MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 2780 0001 4939 7947

October 18, 2011

Ms. Shelley Kendrick, Administrator
Minnesota Veterans Home - Minneapolis
5101 Minnehaha Avenue South
Minneapolis, Minnesota 55417

Re: Enclosed State Nursing Home Licensing Orders - Project Number SL00233022

Dear Ms. Kendrick:

The above facility was surveyed on September 26, 2011 through September 29, 2011 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

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

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

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 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,

Gloria Derfus

Gloria Derfus, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3792 Fax: (651) 201-3790

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

00233s11nhlic.rtf

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 _____	09/29/2011

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	2 000		

*****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 September 26 - 29, 2011, 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

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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		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, document review, and interview, the facility failed to ensure that 2 of 7 residents (R17 and R6) in the sample with pressure ulcers received the necessary care/treatment to promote healing and prevent further development of pressure ulcers for residents identified at risk for the development of pressure ulcers. Findings include: R17's active diagnoses included neurogenic bladder, diabetes mellitus, and neuropathy. R17	2 900		

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2 900	Continued From page 2	2 900		

had a pressure ulcer and the facility did not conduct an accurate assessment of the resident's clinical condition and pressure ulcer risk factors. R17 did not receive intervention to prevent further progression in severity of the pressure ulcer.

On 9/27/10, at 2:10 p.m. wound care was observed for R17. Registered nurse (RN)-A and registered nurse manager (RNM)-A completed cares. At the time of observation RNM-A measured the open areas and found the right ischial area measured 1.5 centimeter (cm) by 1.8 cm and was unstageable due to slough tissue (necrotic light colored avascular tissue) covering the area. The left ischial was measured as four cm by six cm with intact pink skin and superficial depth. RN-A and RNM-A indicated the pressure areas continued to show improvement since occupational therapy (OT) interventions to reduce shearing (defined as interaction of both gravity and friction against the surface of the skin) were initiated for R17.

R17's Minimum Data Set (MDS) dated 7/12/11, indicated the resident did not have cognitive impairment. The MDS indicated that for transfers between surfaces (bed, chair, wheelchair) R17 required extensive assistance from one person to physically assist. The MDS indicated the R17 was independent in bed mobility, moving from lying position, side to side and repositioning body. The resident's range of motion for the lower extremities was indicated to be impaired on both sides. The MDS indicated that R17 had a current pressure ulcer at the time of the assessment, and it was described as an unstageable ulcer with suspected deep tissue injury. Skin and ulcer treatments included pressure reducing device for chair, bed, nutrition and hydration intervention and application of medication.

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2 900	Continued From page 3	2 900		

R17 was hospitalized for an infection on 7/20/11, and was re-admitted to the facility on 7/27/11. The facility's readmission Head to Toe Body Check dated 7/27/11, indicated that there was a scabbed area on the resident's right buttock. Conversely, the Skin Risk Factors Checklist dated 7/29/11, indicated that the resident had a "Stage II pressure wound (defined as partial skin thickness loss involving epidermis, dermis or both) on left ischial".

A Braden Scale Assessment (an assessment that indicates risk for pressure ulcer development) indicated that the resident was at a mild risk of pressure ulcer development. A progress note dated 7/28/11, noted that "buttocks is healed" and was signed by RN-A. A progress note dated 8/2/11, read "it was discovered that his buttock wound had been rubbed open in spots, measuring 3 cm by 1.5 cm total area, but was not one complete wound". A Braden Scale Assessment dated 8/3/11, indicated that R17 was at mild risk for pressure ulcer development. There was no evidence in the documentation available which indicated that a Skin Risk Factors tool was completed after the wound was noted on 8/2/11. There were no treatment orders for the pressure ulcer noted on the resident's Physician's orders from 8/2/11 through 8/10/11. There was no documentation available showing that Weekly Wound Documentation was completed between 8/2/11 and 8/10/11. In the case of R17, the tool was completed after re-admission, but the assessment was inaccurate.

