File 00381

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7008 1830 0003 8091 9009

November 4, 2010

Ms. Carol Gilbertson, Administrator
MN Veterans Home Silver Bay
45 Banks Boulevard
Silver Bay, Minnesota 55614

Re: Enclosed State Nursing Home Licensing Orders - Project Number SL00381019

Dear Ms. Gilbertson:

The above facility was surveyed on October 25, 2010 through October 28, 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.

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

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

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 320 West Second St, Room 703, Duluth, Minnesota 55802-1402. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

Please feel free to call me with any questions.

Sincerely,

Pat Halverson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218) 723-4637   Fax: (218) 723-4920

Enclosure(s)

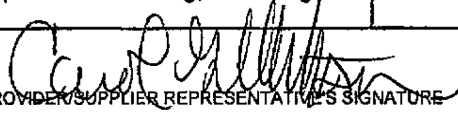
cc: Original - Facility
Licensing and Certification File

SL00381019S11.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00381	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED 10/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME SILVER BAY	45 BANKS BOULEVARD SILVER BAY, MN 55614

(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 10/25/2010 through 10/28/2010, 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	Minnesota Department of Health is documenting the State Licensing Correction Orders using the 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	



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

TITLE Administrator

(X6) DATE 11/22/10

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2 000	Continued From page 1 Certification Program; 320 West 2nd Street, Duluth, MN 55802	2 000	entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for:	2 265		

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2 265	Continued From page 3	2 265		

cognitive impairment. The admission Minimum Data Set (MDS) dated 7/19/2010, indicated R3 had short term memory problems with moderate cognitive impairment, was usually understood, and usually understood others.

R9's diagnoses included dementia with behavioral disturbance, dementia with lewy bodies, Alzheimer's disease, and anxiety. A Vulnerability/Risk Assessment dated 9/4/2010, indicated R9 was at risk for potential abuse/sexual abuse from other residents due to dementia, the behavior of yelling/screaming, living with other residents with impaired cognition, and the inability to move without assistance. The intervention noted was to separate residents immediately, and report any abuse to the RN. The quarterly Minimum Data Set (MDS) dated 9/30/2010, identified R9 had short and long term memory deficits with severely impaired cognition, was sometimes understood, and sometimes understood others.

R16's diagnoses included dementia with behavioral disturbance, and Alzheimer's disease. A Vulnerability/Risk Assessment dated 9/30/2010, indicated R16 was at risk for potential abuse/sexual abuse from other residents due to declining mental and physical health. The intervention noted was to remove R16 from a situation, and notify the RN. The quarterly Minimum Data Set (MDS) dated 10/26/2010, identified R16 had short and long term memory deficits with severely impaired cognition, was rarely/never understood, and sometimes understood others.

Review of a progress note for R3 dated 8/7/2010, indicated staff observed R3 "groping under the shirt of a female resident" (R9). The Incident

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2 265	Continued From page 4	2 265		

Report dated 8/7/2010, indicated the residents were separated to prevent further episodes, and R3 would be monitored closely around female residents. Possible medication interventions would be attempted after psychiatric review. A progress note dated 8/12/2010, indicated R3 was noted "touching" and "fondling" other female residents, and attempted to slap a male resident. The Incident Report dated 8/12/2010, indicated R3 fondled R16's "breasts and crotch" in the dining room before supper. R3 was removed from the area. The intervention noted was to not bring R3 to the dining room until meal trays arrived, and monitor closely around female residents. A progress note dated 8/29/2010, indicated R3 "brushed/groped" the "crotch" area of R16, and the residents were separated. The Incident Report dated 8/29/2010, indicated R3 wheeled a wheelchair to R16, and grabbed her "crotch" area as she was standing by chairs at the nursing station. The noted intervention was a psychiatric follow up, and to continue to monitor closely around female residents.

Although R3's progress notes (7/20/2010, 9/5/2010), indicated his family/legal representatives were notified of the sexual maltreatment to other female residents, the medical records for R9 and R16 lacked any indication the incidents occurred or that their families/legal representatives had been notified of the maltreatment.

At 11:03 a.m. on 10/28/2010, the social workers (BSW-A and LSW-B) were interviewed. BSW-A and LSW-B stated they don't notify residents' representatives regarding maltreatment because the nurses should do so when the maltreatment occurs. Documentation was requested regarding any information related to the incidents from R9

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2 265	Continued From page 5	2 265		

and R16's medical records, and none was provided.

The facility's "Vulnerable Adults Act" policy (not dated), identified the definition of "Abuse" to include "any sexual contact or penetration between facility staff person, or client of the facility." The policy directed the Registered Nurse (RN) on the resident's unit to notify the resident's family/representative of any witnessed or suspected incidents of maltreatment.

At 12:20 p.m. on 10/28/2010, the director of nursing (DON) verified there was no documentation in R9 or R16's medical records regarding the incidents, or any indication that their families/legal representatives had ever been notified of the maltreatment.

SUGGESTED METHOD OF CORRECTION:
The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure all residents' families/legal representatives are notified of all incidents of suspected or witnessed maltreatment.
The Director of Nursing or designee could educate all appropriate staff on the policies and procedures, and could develop monitoring systems to ensure ongoing compliance.

TIME PERIOD FOR CORRECTION: Fourteen (14) Days

2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents	2 560		

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,

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2 560	Continued From page 6	2 560		

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 develop a short term Plan of Care for 1 of 1 residents (R14) in the sample, who were reviewed for dialysis. Findings included:

R14 received dialysis three times a week, and the facility failed to incorporate the resident's needs related to dialysis treatment in the short term Plan of Care.

R14 was admitted to the facility on 10/20/2010. R14's diagnoses included end stage renal disease. R14 received dialysis three times a week, and had three dialysis treatments since admission. The Physician's Order directed a renal, low cholesterol, diabetic diet, and a 2000 cc per day fluid restriction. On 10/27/2010 at 8:35 a.m., R14 was observed in his room, and had a glass containing approximately 200 cc of water on the bedside table. R14 stated he was not aware he was on a fluid restriction. He also stated staff had not checked his AV fistula site (a surgically created connection of an artery to a vein where blood is removed and returned during dialysis treatments) in his left upper arm since he was admitted.

