care plan did not address the scheduled days of treatment, location and telephone number of the dialysis center, scheduled transportation, responsibilities of the dialysis agency with regard to laboratory work, the emergency procedures for missed dialysis	2 560	It is the policy of the Minnesota Veterans Home to ensure residents who are receiving dialysis have a comprehensive plan of care. Resident R8 care plan has been revised to reflect the status of the resident's care plan for all relevant factors related to dialysis care. 9-20-12	

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2 560	Continued From page 2 treatments due to weather emergencies, illness or refusal, as well as potential or actual complications related to the porta-catheter located in the resident's chest area. R8's diagnosis included end stage renal disease requiring hemodialysis. The care plan dated 7/2/12, lacked emergency interventions should R8 miss a dialysis treatment due to weather emergencies, lack of transportation, illness or R8's refusal to go to dialysis. R8's medical record lacked a policy from Golden Valley Dialysis that addressed a procedure guideline which indicated what actions the facility should do when the resident missed a dialysis treatment due to weather emergencies, lack of transportation, illness or R8's refusal to go to dialysis. On 8/15/12, at approximately 9:30 a.m., the unit coordinator registered nurse confirmed the care plan for R8 lacked the information regarding emergency interventions, days of treatment and the interventions pre and post dialysis treatment that the facility should do. She added that there should have been a form completed which addressed these areas related to dialysis at the time the resident was admitted. No further information was provided. R9's clinical record lacked care plan development that accurately and comprehensively reflected the status of the resident for all relevant factors related to dialysis care. The care plan did not address the scheduled days of treatment, location and telephone number of the dialysis center, scheduled transportation, responsibilities of the dialysis agency with regard to laboratory work, the emergency procedures for missed dialysis treatments due to weather emergencies, illness	2 560	Guidelines have been received from dialysis facility and incorporated into the residents plan of care. Completed on 9-20-12	

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2 560	Continued From page 3 or refusal, as well as potential or actual complications related to the porta-catheter located in the resident's chest area. R9's diagnosis included end stage renal disease requiring hemodialysis. The care plan dated 6/28/12, lacked emergency interventions should R9 miss a dialysis treatment due to weather emergencies, lack of transportation, illness or R9's refusal to go to dialysis. R9's medical record lacked a policy from Minneapolis Veterans Administration Health Care System that addressed a procedure/guideline which indicated what actions the facility should do when the resident missed a dialysis treatment due to weather emergencies, lack of transportation, illness or R9's refusal to go to dialysis. On 8/15/2012, at 9:00 a.m. the registered nurse senior confirmed the care plan for R9 lacked the information regarding emergency interventions, days of treatment and the interventions pre and post dialysis treatment that the facility should do. No further information was provided. SUGGESTED METHOD FOR CORRECTION: The director of nursing or designee could direct staff to develop a care plan to include appropriate interventions for all identified care needs. A monitoring program could be established in order to assure ongoing and effective care plan interventions in response to resident care needs. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 560	Resident R9's care plan has been revised/updated to reflect the status of the resident's care plan for all relevant factors related to dialysis Care guidelines have been incorporated into the resident's plan of care on 9-26-12. A dialysis care plan has been developed for all residents to include interventions for appropriate care needs. DON or designee will periodically audit care plans to ensure compliance and report to Quality Council. Audits will continue until compliance is determined by the Quality Council.	
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the	2 915		

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2 915	Continued From page 4 comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, document review, and interview, the facility did not ensure 1 of 4 residents (R26) was transferred properly even though the transfer belt was applied correctly to minimize injury/re-injury to upper extremities. Findings include: R26 was admitted with diagnoses of Alzheimer's disease and gait abnormality. R26's transfer/gait belt was applied properly, however the transfer was not utilized to prevent injury/re-injury to upper extremities. Observation of R26 on 8/14/12, at 11:15 noted the following: The human services technician (HST)-A approached R26 and stated "it's time for your shower". HST-A then wheeled R26 down the	2 915	It is the policy of the Minnesota Veterans Home to ensure residents comprehensive assessment includes rehab activities of daily living according to the residents abilities. Corrective action/education regarding use of a transfer belt when transferring residents was taken with HST-A for inappropriate transfer technique with R26 on 8-14-12.	