A Referral Physician's Order Sheet described an appointment R17 had at the Minnesota Veteran's Hospital (MVH) Wound Clinic on 8/10/11. The facility nursing comments directed to the wound

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2 900	Continued From page 4 clinic regarding R17's skin were "multiple Stage II pressure ulcers due to excessive moisture and shearing". The return comments to the facility from the Wound Clinic indicated the resident's skin problems were related to moisture under the buttocks, and the residents cushion did not provide adequate pressure relief or circulation. The comments section indicated that they were to place a consult with OT for a seating and positioning evaluation for R17. New orders included medication and dressing changes as well as limiting the use of disposable briefs. A progress note dated 8/10/11, indicated that R17's nurse practitioner was notified of the status of his pressure ulcers. The 8/10/11, Weekly Wound Monitoring documentation indicates R17 had a Stage II pressure ulcer on the left ischial that was two cm in length by two cm in width by 0.1 cm in depth. The area was described as granulation tissue with no drainage and the surrounding skin was red. The wound was described as "a field of many small superficial areas, looks like shearing". The care plan interventions noted were wheelchair cushions, treatments as ordered, monitoring as set by the facility policy, alternating air mattress and no incontinence briefs. The summary of the problem was R17 had been resistive with using the OT preferred cushions but the MVH Wound Clinic was to see him and he would be compliant with the cushion they prescribed. The 8/17/11, Weekly Wound Monitoring indicated that the pressure ulcer had increased in size from the last assessment. The wound was described as a Stage II pressure ulcer that was four cm in length by two cm in width by 0.1 cm in depth. The wound was described as "slough" with no	2 900		

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2 900	Continued From page 5 drainage and pink surrounding skin. No care plan interventions were noted. A progress note dated 8/17/11, indicated that R17 had Stage II open areas on right ischial measuring two cm by two cm, right buttocks measuring four cm by three cm and left ischial four cm by three cm. The note indicated that the right ischial and buttock area were new since the resident's hospitalization and the left ischial area was worse. That documentation was noted to be inconsistent with the above Weekly Wound Monitoring documentation completed on the same date (noted above). A progress note dated 8/18/11, that the Nurse Practitioner (NP) was notified that R17's pressure ulcer size and number of open areas on buttocks and ischial areas had increased. The NP responded that staff should continue with the current medication orders for treatment and to monitor the area. A Physical Therapy (PT) evaluation was completed with R17 on 8/23/11, for shoulder strengthening. There was no evidence in the medical record that a seating and positioning evaluation was completed or addressed as ordered by the MVH Wound Clinic on 8/10/11. A progress note dated 8/28/11, indicated the R17 continued to have pressure areas on the right ischial measuring one cm by 0.5 cm Stage II, left ischial three cm by 1.8 cm Stage II, and across coccyx and buttocks measuring four cm by six cm Stage I (intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area). The note indicated the	2 900		

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2 900	Continued From page 6 resident continued to receive the same medication and treatment orders from the MVH Wound Clinic on 8/10/11. Progress notes reveal that R17 was seen by the facility's Wound Care Nurse, assistant director of nursing (ADON)-A, on 9/8/11. ADON-A assessed the resident's pressure areas as follows "Large Stage III pressure ulcer {defined as full thickness skin loss involving damage to or necrosis of underlying tissue that may extend to, but not through, underlying fascia} to left ischial tuberosity {IT}. Wound is oval in shape over IT and extending toward lower buttocks/upper thigh. Wound bed is beefy red with macerated edges. Wound bed is moist and has no signs or symptoms of infection. Perineum wound is within normal limits and blanches. Smaller Stage II pressure ulcer over right IT, round in shape. Wound bed is moist and beefy red in color with noted adipose tissue visualized in center of wound bed. Wound edges are regular and attached. No signs of infection, denies pain". The note further detailed that ADON-A assessed that the open areas were related to R17 self transferring out of the wheelchair, and treatment recommendations for treatment included limited time up in chair, frequent repositioning, hydrocolloid dressing (an opaque dressing used to provide a moist healing environment, while protecting from contamination) and use of standing lift for transfers to decrease shearing. ADON-A made a referral to the facility's occupational therapist-A to work with the client on self-transferring strategies to reduce shearing. RNM-A was interviewed on 9/28/11, at 12:30 p.m. RNM-A indicated that a consult was put in for a MVH OT assessment, but that it was canceled and the facility was not notified. RNM-A again	2 900		