An interview with the human services technician (HST-F) was done on 10/27/2010, at 8:45 a.m. HST-F stated she was aware R14 received

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2 560	Continued From page 7	2 560		

dialysis, but was not aware he was on a fluid restriction. HST-F stated she was unaware of his AV fistula, and was not told how to care for it, or how to report complications or changes in his condition. HST-F's care guide for R14 did not address the dialysis, AV fistula, fluid restriction, or what to do if a complication or emergency arose.

An interview with the licensed practical nurse (LPN-D) was done on 10/27/2010 at 8:50 a.m. LPN-D stated she had not checked R14's AV fistula site. LPN-D stated she was unaware of how to contact the dialysis center if there were complications or changes in R14's condition. LPN-D stated she was unaware that R14 was on a fluid restriction, and added, the dietary staff should have sent a memo to the nursing staff indicating how much fluid R14 would receive on his meal trays, and how much fluid R14 could have from nursing staff. LPN-D confirmed this had not been done.

An interview with the cook supervisor (CS-D) was done on 10/27/2010, at 8:55 a.m. CS-D stated she received the diet and fluid restriction orders for R14. CS-D stated the dietary department usually separates the fluid amounts out, but this had not been done yet.

An interview was done with the registered nurse (RN-A) on 10/27/2010, at 7:42 a.m. RN-A verified the short term Plan of Care did not address the dialysis needs of R14.

SUGGESTED METHOD FOR CORRECTION:
The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure all resident short term Care Plans address each resident's immediate dialysis needs.

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2 560	Continued From page 8 The Director of Nursing or designee could educate all the appropriate staff on the polices/procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) Days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to follow the Plan of Care for 1 of 10 residents (R13) in the sample, who were reviewed for positioning; and 3 of 11 residents (R3, R10 and R11) in the sample, who were reviewed for toileting services. Findings included: R13 was observed continuously from 7:25 a.m. to 10:00 a.m. on 10/27/2010. R13 was lying in the supine position in his bed, and had not been repositioned during that time. A review of the Care Plan dated 7/29/2010, revealed R13 was alert and oriented to person, place and time. The Care Plan directed 1-2 staff to assist to reposition in bed every 2 hours and as needed. During observation of R13 at 8:10 a.m. on	2 565		

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2 565	Continued From page 9 10/27/2010, a health services technician (HST) emptied his urinal and offered him a wet wash cloth to wash his hands face, however, did not offer to reposition him. The HST served a breakfast tray to R13 in bed at 8:27 a.m. and at 9:25 a.m. the tray was removed. At no other time did staff enter the room. During an interview at 10:05 a.m. on 10/27/2010, registered nurse (RN)-B verified that the Plan of Care for R13 directed staff to reposition him every 2 hours, and the HST should have at least asked R13 about repositioning. R10 did not receive toileting assistance as directed by the plan of care. R10's diagnosis included Alzheimer's disease, Hypertension (high blood pressure), renal insufficiency, constipation, and benign prostate hypertrophy(BPH). The quarterly Minimum Data Set (MDS) dated 7/14/2010 identified R10 as having short and long term memory impairment and had moderately impaired decision making skills. R10 was coded as being frequently incontinent of bladder and required extensive assistance with toileting needs. The Bladder and Bowel Assessment dated 1/25/2010, indicated R10 was incontinent of urine, received a diuretic (increases urinary output), had urge incontinence, and needed assisted toileting every 2 hours. The care plan dated 1/27/2010, indicated R10 required assistance to be toileted/checked for incontinence every 2 hours and as needed (PRN). At 5:15 p.m. on 10/25/2010, R10 was observed sitting in his wheelchair eating supper in the dining room. R10 finished his supper at 5:55 p.m.	2 565		

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2 565	Continued From page 10	2 565		

and remained at the supper table drinking milk until 6:45 p.m. R10 remained seated at the table until 7:30 p.m. when he was wheeled to the TV area where a movie was being shown. R10 remained in front of the TV area until 7:45 p.m. At 7:45 p.m. Health Services Technician (HST) H wheeled R10 to his room. HST-H brought R10 into the bathroom, placed on the toilet and noted to have moderate amount of urine in his brief.

HST-H, interviewed at 7:50 p.m. on 10/25/2010, stated that he had just started working there and was still in training and was not sure how often R10 should be toileted.

At 7:55 p.m. on 10/25/2010, interview with HST-A stated that R10 should have been toileted at 6:10 p.m. HST-A stated that R10 is not to be interrupted during meals as he often will not eat once he's been interrupted. HST-A stated that R10 should have been toileted prior to supper.

Toileting tracking tool dated 10/25/2010 had R10 toileted at 4:10 p.m. The next entry for toileting time had 6:10 p.m. written down with the word eating next to it. HST-A verified that's the time R10 should had been toileted at 6:10 p.m. but he was not.

R11 did not receive toileting assistance according to his plan of care. R11's care plan indicated to bring R11 to the bathroom every 2 hours, staff checked and changed him with out toileting him per his plan of care.

R11's diagnosis include advanced Alzheimer's disease. the quarterly Minimum Data Set (MDS) dated 6/11/2010 indicated that R11 had short and long term memory problem, and has severe impaired cognitive skills for daily decision making.

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2 565	Continued From page 11	2 565		

Continued From page 11

The Care Guide sheet indicated staff is to bring R11 to the bathroom every 2 hours. The care plan dated 6/13/2010 indicated staff to bring R11 to the toilet every 2 hours.

At 7:15 p.m. on 10/25/2010, R11 was observed getting ready for evening cares. Health Services Technicians (HST)-C and HST-H placed the sling under R11 hooked him up to the standing lift, raised R11 to a standing position, and removed his pants and brief. R11 was incontinent of moderate amount of urine. HST-C provided peri care and then placed R11 into bed without first toileting per his plan of care.

At 10:27 a.m. Registered Nurse (RN)-A verified that R11 should have been placed on the toilet prior to going to bed per his plan of care.

R3, who had urinary retention and a history of urinary tract infections, was not toileted the PM of 10/25/2010, as directed by the Plan of Care.