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2 915	Continued From page 5 hallway and stopped in front of the resident room. HST-A stated, "I need to get supplies." R26 began to wheel self back toward to the dining room. At 11:25 a.m. HST-A came out of the room and again brought R26 back to their room. HST-A put the transfer belt loosely on R26. HST-A proceeded to transfer R26 out of the wheelchair by grasping the right arm and forearm and exerting upward pressure. R26 was then pivot turned and told to sit on the toilet. HST-A did not attempt to utilize the donned gait belt on R26. R26 made a grabbing motion for balance and HST-A directed R26's hand to the toilet safety bar. The gait belt was removed, as was R26's clothing. R26 was noted to have two bruises on the right inner and upper arm, one large bruise on the right forearm, and a smaller bruise on the left forearm. The bruises had multiple shades of red/purple bruising from deep purple to medium purple. The shower chair was placed away from the resident and into the shower stall. HST-A did apply the transfer belt correctly, but then used the right arm and forearm to transfer R26 out of the wheelchair by exerting upward pressure on the right arm. HST-A then tilted R26 forward into ambulation toward the shower stall. R26 was grabbing outward to attempt to balance self and was told to hold onto the shower safety bar. The shower chair was positioned behind R26 and R26 was told to sit in the shower chair. R26 was hesitant to let go of the safety bar. R26 was the bathed. Licesned practical nurse (LPN)-A performed the skin check on R26 and noted the bruises on the right arm, and stated, "they were old." An incident report initiated 5/7/12, describes two new bruised areas on right arm. The first bruise measured 2 centimeters (cm) in diameter on the upper arm, midway between elbow and armpit.	2 915		

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F 915	Continued From page 6 The second bruise was 4 cm by 2 cm on lower right arm. The incident report noted, "Resident was unable to state how the bruising occurred. Resident self propels her wheelchair throughout the halls and frequently runs into other wheelchairs and handrails. [R26] was also combative with cares. Interventions included, protect from bumping into obstacles, but don't restrict wandering, very fragile skin, bruises easily." A temporary care plan dated 5/7/12, for bruise hematoma, indicated bruise, right upper arm 2 cm, right lower arm 4 cm by 2 cm. The care plan interventions included observe daily and assess for changes in appearance, notify physician if changes were inconsistent with normal resolution. The staff was to protect area from further injury and assess for safety issues. Staff were to use extra caution in transferring and handling resident. The incident report dated 7/19/12, indicated a 3 cm by 3.5 cm bruise on left upper arm and old faded bruise gray in color on forearm, left 5 cm by 2.5 cm also upper arm right arm dark purple bruise 1.5 cm diameter. She was unable to tell staff how it happened. The incident report interventions directed staff to protect from bumping into obstacles and place arm protectors on that resident. The minimum data set (MDS) dated 8/8/12, indicated R26 had both short term and long term memory loss, had moderately impaired cognitive skills, was short tempered and easily annoyed, did strike out at others, had disruptive behaviors and wandered daily. At 12:00 p.m. on 8/14/12, LPN-A verified that the	F 915		

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2 915	Continued From page 7 bruises on the right arm could potentially have been caused by the arm grasp/lift performed by HST-A. At 12:15 p.m.on 8/14/12, NM-A stated HST-A, "Should have used a gait belt to transfer and not pulled on arm and shoulder." LPN-A further replied, "An incident report will be done and the bruises will be measured." NM-A further stated, "[LPN-A] had reported the bruises already, but thought they were old." At 3:00 p.m. on 8/14/12, NM-A reported the right upper arm bruise measured 5 cm by 5 cm, the right forearm bruise measured 3 cm by 3 cm and the left forearm bruise measured 1 cm by 2 cm. NM-A did verify that the bruises on the right arm are larger that when last measured on 5/7/12. NM-A further stated the staff had already been retrained. At 3:00 p.m. on 8/15/12, the DON stated, "...very disturbing to me, we have trained and trained the staff." SUGGESTED METHOD FOR CORRECTION: The DON or designee(s) could review and revise as necessary the policies and procedures regarding the need for assistance with transfers. The DON or designee (s) could provide training for all appropriate staff on these policies and procedures. The DON or designee (s) could monitor to assure all residents are receiving adequate and appropriate care. TIME PERIOD FOR CORRECTION: Twenty One (21) Days.	2 915	Transfer belt policy and safe patient handling policy have been reviewed and revised. In-service for direct care staff was developed and implemented on 9-13-12 to reinforce correct application and use of a transfer belt including a return demonstration by staff to ensure competency. Completed 9-26-12. RNM/designee will perform random care observation audits to ensure compliance with policies and resident care plan and report to Quality Council. Audits will continue until compliance is determined by the Quality Council.	
21055	MN Rule 4658.0625 Subp. 2 Menus; Food Habits and Customs	21055		