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2 900	Continued From page 7 indicated she was on vacation at the time the referral was made and was unclear on why it was not routed on to the facility's OT department. RNM-A was interviewed on 9/28/11, at 2:00 p.m. The RNM-A was asked to clarify the above documentation of the resident's pressure areas. RNM-A indicated that she was not certain which documentation was correct because she was on vacation during the dates noted. The RNM-A stated that she tended to believe that the progress note documentation signed by RN-A on 7/28/11, was correct because they were R17's usual caregiver. RNM-A also indicated there was a "previous values" option on the Skin Risk Factors Checklist where the caregiver could fill in the values of the last assessment. RNM-A believed that was done in error and that the resident was in fact readmitted with a healed pressure ulcer as stated in the progress notes and on the Head to toe Body Check. The RNM-A acknowledged that the Skin Risk Factors Checklist was likely an inaccurate assessment. ADON-A was interviewed on 9/29/11, at 9:45 a.m. ADON-A stated that not everyone in the facility is seen for wound evaluation, but residents with Pressure Ulcers greater than a Stage II would typically be seen. ADON-A stated that R17's open areas were reported to her through a report from RNM-A during the facility's daily "24 hour report" meeting and she saw the resident after receiving the report on 9/8/11. ADON-A was asked if she was aware about the resident's MVH Wound Clinic assessment on 8/10/11. ADON-A stated she was familiar with the clinic and aware that they saw R17 on occasion, but was not aware of that particular visit because she had been on vacation at that time. ADON-A stated that typically referrals to OT from the wound clinic	2 900		

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2 900	Continued From page 8 would be reviewed by the nurse on the floor who receives the referral and routed appropriately. ADON-A stated that for resident convenience, the OT for the facility typically sees the resident in the facility rather than receiving the assessment at MVH. When asked why that particular referral to OT was not completed, ADON-A responded that there may have been a miscommunication between MVH and the facility, and that "it appears it got missed". ADON-A stated that she made a referral to OT after her assessment on 9/8/11. Occupational therapist-A was interviewed on 9/29/11, at 10:30 a.m. occupational therapist-A indicated he initiated an assessment and consultation with R17 after receiving the referral from ADON-A on 9/8/11. Occupational therapist-A stated that after initiating consultation and working on strategies to reduce shearing with transfers R17's pressure areas have improved and reduced in size and severity. Occupational therapist-A interventions with R17 included lowering the wheelchair seat, using a seat belt to position R17 farther back in the wheelchair, and use of a specialized cushion. Occupational therapist-A indicated that when referrals are received from MVH wound clinic for a seating and positioning evaluation he was typically notified by the nurse who receives the resident's referral upon return to the facility. Occupational therapist-A stated that the communication between MVH and the facility "is not a clear system". When asked if there was a policy on communication with MVH, occupational therapist-A indicated there was no official policy. The facility's Skin Integrity Management Policy dated 9/10, was reviewed. The policy indicated that a Skin Risk Factors tool was completed on admission/re-admission and with significant	2 900		