The elimination Care Plan updated 10/6/2010, directed staff to provide one to two person limited to physical assistance for toileting, and to toilet every two hours and as needed (prn).

During observations at 5:25 p.m. on 10/25/2010, R3 was seated in a wheelchair in the dining room, received his dinner meal, and was fed by a human services technician (HST-C). R3 finished eating at 6:07 p.m., and at 6:25 p.m. the licensed practical nurse (LPN-B) wheeled R3 over to the TV area of the dining room. At 6:53 p.m. HST-B wheeled R3 to his room, transferred him to bed, and completed p.m. cares. R3's incontinent product was dry. The surveyor questioned HST-B regarding R3's toileting program. HST-B stated R3 does not get toileted, and is only checked and

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 12 changed. HST-B stated R3 was last checked at 5:22 p.m., was dry, and was not toileted. At 4:15 p.m. on 10/26/2010, the director of nursing (DON) confirmed R3 should be toileted every two hours as directed on the Care Plan. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure all resident Care Plans are used and followed by staff. The Director of Nursing or designee could educate all the appropriate staff on the polices/procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00381	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME SILVER BAY	**45 BANKS BOULEVARD SILVER BAY, MN 55614**

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2 570	Continued From page 13	2 570		

review, the facility failed to revise the care plan for 1 of 10 residents (R10) in the sample who was reviewed for repositioning needs. Findings include:

R10's care plan was not revised to reflect a change in wheel chair positioning as identified in the progress note dated 1/27/2010.

R10's diagnosis include Alzheimers disease, arthritis, and delusional disorder. The quarterly Minimum Data Set (MDS) dated 7/14/2010, indicated R10 had short term and long term memory problems, and moderate impairment for cognitive skills for daily decision making. The Resident Assessment Protocol Summary (RAP) dated 2/7/2010 indicated that R10 needs assistance from staff with all of his Activity of Daily Living (ADL's). Progress note dated 1/27/2010, indicates R10 will be a 2 hour repositioning check per off-loading (repositioning a resident to alleviate pressure for at least 1 minute) protocol for 24 hours. The care plan dated 7/17/2010 indicated R10's repositioning in bed as independent with assist of 1 as needed (PRN). The care plan did not address R10's repositioning in his wheel chair.

On 10/25/2010, R10 was continually observed in the dining room to be sitting in his wheel chair without being repositioned by staff from 5:15 p.m. until 7:45 p.m.

At 8:56 a.m. on 10/28/2010, interview with Registered Nurse (RN)-C verified that R10 should be repositioned in his wheelchair every 2 hours.

At 9:05 a.m. on 10/28/2010, interview with Health Services Technician (HST)-I stated that R10 is to be repositioned every 2 hours.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00381	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED 10/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME SILVER BAY	**45 BANKS BOULEVARD SILVER BAY, MN 55614**

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2 570	Continued From page 14 At 9:30 a.m. RN-D verified that R 10 should be repositioned in his wheel chair every 2 hours and the care plan needs to be updated to reflect this. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure all resident Care Plans are revised in a timely manner based on their assessed needs. The Director of Nursing or designee could educate all the appropriate staff on the polices/procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) Days.	2 570		
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval. This MN Requirement is not met as evidenced by: R13 was observed continuously from 7:25 a.m. to 10:00 a.m. on 10/27/2010. R13 was lying in the supine position in his bed and had not been repositioned during that time.	2 905		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00381	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 10/28/2010
NAME OF PROVIDER OR SUPPLIER: MN VETERANS HOME SILVER BAY	STREET ADDRESS, CITY, STATE, ZIP CODE: 45 BANKS BOULEVARD SILVER BAY, MN 55614		

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2 905	Continued From page 15	2 905		

R13 had diagnoses that included, Ankylosing Spondylitis, Osteoporosis, Asthma and Carpal Tunnel. A review of the care plan dated 7/29/2010 revealed R13 was alert and oriented to person, place and time. The care plan directed 1-2 staff to assist to reposition in bed every 2 hours and as needed.

During observation of R13 at 8:10 a.m. on 10/27/2010, a health services technician (HST) emptied his urinal and offered him a wet wash cloth to wash his hands face, however did not offer to reposition him. The HST served a breakfast tray to R13 in bed at 8:27 a.m. and at 9:25 a.m. the tray was removed. At no other time did staff enter the room.

During an interview at 10:05 a.m. on 10/27/10, registered nurse (RN)-B verified that the plan of care for R13 directed staff to reposition him every 2 hours and the HST should have at least asked R13 about repositioning.

A review of the facility policy revealed "Residents will be positioned or moved observing correct positioning and mobility techniques, and will be repositioned at least every 2 hours or as care planned through individual assessment."

SUGGESTED METHOD FOR CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure all residents are assisted with repositioning based on their comprehensive assessment, and as directed by the Plan of Care. The Director of Nursing or designee could educate all the appropriate staff on the polices/procedures, and could develop monitoring systems to ensure ongoing compliance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00381	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME SILVER BAY	**45 BANKS BOULEVARD SILVER BAY, MN 55614**

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2 905	Continued From page 16 TIME PERIOD FOR CORRECTION: Fourteen (14) Days. Based on observation, interview and record review, the facility failed to provide repositioning services for 2 of 10 residents (R10 and R13) in the sample, who were reviewed for repositioning. Findings included: R10 was not repositioned every 2 hours as indicted by assessment. R10's diagnosis include Alzheimer's disease, Hypertension (high Blood Pressure), renal insufficiency, constipation, and benign prostate hypertrophy(BPH). The quarterly Minimum Data Set (MDS) dated 7/14/2010 identified R10 as having short and long term memory impairment and had moderately impaired decision making skills for daily decision making. At 5:15 p.m. on 10/25/2010, R10 was observed sitting in his wheelchair eating supper in the dining room. R10 finished his supper at 5:55 p.m. and remained at the supper table drinking milk until 6:45 p.m. R10 remained seated at the table until 7:30 p.m. when he was wheeled to the TV area where a movie was being shown. R10 remained in front of the TV area until 7:45 p.m. At 7:45 p.m. Health Services Technician (HST) H	2 905		