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21055	Continued From page 8 Subp. 2. Food habits and customs. There must be adjustment to the food habits, customs, likes, and appetites of individual residents including condiments, seasonings, and salad dressings. There must be resident involvement in menu planning. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to follow the posted menu for the pureed diets. This had the potential to affect 40 of 287 residents in the facility who received a pureed diet. Findings include: The pureed diet menu for the facility limited food choices for residents by restricting certain foods. The changes to the menu were not posted or provided to the residents and/or guardians. The pureed diet extension sheet was reviewed with the director of dietary on 8/15/12, at 1:00 p.m. The diet followed the national dysphagia diet (NND) protocol for level 1: dysphagia pureed. The diet principles read, "the diet consists of pureed, homogenous, and cohesive foods. Food should be 'pudding like'. No course textures, raw fruits or vegetables, nuts, and so forth are allowed. Any foods that require bolus formation, controlled manipulation, or mastication are excluded. Blenderized foods are stabilized with a variety of products to obtain a consistency similar to pudding or mashed potatoes". The dietary director (DD) explained that she had worked with the speech therapist to develop the menu to work within the NDD Level 1: dysphagia	21055	It is the policy of the Minnesota Veterans Home to ensure the posted menu is followed for puree diets.	9-27-12

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21055	Continued From page 9 pureed guidelines. But, since the diet excluded fresh fruits and vegetables and any items with skins or any items that may not puree up to a smooth pudding consistency, substitutions were made from the regular diet. Some of the substitutions made were: pureed pears in place of blueberries with topping due to the skins on the blueberries; chocolate pudding in place of a brownie; Cream of Wheat in place of oatmeal; V8 juice in place of rotini pasta salad due to the addition of celery and other vegetables. Whether all 40 residents in the facility on a pureed diet required the level of restriction as indicated by the diet protocols was not clear. During an interview with the director of nursing (DON) on 8/16/12, at approximately 9:00 a.m. he indicated he was not aware of the degree of restriction for the pureed diet. He did not think restriction of pureed fresh fruits, and vegetables would be needed for all cases. The speech therapist could not be reached. At 10:00 a.m. on 8/16/12, the DON and the DD were interviewed. The DD indicated the menu changes to the pureed diet were available to the staff. Family members and/or residents would need to ask the staff for information on what would be served to residents on a pureed diet. The DD indicated family or residents were not routinely given the information about changes to the menu for the pureed diet. SUGGESTED METHOD FOR COMPLIANCE: The administrator with the director of food service could review and revise food service policies and procedures to assure that food is served to residents as indicated on the weekly menu. TIME PERIOD FOR COMPLIANCE: Twenty one	21055	Food service policies have been reviewed to assure food served to residents are as indicated on the menu. Posted menus will reflect food served to residents completed 9-23-12.	

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21055	Continued From page 10 (21) days.	21055		
21285	MN Rule 4658.0710 Subp. 2 Admission Orders and Physician Evaluations Subp. 2. Admission orders. A nursing home must have physician orders for a resident's admission and immediate care at the time of admission. This MN Requirement is not met as evidenced by: Based on document review and resident and staff interview, the facility failed to obtain physician's admission orders for dialysis for 1 of 1 newly admitted resident (R8) that was reviewed for dialysis treatment. Findings include: R8 was admitted to the facility on 6/13/12, without physician's orders for dialysis treatment including care of access site, days of treatment, and emergency interventions the facility would utilize with regards to refusal of treatment, weather causing missed treatment and illness of R8 to cause missed treatment. During the initial facility tour, at 1:15 p.m. on 8/14/12, and again at 5:00 p.m., R8 was interviewed in his room and began to describe his four year dialysis treatment history and that he still was being treated three times a week. He stated his previous access sites had been in his arms but at present it was located in his chest area. When questioned if there had been any problems with this site and how it was cared for, he added that it at times it had to be replaced so	21285	It is the policy of the Minnesota Veterans Home to ensure all residents have physician orders for the resident's admission and immediate care at the time of admissions.	