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2 900	Continued From page 9 change with development of a pressure ulcer. A further Skin Risk Factors tool was not completed for R17 since 7/30/11, through the time of the survey. The Skin Integrity Management Policy also indicated that a weekly report was generated by the RNM or designee to the ADON for review and tracking. In the case of R17, a Stage II pressure ulcer was noted on 8/10/11, but the ADON did not see R17 until 9/8/11. The Skin Integrity Management Policy further indicated that therapy interventions should include obtaining orders for skilled therapy evaluations as needed, to explore positioning interventions and modifications, and to assist with assessing for appropriate physical devices as needed. R17 received a referral for an OT evaluation 8/10/11, but these orders were not carried out until 9/8/11. R6 was admitted to that facility 7/28/10, with diagnoses which included Alzheimer's Disease, diabetes, depression, and history of open areas on the buttocks. R6 had recurrent pressure ulcers and the facility did not complete accurate and comprehensive assessments. Also, the facility did not provide appropriate interventions to promote healing of the pressures and prevent the development of new pressure ulcers. When observed on 9/29/11, at 10:30 a.m. R6's treatment was observed. The resident had one stage II pressure ulcer on his right buttock which measured one cm x 0.75 cm x 0.25 cm, and he had no air mattress on his bed. The resident's RNM-B was in the resident's room during the observation at 10:35 a.m. on 9/29/11, and stated that she did not know what happened to the resident's air mattress and she would	2 900		

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2 900	Continued From page 10 immediately order another one. The admission "Skin Risk Factors" assessment, dated 8/8/10, described that resident as having a Braden score of 19, a history of pressure ulcers, and excoriation on both buttocks. The form included a list of interventions implemented by the facility to address the skin risk factors, and that list did not include a pressure reduction support surface in bed, a pressure reduction support sitting surface, or a turning and repositioning schedule. The resident's medical record contained two "Tissue Tolerance Evaluation" forms (assessments that evaluate the ability of the skin and its supporting structures to endure the effects of pressure without adverse effects), dated 7/29/10 and 3/22/11. Both of these forms described the resident as independent with repositioning in a chair and in bed. The current "Care Planning Report" effective 7/13/11, contained a focus that read, "SKIN INTEGRITY--*I am at risk for skin breakdown r/t [related to] incontinence, fragile skin, and cognitive impairment. OPEN AREAS BOTH BUTTOCKS..." One of the interventions listed for that problem read, "Pressure relief mattress in bed." The "Progress Notes" read: - On 12/26/10, read that the wound on the resident's right buttock was healed, then a "Progress Notes" form, dated 1/9/11, read that the resident had an open area on the left buttock measuring two cm x two cm, and an open area on the right buttock measuring two cm x 1.5 cm. - On 3/31/11, "Progress Notes" detailed a wound on the left buttock as measuring one cm x 0.5 cm, with the right buttock wound healed.	2 900		

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2 900	Continued From page 11 - On 4/5/11, a "Progress Notes" listed the wound on the left buttock as healed and a wound on the right buttock that measured one cm x 0.5 cm. - On 4/19/11, "Progress Note" the left buttock remained healed, but a wound on the right buttock measured two cm x 0.8 cm. - On 6/26/11, a new open area on the right buttock, measuring 0.25cm x 0.25 cm, and classified as a stage II was documented. A "Wound Documentation-Weekly" form dated 8/23/11, described a stage III pressure ulcer measuring 1.0 x 0.4, with depth of 0.0 cm on the left buttock, and a "Wound Documentation-Weekly" form, dated 9/20/11, described a stage III pressure ulcer measuring 0.8 cm x 0.4 cm, with depth of 0.0 cm on the right buttock. When interviewed at 9:30 a.m. on 9/29/11, the RNM-B for R6's unit stated that she was unsure if some of these wounds had healed and reopened in the same spot, or if the wounds developed in new areas of the buttocks. When interviewed at 9:30 a.m. on 9/29/11, regarding these assessments, the unit's Senior RN stated that she did not believe that the tissue tolerance assessments needed to be repeated because the resident was independent with repositioning and every resident on the floor was on the routine of repositioning and toileting every two hours. When interviewed at 9:30 a.m. on 9/29/11, the Senior RN for that unit stated that that resident never had a stage three pressure ulcer, the worst was stage two. When interviewed at 9:30 a.m. on 9/29/11, the RNM-B for R6 stated that a "air mattress" was added to that resident's bed in May 2011.	2 900		