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	00381	A. BUILDING ____ B. WING ____	10/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME SILVER BAY	45 BANKS BOULEVARD SILVER BAY, MN 55614

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2 905	Continued From page 17 wheeled R10 to his room. HST-H brought R10 into the bathroom and assisted R10 to the toilet. At 8:56 a.m. on 10/28/2010, interview with Registered Nurse (RN) C verified that R10 should be repositioned in his wheel chair every 2 hours. At 9:05 a.m. on 10/28/2010, interview with HST-I verified that R10 should be repositioned in his wheel chair every 2 hours.	2 905		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide toileting services for 3 of 11 residents (R3, R10, R11) in the sample, who were observed for incontinence. Findings included:	2 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00381	A. BUILDING _______ B. WING _______	10/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME SILVER BAY	**45 BANKS BOULEVARD SILVER BAY, MN 55614**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 910	Continued From page 18	2 910		

R3 was not toileted the evening of 10/25/2010 as indicated by the comprehensive assessment.

R3's diagnoses included urinary retention, urinary incontinence, dementia, diabetes, Parkinson's disease, and hypothyroidism.

The admission Minimum Data Set (MDS) dated 7/19/2010, indicated R3 had short term memory problems with moderate decision making impairment; required limited assistance of one staff for transfers and toilet use; was non-ambulatory; and was incontinent daily, but did have some control. The MDS further identified the use of an intermittent urinary catheter.

A Bladder and Bowel Questionnaire in the nursing progress notes dated 7/10/2010, indicated R3 was intermittently catheterized for urinary retention, but was at times able to use a urinal successfully to void small amounts, and urinate in the toilet. A Bladder Assessment dated 7/10/2010, indicated R3 was aware of the urge to urinate, and would urinate when on the toilet. The assessment further indicated R3 was sometimes straight cathed for post void residual (urine that remains in the bladder after voiding) greater than 350cc, and was asked every two hours if he needed to use the toilet. R3 was receiving current treatment for a UTI during the assessment period.

The elimination Care Plan updated 10/6/2010, directed staff to provide one to two person limited to physical assistance for toileting, and to toilet every two hours and as needed (prn).

During observations at 5:25 p.m. on 10/25/2010, R3 was seated in a wheelchair in the dining room, received his dinner meal, and was fed by a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00381	A. BUILDING ______ B. WING ______	10/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME SILVER BAY	45 BANKS BOULEVARD SILVER BAY, MN 55614

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 910	Continued From page 19 human services technician (HST-C). R3 finished eating at 6:07 p.m., and at 6:25 p.m. the licensed practical nurse (LPN-B) wheeled R3 over to the TV area of the dining room. At 6:53 p.m. HST-B wheeled R3 to his room, transferred him to bed, and completed p.m. cares. R3's incontinent product was dry. The surveyor questioned HST-B regarding R3's toileting program. HST-B stated R3 does not get toileted, and is only checked and changed. HST-B stated R3 was last checked at 5:22 p.m., was dry, and was not toileted. At 4:15 p.m. on 10/26/2010, the director of nursing (DON) stated she could not find any evidence in R3's medical records to indicate he should not be toileted, and confirmed R3 should be toileted every two hours as directed on the Care Plan. R10 did not receive toileting assistance according to his plan of care. R10's care plan indicated that he should be toileted every 2 hours. R10 was not toileted for 3 hours and 35 minutes. R10's diagnosis include Alzheimer's disease, Hypertension (high Blood Pressure), renal insufficiency, constipation, and benign prostate hypertrophy(BPH). The quarterly Minimum Data Set (MDS) dated 7/14/2010 identified R10 as having short and long term memory impairment and had moderately impaired decision making skills. R10 was coded as being frequently incontinent of bladder and required extensive assistance with toileting needs. Bladder and Bowel Assessment dated 1/25/2010, indicated R10 is incontinent of urine, receives a diuretic (increases urinary output), has urge incontinence, and needs to be toileted every 2 hours. The care plan dated 1/27/2010, indicates R10 is to be toileted/checked for incontinence	2 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00381	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED 10/28/2010
NAME OF PROVIDER OR SUPPLIER: **MN VETERANS HOME SILVER BAY**	STREET ADDRESS, CITY, STATE, ZIP CODE: **45 BANKS BOULEVARD SILVER BAY, MN 55614**		

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2 910	Continued From page 20	2 910		

every 2 hours and as needed (PRN)

At 5:15 p.m. on 10/25/2010, R10 was observed sitting in his wheelchair eating supper in the dining room. R10 finished his supper at 5:55 p.m. R10 remained at the supper table drinking milk until 6:45p.m. R10 remained seated at the table until 7:30 p.m. when he was wheeled to the TV area where a movie was being shown. R10 remained in front of the TV area until 7:45 p.m. At 7:45 p.m. Health Services Technician (HST) H wheeled R10 to his room. HST-H brought R10 into the bathroom. R10 was placed on the toilet and noted to have moderate amount of urine in his brief.

At 7:50 p.m. on 10/25/2010, interview with HST-H regarding R10's toileting schedule. HST-H stated that he had just started working there and was still in training and was not sure how often R10 should be toileted. Toileting tracking tool dated 10/25/2010 had R10 toileted at 4:10 p.m. The next entry for toileting time had 6:10 p.m. written down with the word eating next to it. HST-A verified that's the time R10 should had been toileted at 6:10 p.m. but he was not.

At 7:55 p.m. on 10/25/2010, interview with HST-A stated that R10 should have been toileted at 6:10 p.m. HST-A stated that R10 is not to be interrupted during meals as he often will not eat once he's been interrupted. HST-A stated that R10 should have been toileted prior to supper.

R11 did not receive toileting assistance according to his plan of care.