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 _____	08/16/2012

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
21285	Continued From page 11 dialysis could be done but the staff did not do anything with it here nor check it for anything to see if it had a problem. He did not know what the staff would have to do in case of an emergency and wasn't sure if the staff knew. Record review indicated the attending physician's office was notified regarding the resident's admission and orders were verified regarding the medications, diet, and fluid restrictions. Review of those admission orders lacked the following: the scheduled days of treatment, location and telephone number of the dialysis center, responsibilities of the dialysis agency with regard to laboratory work, the emergency procedures for missed dialysis treatments due to weather emergencies, illness or refusal, as well as potential or actual complications related to the porta-catheter located in the resident's chest area. On 8/15/12, at 9:00 a.m. the Unit manager registered nurse (RN-Mgr) was interviewed regarding R8's admission dialysis orders not being complete for treatment days, emergency interventions and general care to access sites. The RN-Mgr said the facility should have completed a specific form for dialysis information when the resident was admitted which the physician would then approve. She confirmed the admission orders did not have specific orders for the treatment schedule, the emergency interventions and general access site. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing or designee could develop a system that would ensure all residents had signed physician's orders at the time of admission. The DON could provide education for appropriate staff and develop a monitoring	21285	The physician order policy/procedure has been revised. Completed on 9-26-12. A dialysis physician order template was developed to include relevant factors of dialysis care to be implemented on admission by the medical provider. Completed 9-26-12. The DON/designee will perform random audits to ensure physician orders are signed at the time of admission. Audit findings will be report to Quality Council. Audits will continue until compliance is determined by the Quality Council.	

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21285	Continued From page 12 system to ensure that all residents had signed physician's orders. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21285		
21305	MN Rule 4658.0715 A.-I. Medical Information For Clinical Record A physician or physician designee must provide the following information for the clinical record: A. the report of the admission history and physical examination; B. the admitting diagnosis; C. a description of the general medical condition, including disabilities and limitations; D. a report of subsequent physical examinations; E. instructions relative to the resident's total program of care; F. written orders for all medications with stop dates, treatments, rehabilitations, and any medically prescribed special diets; G. progress notes; H. any advanced directives; and I. condition on discharge or transfer, or cause of death. This MN Requirement is not met as evidenced by: Based on document review and resident and staff interview, the facility failed to obtain physician's admission orders for dialysis for 1 of 1 resident (R9) that was reviewed for dialysis treatment. Findings include: On 8/13/12, at 5:45 p.m. R9 indicated he received dialysis treatment three times a week at the	21305	It is the policy of the Minnesota Veterans Home to ensure the physician or physician designee provides physician admission orders and information for the clinical record.	9-21-12

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21305	Continued From page 13 hospital. R9 was admitted to the facility on 5/15/00. Review of the current physician's orders dated 8/15/12, revealed no order for dialysis treatment which included days of treatment, and emergency interventions the facility would utilize with regards to refusal of treatment, weather causing missed treatment and illness of R9 to cause missed treatment. The physician orders for R9 lacked the following: the scheduled days of treatment, location and telephone number of the dialysis center, responsibilities of the dialysis agency with regard to laboratory work, the emergency procedures for missed dialysis treatments due to weather emergencies, illness or refusal. On 8/15/12, at 9:00 a.m. the registered nurse senior (RNS) confirmed R9's orders lacked the treatment days and emergency interventions for dialysis treatment. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review policy and procedures related to the physician orders. Facility could provide education to staff to ensure understanding of the policy. Provide ongoing monitoring to ensure written orders are provided for all medications and treatments. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21305	The physician order policy/procedure has been revised. Completed 9-26-12. Medical provider and licensed staff will be educated on the physician order policy. A dialysis physician order template has been developed to include ill relevant factors of dialysis care to be implemented on admission by the medical provider. Completed 9-26-12. The DON/designee will complete random audits to ensure written orders are provided for all medications and treatments. Audit results will be report to Quality Council. Audits will continue until compliance is determined by the Quality Council.	
21855	MN St. Statute 144.651 Subd. 15 Patients & Residents of HC Fac.Bill of Rights Subd. 15. Treatment privacy. Patients and residents shall have the right to respectfulness	21855		