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 _____	09/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 900	Continued From page 12 Although the facility's "Skin Integrity Management" policy and procedure dated 9/10, read, "Tissue Tolerance will be completed in the first 7 days after admission, annually, with a significant change of condition, and with the development of a new pressure ulcer." R6 did not have a new Tissue Tolerance assessment completed. The "Minneapolis Veterans Home Best Practice Guidelines Pressure Ulcer, Partial & Full-Thickness Skin Loss" guideline dated 8/10, that the facility used to stage pressure ulcers described a stage III pressure ulcer as the following: "Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling." SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could review policies and procedures regarding care for residents at risk or with pressure ulcers, educate staff on pressure ulcers protocols and develop a monitoring system to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 900		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written	21685		

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21685	Continued From page 13 routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to monitor the status of physical plant conditions periodically to insure that a routine maintenance plan in place is being effectively instituted. This had the potential to affect some of the 286 residents in the facility. Finding include: Observation was conducted via environmental tour on 9/29/11, at 1.00 p.m. with the Physical Plant Director (PPD). Building 17 had five utility rooms for clean items storage. The vanities in each of the rooms had unfinished vanities (one the side of the vanity surface was uncleanable). The PPD stated he was not aware of current conditions, and he suspected that when another cupboard was removed the vanity was not finished/covered with a cleanable surface. Three of the five rooms also had gouges in the walls. Room 319 had a two feet by three inch gouge, Room 380 had a three feet by two inch gouge in the wall. PPD stated these were caused by staff pushing the linen cart into the wall. room 219 had two small gouges in the wall above the paper towel holders. In two (Room 279, 220) of the dirty utility rooms there was strong foul odor. The PPD checked the airflow and confirmed that the venting systems were not properly functioning. There were three elevators in building 17 for staff and resident use. On the far left elevator on the	21685		

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21685	Continued From page 14 second floor the right side of the door frame had two feet long siding pealing away on the bottom. The paint was chipped and scuffed on the frame of the elevator on the far right side. Both sides of the doorway from bottom to the top had chipped paint. The PDA stated this elevator lacked the vinyl siding the other two elevators had. Building 6 had six utility rooms for clean items storage. The edges of the counter tops were unfinished/ missing siding rendering them uncleanable. During interview PPD stated the facility did not have a preventative maintenance program for common areas, staff supposed to use the work request system to report needed repairs. SUGGESTED METHOD OF CORRECTION: The director of maintenance or his designee could develop and implement policies and procedures to ensure that the nursing home was maintained in a safe, clean, functional, comfortable and homelike manner. Ongoing maintenance, monitoring and record keeping to ensure that the environment, including resident rooms and equipment are maintained to eliminate offensive odors. Develop a system to audit the environment on an ongoing basis to ensure compliance and monitor staff for adherence to these policies. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21685		
21995	MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an	21995		

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21995	Continued From page 15 ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. This MN Requirement is not met as evidenced by: Based on interview, record review and document review the facility failed to receive clearance from background studies for three of five employee (E1, E2, E3) records reviewed and allowed the employees to have direct unsupervised contact with residents. Findings include: Employee one (E1), a licensed practical nurse, was hired on 5/16/11, and had a background study completed on 7/13/11. E1 was cleared to be on the nursing unit working unsupervised on 6/9/11. E1 worked with residents for 35 days without a background check completed. Employee two (E2), a human service technician, was hired on 5/2/11, and had a background study completed on 7/13/11. E2 was cleared to be on the nursing unit working unsupervised on 5/24/11. E2 worked with residents for 51 days without a background check completed. Employee three (E3), a human service technician, was hired on 6/13/11, and had a background study completed on 7/13/11. E3 was cleared to be on the nursing unit working unsupervised on 6/28/11. E3 worked with	21995		