R11's diagnosis include advanced Alzheimer's disease. the quarterly Minimum Data Set (MDS) dated 6/11/2010 indicated that R11 had short and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00381	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED 10/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME SILVER BAY	**45 BANKS BOULEVARD SILVER BAY, MN 55614**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 910	Continued From page 21 long term memory problem, and has severe impaired cognitive skills for daily decision making. The Care Guide sheet indicated staff is to bring R11 to the bathroom every 2 hours. The care plan dated 6/13/2010 indicated staff assist R11 to the toilet every 2 hours. At 7:15 p.m. on 10/25/2010, R11 was observed getting ready for evening cares. Health Services Technicians (HST)-C and HST-H placed the sling under R11 hooked him up to the standing lift, raised R11 to a standing position, and removed his pants and brief. R11 was incontinent of moderate amount of urine in his brief. HST-C provided peri care and then place R11 into bed without placing R11 on the toilet per his plan of care. At 10:27a.m. Registered Nurse (RN)-A verified that R11 should have been placed on the toilet prior to going to bed per his plan of care. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure all residents are assisted with toileting needs based on their comprehensive assessment, and as directed by the Plan of Care. The Director of Nursing or designee could educate all the appropriate staff on the polices/procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) Days.	2 910		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi	21015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00381	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/28/2010
NAME OF PROVIDER OR SUPPLIER: **MN VETERANS HOME SILVER BAY**	STREET ADDRESS, CITY, STATE, ZIP CODE: **45 BANKS BOULEVARD SILVER BAY, MN 55614**		

(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
21015	Continued From page 22	21015		

Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times.

This MN Requirement is not met as evidenced by:
At 12:00 p.m. on 10/27/10, food service worker (FSW)-A was observed serving lunch from a steam table in the Birch unit kitchen area. FSW-A was observed wearing gloves to open a drawer and take out a knife and spoon, then opening the butter container, removing butter and placing it on mashed potatoes using the knife and spoon. While wearing the same gloves, FSW-A removed the lids from the steam table and dished up salmon loaf using a spatula and, with her left gloved hand, pushed the salmon off the spatula and onto the plate. FSW-A went on to touch silverware and napkins to place them on the tray being served to a resident without changing gloves.

FSW-A opened the refrigerator, took out 2 small containers of juice, then removed her gloves, washed her hands and put on a new pair of gloves. She then opened the juice containers wearing gloves and poured the juice into a graduate and scooped "thick it" into the container. FSW-A then used a whisk to stir the thick it into the juice. While wearing the same gloves, she went back to the steam table, removed the lids and dished up the salmon loaf using a spatula, again using her gloved left hand to push the salmon off the spatula and onto the plate. FSW-A then scooped up red potatoes and used her gloved left hand to hold the potatoes in the scoop and put them on the plate. She touched the potatoes again to arrange them on the plate.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00381	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED 10/28/2010
NAME OF PROVIDER OR SUPPLIER: MN VETERANS HOME SILVER BAY	STREET ADDRESS, CITY, STATE, ZIP CODE: 45 BANKS BOULEVARD SILVER BAY, MN 55614		

(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
21015	Continued From page 23	21015		

FSW-A then picked up silverware and a napkin and placed on the tray to be served to a resident, wearing the same gloves. FSW-A went back to stirring the juice in the graduate with the thick it without removing gloves. She opened the refrigerator and took out the milk and poured it in a glass, scooped the pudding consistency juice into a bowl, covered it with a wrap and carried it out to the table, all while wearing the same gloves.

FSW-A removed her gloves, opened the freezer and took out frozen hamburger patties. She washed her hands, put on gloves and removed the hamburger from the plastic bag, placed it on a plate, put it in the microwave and then touched the panel for cook time, removed her gloves and washed her hands.

FSW-A put on gloves, opened the bag containing hamburger buns and removed a bun using her hand. She then reached into the cabinet and took down a plate, placed the bun on the plate, took the hamburger out of the microwave with her gloved hand, and used a thermometer to check the temperature of the hamburger while holding the hamburger still with her left hand. She took the ketchup container and put ketchup on the hamburger and then held the hamburger with her gloved left hand and cut it in half. After handling the hamburger with gloved hands she dished up a dessert for another resident and placed silverware and napkins on a tray, using the same gloves.

FSW-A was asked to make a sandwich for another resident. Wearing gloves, she opened the bread bag, reached in, took out 2 slices of bread, used her gloved hands to hold the bread while she buttered them and placed them on a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00381	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED 10/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME SILVER BAY	**45 BANKS BOULEVARD SILVER BAY, MN 55614**

(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
21015	Continued From page 24	21015		

plate. She went into the refrigerator and took out salami and cheese and used her gloved hands to open the containers and then picked up pieces of salami and cheese and put them on the bread. She then dished up mashed potatoes into a bowl, and went back to the sandwich and held it with her gloved hands to cut it in half. She picked up the sandwich halves and placed each one in a Styrofoam cup and covered each one with clear wrap wearing the same gloves the entire time.

During an interview at 12:45 p.m. on 10/27/2010, FSW-A stated she didn't understand the use of the gloves, when touching food and nonfood surfaces. FSW-A stated she was unaware of the facility policy and she was "new" at serving food.

A review of the facility policy revealed there would be "no bare hand contact with ready to eat foods. Staff will use tongs, utensils, paper or gloves when preparing resident food. However the policy was not clear about not touching food with gloves that have been worn to touch unclean surfaces.

During an interview at 11:45 a.m. on 10/28/2010, the Cook Supervisor (CS)-D verified that the food service from the unit dining rooms is fairly new; however, the "FSW should not be touching the food with dirty gloves."