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21855	Continued From page 14 and privacy as it relates to their medical and personal care program. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly. Privacy shall be respected during toileting, bathing, and other activities of personal hygiene, except as needed for patient or resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation interview, the facility failed to ensure privacy was maintained during the provision of cares for 1 of 2 residents (R27) reviewed who required the use of palm protector hand splints, and for 1 of 3 residents (R11) who was observed during morning cares. Findings include: R27 had diagnoses that included fronto-temporal dementia, alteration of consciousness, Bells Palsy, and Parkinson disease. On 8/12/12, at 6 p.m., R27 was observed to be seated in an adaptive wheelchair, in the dining room at a table with five peers. R27 had bilateral palm protector splints on that had a Velcro strap that crossed the back of his hand to keep them in proper position which had his name printed in large black magic marker letters. R27's name was easily readable by his peers, staff, and any other persons that would be in the area. The same was also noted on 8/15/12, after his morning cares and the same palm protector splints were applied. On 8/15/12, at 7:20 a.m. during R27's morning personal cares, nursing assistant (NA)-A was	21855	It is the policy of the Minnesota Veterans Home to ensure privacy is maintained for residents. All resident adaptive equipment has been checked and is labeled in a manner to protect the residents personal privacy. Completed 9-26-12.	

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21855	Continued From page 15 asked about the marking of the palm protectors with his name but did not know who had written his name on them. R27 did not respond when questioned, at either observation, about the palm protector splints but sat with his eyes closed. On 8/15/12, at 9:30 a.m., the registered nurse unit manager (RN-Mgr) verified R27's palm protector splints should not have his name on the straps so that he would be identified to other persons. She agreed that was a privacy problem for R27. The facility failed to maintain privacy for R11 during observation of cares. On 8/15/12, at 7:18 a.m. morning cares were observed for R11. The human service technician (HST)-B was observed to assist the resident while in bed with personal cares which include removing incontinent pad and providing peri care with the room privacy curtain open. R11's roommate remained in the room during observed cares, sitting in a room chair on his side of the room and was in view of the morning cares of R11. On 8/16/12, at 10:00 a.m. the registered nurse senior (RNS) was informed of the above findings. No further information was provided. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing (DON) or designee(s) could review and revise as necessary the policies and procedures regarding resident personal privacy. The DON, or designee(s) could provide an in-service for all appropriate staff on providing personal privacy. The DON, or designee(s) could monitor to assure each resident 's personal	21855	Corrective action/education regarding providing resident personal privacy was taken with HST-B on 8-13-12 for not providing personal privacy during cares with resident R11 on 8-13-12. DON/designee will provide in-service for all appropriate staff on providing personal privacy to be completed by 10-10-12. The DON/designee will conduct random audits to assure resident personal privacy. Audit findings will be report to the Quality Council. Audits will continue until compliance is determined by the Quality Council.	

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21855	Continued From page 16 privacy. TIME PERIOD FOR CORRECTION: Thirty (30) days.	21855		

file

MINNESOTA
MDH
DEPARTMENT of HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

September 5, 2012

Mr. Dennis Decosta, Administrator
Minnesota Veterans Home - Minneapolis
5101 Minnehaha Avenue South
Minneapolis, Minnesota 55417

Re: Project Number SL00233023

Dear Mr. Decosta:

The above facility survey was completed on August 16, 2012 for the purpose of assessing compliance with Minnesota Department of Health Boarding Care Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Attached is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

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

Feel free to contact me with any questions related to this letter.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure(s)
cc: Original - Facility
Licensing and Certification File

L00233s12lic.rtf

Minnesota Department of Health

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3 000	INITIAL COMMENTS ******ATTENTION****** BOARDING CARE HOME LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On August 13 through 16, 2012, surveyors of this Department's staff, visited the above provider and was in compliance with the Minnesota State Boarding Care Home Rules.	3 000		