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21995	Continued From page 16 residents for 16 days without a background check completed. An interview was conducted with the director of human resources on 9/28/11, at 8:50 a.m. The human resources director indicated a background study was not completed for the three employees until 7/13/11. The human resources director stated she spoke with the human resource staff and it was unclear as to why a background study was conducted on 7/13/11, and not before the employees were given clearance to provide direct resident care. An interview was conducted with the director of nursing (DON) on 9/29/11, at 9:35 a.m. The DON stated he was not aware the background checks were not completed prior to the employees working directly with residents. The DON indicated had he been aware, the employees would not have been working unsupervised on the nursing units. The policy entitled: Vulnerable Adult Reporting with review date of 1/4/11, was reviewed and identified, "all employees shall have background screening checks completed and be cleared prior to their unsupervised assignment to resident care ." SUGGESTED METHOD FOR CORRECTION:The administrator, DON, social services or designee(s) could review and revise as necessary the policies and procedures regarding the background checks. The administrator, DON, social services or designee (s) could provide training for all appropriate staff on these policies and procedures. The administrator, DON, social services or designee (s) could monitor to assure all background	21995		

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21995	Continued From page 17 checks are being conducted in a timely manner. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21995		

MINNESOTA VETERANS HOME
Minneapolis

Plan of Correction: MDH Survey
Inspection Date: September 26 through September 29, 2011

REGULATION Rule Statue	CITATION SUBJECT	PLAN of CORRECTION	RESPONSIBLE PERSON	COMPLETION DATE
Tag MN. Rule 4658.0525 Subp 3	Residents with pressure sores or at risk receive care/treatment and prevention. Inaccurate assessments and documentation	1. Education to all licensed staff on the process required for skin integrity and wound care. 2. Education for pressure ulcer prevention for all HSTs. 3. Review Skin Integrity Management Policy. 4. Dietitians to review all current residents with pressure areas. 5. OT to review residents for pressure relief devices, positioning 6. Weekly wound documentation will be reviewed by RN for completeness and accuracy. Random audits will be performed and reported to Quality Council for ongoing monitoring.	Education Director Education Director ADON/DON Dietary Director Rehab Director RNM/ ADON	Education completed 10-14-11 Education completed 10-21-11 Policy Review completed. 10-7-11 Residents reviewed 10-14-11 Residents reviewed 10-14-11 RNM/RN SR reviewed all current residents with pressure sores and those at risk 10-14-11. Care plans have been revised as needed.
Tag MN Rule 4658.1415 Subp. 2	Preventative maintenance and monitoring status of physical plant conditions	1. Physical Plant Director's rounds will Include nursing units, store rooms basements, walkways, chapel and dining and common areas. 2. Rounds will be life safety and environmentally focused to maintain egress pathways, check fire extinguishers, and to note any environmental damage. Any damage noted will be addressed via a work request in Archibus and reported by the Physical Plant Director to the Quality Council.	Physical Plant Director	Developed a monthly inspection form to start on 11-1-11

10-31-11

11-1-11

accepted 11-1-11 Gloria Dop

MINNESOTA VETERANS HOME
Minneapolis

Plan of Correction: MDH Survey
Inspection Date: September 26 through September 29, 2011

REGULATION Rule Statue	CITATION SUBJECT	PLAN of CORRECTION	RESPONSIBLE PERSON	COMPLETION DATE
Tag MN Rule 626.557 Subp. 4	Background checks not completed prior to providing unsupervised care	1. All employees will have clearance on background checks prior to working with residents unsupervised.	HR Director	All new employees have clearance with background checks. 10-3-11

10-27-11

10-31

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

October 18, 2011

Ms. Shelley Kendrick, Administrator
Minnesota Veterans Home - Minneapolis
5101 Minnehaha Avenue South
Minneapolis, Minnesota 55417

Re: Project Number SL00233022

Dear Ms. Kendrick:

The above facility survey was completed on September 29, 2011 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.

Please feel free to call me with any questions.

Sincerely,

Gloria Derfus

Gloria Derfus, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3792 Fax: (651) 201-3790

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

00233s11.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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3 000	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: This facility was surveyed on September 26 - 29, 2011, and was in compliance with the MN State Boarding Care Home Rules.	3 000		