SUGGESTED METHOD OF CORRECTION:
The Cook Supervisor or designee could develop, review, and/or revise policies and procedures to ensure sanitary conditions are maintained in the kitchen, and during the preparation and serving of food.
The Dietary Supervisor or designee could educate all appropriate staff on the policies and procedures, and could develop monitoring

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00381	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/28/2010
NAME OF PROVIDER OR SUPPLIER: MN VETERANS HOME SILVER BAY	STREET ADDRESS, CITY, STATE, ZIP CODE: 45 BANKS BOULEVARD SILVER BAY, MN 55614		

(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
21015	Continued From page 25 systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) Days Based on observation and interview the facility failed to maintain sanitary conditions in the kitchen during the preparation and serving of food. This practice had the potential to affect all 78 residents in the facility. Findings included: At 2:15 p.m. on 10/25/10, the large vent filters located directly over the stove were observed to be caked with dust. At 8:20 a.m. on 10/28/2010, the vent filters still remained dirty. At 2:15 p.m. on 10/25/2010, interview with the Cook Supervisor (CS)-D verified that the vents were dirty and should be cleaned. The monthly cleaning schedule dated for September 2010 did indicate the vents were cleaned, however, CS-D stated apparently it was not enough with all the construction going on. At 8:15 a.m. on 10/28/2010, interview with Building Maintenance Foreman (BMF)-C stated that the filters should be cleaned by running them through the dishwasher every Sunday. BMF-C verified that the vent filters were dirty and need to be cleaned. He stated, "they are the dirtiest I've ever seen them." At 8:20 a.m. on 10/28/2010, interview with Cook-A verified that the vent filters were dirty and should be cleaned. Cook-A stated she was not aware that the vent filters should be cleaned weekly by running them through the dishwasher. Cook-A also stated that they are, "crunched for time."	21015		
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance	21385		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00381	A. BUILDING ______ B. WING ______	10/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME SILVER BAY	45 BANKS BOULEVARD SILVER BAY, MN 55614

(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
21385	Continued From page 26 Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the facility failed to maintain infection control procedures per manufacturer's recommendation regarding disinfection of glucometers for 2 of 2 residents (R1 and R3) in the sample, who were reviewed for glucose monitoring. Findings included: At 7:10 p.m. on 10/25/2010, licensed practical nurse (LPN)-F was observed performing an accucheck for R1. LPN-F brought the glucometer in the room, set it on the resident's bed, put on gloves and put a test strip in the machine. LPN-F then poked R1 to draw blood for the test. The blood was wicked up into the test strip and the result was read. LPN-B then removed the test strip and her gloves and put them in the trash; she put the lancet in the sharps container. LPN-F had brought in a paper cup with a sanitizing wipe in it. She removed the wipe from the cup and wiped off the glucometer. She wiped it for approximately 10 seconds. She then stated she lets it dry and doesn't use it for 2 minutes. LPN-F stated "it dries pretty quickly though." LPN-F verified she was unaware of having to leave the device visibly wet for any length of time. At 11:25 a.m. on 10/27/2010, Licensed Practical Nurse (LPN)- E entered R 3's room to obtain a accu check . LPN-E donned gloves, poked R3's	21385		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00381	A. BUILDING ______ B. WING ______	10/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME SILVER BAY	45 BANKS BOULEVARD SILVER BAY, MN 55614

(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
21385	Continued From page 27	21385		

middle finger on right hand with lancet and obtained blood sample on the test strip. LPN-E disposed of lancet in the sharps container and, disposed the gloves in the garbage. At 11:30 a.m. LPN-E returned to the medication room with the glucometer machine. LPN-E wiped down the glucometer machine with a Super Sani Wipe Cloth. The glucometer machine remained visibly wet for 30 seconds before completely drying. When questioned regarding the disinfecting of the glucometer machine LPN-E stated that, "a quick wipe down is good as long as all surfaces have been touched, the main thing is that it dries for 2 minutes before you can use it on another resident." LPN-E verified that she was not aware of the manufactures recommendations for disinfecting the glucometer.

At 11:40 a.m. on 10/27/2010, interview with the Director of Nursing (DON) verified that staff should be following manufactures recommendations for disinfecting glucometers. DON stated they recently had training on the disinfecting of the glucometer machines.

At 12:10 p.m. on 10/27/2010, interview with Registered Nurse Supervisor (RNS)-B regarding disinfecting glucometers. RNS-B stated the facility uses the purple top Sani Wipes, the glucometers are wiped down between each resident, a quick wipe down is all that is needed, the main thing is that the glucometers are dry for 2 minutes before using on another resident. RNS-B verified that he was not aware of the manufactures recommendation for disinfecting the glucometers. RNS-B stated that he will update the facility policy to reflect the manufactures recommendations for proper disinfecting.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00381	A. BUILDING ______ B. WING ______	10/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME SILVER BAY	45 BANKS BOULEVARD SILVER BAY, MN 55614

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21385	Continued From page 28 Review of Sani Wipe Cloth manufactures recommendation indicated that treated surfaces must remain visibly wet for a full 2 minutes and to use additional wipes if needed to assure continuous 2 minutes wet time. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure all multiple resident use equipment is appropriately disinfected between each use according to the manufacturers instructions. The Director of Nursing or designee could educate all the appropriate staff on the polices/procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) Days.	21385		
21420	MN Rule 4658.0815 Subp. 3 Employee Tuberculosis Program Subp. 3. Written documentation of compliance. Reports or copies of reports of the tuberculin test or chest X-ray must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to provide written documentation that tuberculosis (TB) baseline screening was done for 3 of 5 new employees (FSW-V, FSW-W, HST-X) whose personnel records were reviewed for TB testing. Findings included:	21420		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00381	A. BUILDING ______ B. WING ______	10/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME SILVER BAY	45 BANKS BOULEVARD SILVER BAY, MN 55614

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21420	Continued From page 29	21420		

Employee files reviewed on 10/28/2010, lacked evidence of TB screening according to the Centers for Disease Control (CDC) guidelines for food service workers (FSW-V and FSW-W), and human services technician (HST-X).

Employee FSW-V hired 6/2/2010, did not have documentation that TB screening was done.

Employee FSW-W hired 6/8/2010, did not have documentation that TB screening was done.

Employee HST-X hired 6/2/2010, did not have documentation that TB screening was done.

The personnel officer (PO-E) was interviewed on 10/28/2010 at 11:20 a.m. PO-E stated FSW-V, FSW-W, and HST-X had received proper TB screening, but there was no documentation evidence. On 10/28/2010 at 2:05 p.m., the director of nursing (DON) was interviewed and verified the facility could not locate the written documentation.

SUGGESTED METHOD FOR CORRECTION:
The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure all new employees receive a two-step tuberculin skin test (TST), and documentation of the TST's are maintained in the employees personnel record.
The Director of Nursing or designee could educate all the appropriate staff on the polices/procedures, and could develop monitoring systems to ensure ongoing compliance.

TIME PERIOD FOR CORRECTION: Fourteen (14) Days.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00381	A. BUILDING ____ B. WING ____	10/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME SILVER BAY	45 BANKS BOULEVARD SILVER BAY, MN 55614

(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
21530	Continued From page 30	21530		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee.	21530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00381	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED 10/28/2010
NAME OF PROVIDER OR SUPPLIER: MN VETERANS HOME SILVER BAY	STREET ADDRESS, CITY, STATE, ZIP CODE: 45 BANKS BOULEVARD SILVER BAY, MN 55614		

(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
21530	Continued From page 31	21530		

This MN Requirement is not met as evidenced by:
Based on interview and record review, the consultant pharmacist failed to identify irregularities in the drug regimen for 1 of 14 residents (R11) in the sample. Findings included:

R11 has received Seroquel 25 milligrams (mg) 1-2 tablets at night time (hs) since June 11, 2010 with no parameters to indicate when R11 should receive 1 tablet or 2 tablets.

On June 11, 2010 the physician ordered Seroquel 25 mg 1-2 tablets at hs. The Medication Administration Records (MAR) from June 2010 to October 2010 indicated that some days R11 received 1 tablet of Seroquel and other days he would receive 2 tablets.

Review of the Consultant Pharmacist Medication Regimen Review (MRR) and Physician Notification form indicated that the consultant pharmacist reviewed the medications for R11 on 7/30/2010, 8/31/2010 and again on 9/30/2010 with no irregularities noted.

At 9:05 a.m. on 10/26/2010, the Registered Nurse Supervisor (RNS)-B stated that the Licensed Practical Nurse (LPN) and the Registered Nurse (RN) should be communicating and documenting the efficacy of one tablet verses two tablets. RNS-B verified parameters should be set as to when R11 receives one tablet or two tablets.

At 8:45 a.m. on 10/27/2010, interview with the consultant pharmacist verified that parameters were required to determine when R11 gets one

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00381	A. BUILDING ______ B. WING ______	10/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME SILVER BAY	45 BANKS BOULEVARD SILVER BAY, MN 55614

(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
21530	Continued From page 32 tablet or two tablets of Seroquel. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could work with the Consultant Pharmacist to develop, review, and/or revise policies and procedures to ensure all residents' medication irregularities are identified, reported, and acted upon as required. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	21530		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00381	A. BUILDING ______ B. WING ______	10/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME SILVER BAY	**45 BANKS BOULEVARD SILVER BAY, MN 55614**

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21535	Continued From page 33	21535		

available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change.

This MN Requirement is not met as evidenced by:
Based on record review and interview, the facility failed to adequately identify, assess and monitor indications for continued use of medications for 2 of 14 residents (R2 and R11) in the sample, who were reviewed for medication use. Findings included:

R2 continued to receive omeprazole 20 mg daily (medication for short term use to treat esophogeal ulcers or gastroesophageal reflux disease) for 3 1/2 months after the pharmacist and the MD recommended it be discontinued unless a supporting diagnosis for continued use could be found in the patients history.

A review of the pharmacist review sheets dated 6/2/2010 for R2 revealed a suggestion to the physician that stated, "unless he's had a history of GI bleed, he does not need omeprazole. please discontinue. (it will increase the risk of bone fractures)." The physicians progress note dated 6/2/2010, stated, "PharmD note reviewed, will review med use at next scheduled 60 day visit."

A doctor's note dated 7/2/2010 and faxed to the facility on 7/7/2010 stated, "Agree with the recommendations to discontinue if they cannot find a compelling reason to continue his medication, or I would ask the nursing home staff to please look through historical records and see we can clarify what started and indications for this medication."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00381	(X2) MULTIPLE CONSTRUCTION A. BUILDING ___ B. WING ___	(X3) DATE SURVEY COMPLETED 10/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME SILVER BAY	**45 BANKS BOULEVARD SILVER BAY, MN 55614**

(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
21535	Continued From page 34 A review of the current signed physicians orders revealed there was no supporting diagnosis for the use of Omeprazole. The medication administration records for the months of July, August, September and October revealed the medication was never discontinued and R2 continued to receive it daily. At 9:30 a.m. on 10/28/10, Registered Nurse (RN) -B verified they had "missed it" and the medication should have been reviewed by nursing staff and discontinued. R11 had been on Seroquel 25 milligrams (mg) 1-2 tablets at night time (hs) since June 11, 2010, with no parameters to determine when R11 should receive 1 tablet or 2 tablets. On June 11, 2010 the physician ordered Seroquel 25 mg 1-2 tablets at hs. The Medication Administration Records (MAR) from June 2010 to October 2010 indicated that some days R11 would receive 1 tablet of Seroquel and other days he would receive 2 tablets. At 9:05 a.m. on 10/26/2010, interview with the Registered Nurse Supervisor (RNS)-B stated that the Licensed Practical Nurse (LPN) and the Registered Nurse (RN) should be communicating and documenting the efficacy of one tablet verses two tablets. RNS-B verified parameters should be set as to when R11 receives one tablet or two tablets. At 9:50 a.m. on 10/25/2010, interview with the Director of Nursing (DON) verified that there should be parameters in place indicating when one Seroquel or two should be used. SUGGESTED METHOD OF CORRECTION:	21535		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00381	A. BUILDING ___ B. WING ___	10/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME SILVER BAY	45 BANKS BOULEVARD SILVER BAY, MN 55614

(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
21535	Continued From page 35	21535		

The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure all residents' have indications for the continued use, and parameters for use of all medications.
The Director of Nursing or designee could educate all appropriate staff on the policies and procedures, and could develop monitoring systems to ensure ongoing compliance.

TIME PERIOD FOR CORRECTION: Twenty One (21) Days

21980 MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults — 21980

Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless:

(1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or
(2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4).
(b) A person not required to report under the provisions of this section may voluntarily report as described above.
(c) Nothing in this section requires a report of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00381	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED 10/28/2010
NAME OF PROVIDER OR SUPPLIER: **MN VETERANS HOME SILVER BAY**	STREET ADDRESS, CITY, STATE, ZIP CODE: **45 BANKS BOULEVARD SILVER BAY, MN 55614**		

(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
21980	Continued From page 36	21980		

Continued From page 36

known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.

(d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.

(e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c.

This MN Requirement is not met as evidenced by:
Based on record review, policy review and interview, the facility failed to report 3 of 3 incidents of maltreatment to the appropriate external agency; and failed to report 3 of 6 alleged violations of maltreatment immediately (within 24 hours) to the appropriate external agency. Findings included:

R9 and R16, who were cognitively impaired, were inappropriately touched in a sexual manner by another resident (R3), who was also cognitively impaired. The incidents of maltreatment were not reported according to the facility's "Vulnerable

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00381	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 10/28/2010
NAME OF PROVIDER OR SUPPLIER: MN VETERANS HOME SILVER BAY	STREET ADDRESS, CITY, STATE, ZIP CODE: 45 BANKS BOULEVARD SILVER BAY, MN 55614		

(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
21980	Continued From page 37	21980		

Adults Act" policy (not dated) to the Common Entry Point (CEP) immediately (within 24 hours).

R3 had a diagnosis of dementia. Review of an Orientation-Memory-Concentration Test dated 7/12/2010, indicated R3 had severe cognitive impairment. The admission Minimum Data Set (MDS) dated 7/19/2010, indicated R3 had short term memory problems with moderate cognitive impairment, was usually understood, and usually understood others.

R9's diagnoses included dementia with behavioral disturbance, dementia with lewy bodies, Alzheimer's disease, and anxiety. A Vulnerability/Risk Assessment dated 9/4/2010, indicated R9 was at risk for potential abuse/sexual abuse from other residents due to dementia, the behavior of yelling/screaming, living with other residents with impaired cognition, and the inability to move without assistance. The intervention noted was to separate residents immediately, and report any abuse to the RN. The quarterly Minimum Data Set (MDS) dated 9/30/2010, identified R9 had short and long term memory deficits with severely impaired cognition, was sometimes understood, and sometimes understood others.

R16's diagnoses included dementia with behavioral disturbance, and Alzheimer's disease. A Vulnerability/Risk Assessment dated 9/30/2010, indicated R16 was at risk for potential abuse/sexual abuse from other residents due to declining mental and physical health. The intervention noted was to remove R16 from a situation, and notify the RN. The quarterly Minimum Data Set (MDS) dated 10/26/2010, identified R16 had short and long term memory deficits with severely impaired cognition, was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00381	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 10/28/2010
NAME OF PROVIDER OR SUPPLIER: **MN VETERANS HOME SILVER BAY**	STREET ADDRESS, CITY, STATE, ZIP CODE: **45 BANKS BOULEVARD SILVER BAY, MN 55614**		

(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
21980	Continued From page 38	21980		

rarely/never understood, and sometimes understood others.

Review of a progress note for R3 dated 8/7/2010, indicated staff observed R3 "groping under the shirt of a female resident" (R9). The Incident Report dated 8/7/2010, indicated the residents were separated to prevent further episodes, and R3 would be monitored closely around female residents. Possible medication interventions would be attempted after psychiatric review. A progress note dated 8/12/2010, indicated R3 was noted "touching" and "fondling" other female residents, and attempted to slap a male resident. The Incident Report dated 8/12/2010, indicated R3 fondled R16's "breasts and crotch" in the dining room before supper. R3 was removed from the area. The intervention noted was to not bring R3 to the dining room until meal trays arrive, and monitor closely around female residents. A progress note dated 8/29/2010, indicated R3 "brushed/groped" the "crotch" area of R16, and the residents were separated. The Incident Report dated 8/29/2010, indicated R3 wheeled a wheelchair to R16, and grabbed her "crotch" area as she was standing by chairs at the nursing station. The noted intervention was a psychiatric follow up, and to continue to monitor closely around female residents.

The medical records lacked any indication the incidents of maltreatment were externally reported to the CEP according to the facility's "Vulnerable Adults Act" policy.
The policy identified the definition of "Abuse" to include "any sexual contact or penetration between facility staff person, or client of the facility", and directed that "any employee, volunteer, consultant, or other person providing services in the facility is required by law and this

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00381	A. BUILDING ______ B. WING ______	10/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME SILVER BAY	45 BANKS BOULEVARD SILVER BAY, MN 55614

(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
21980	Continued From page 39	21980		

policy to report any situation of maltreatment (abuse, neglect, financial exploitation) of residents they have witnessed, been informed of, or believe that there is or has been maltreatment of a resident." The policy further directed the DON/OD or designee, as appointed by the Administrator, shall call the report to the "Common Entry Point within 24 hours."

At 2:15 p.m. on 10/27/2010, the Director of Nursing (DON) verified the incidents of maltreatment to R9 and R16 had not been reported to the CEP. The DON stated the incidents were not reported because all residents involved had dementia, and the incidents didn't affect R9 and R16.

In addition,

Three reported alleged violations of potential abuse/neglect were not reported to the CEP immediately (within 24 hours), and one of the three alleged violations was not reported to the Administrator within 24 hours.

On 10/28/2010, review of the facility's externally reported "Internal Notification Of Vulnerable Adult Report To The CEP" incidents noted as follows:

An incident which occurred at noon on 7/25/2010, regarding potential verbal abuse by a staff member to R2 was not reported until 7/29/2010, to the Administrator (9:35 a.m.) or CEP (1:35 p.m.). Although the incident was thoroughly investigated, and interventions were implemented, the investigation was not initiated until 7/29/2010.

An incident which occurred at 7:00 a.m. on 8/15/2010, regarding a 3.9cm x 1.9cm bruise

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00381	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/28/2010

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MN VETERANS HOME SILVER BAY	45 BANKS BOULEVARD SILVER BAY, MN 55614

(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
21980	Continued From page 40	21980		

next to R17's left eye was not reported to the CEP until 8/16/2010, at 2:30 p.m. (31 and 1/2 hours later). Although the incident was thoroughly investigated, and interventions were implemented, the investigation was not initiated until 8/16/2010. The Administrator was notified on 8/15/2010.

An incident which occurred on 9/10/2010, (time documented as "a.m./p.m.), regarding R7's pain medication being unavailable due to licensed nurses not obtaining the medication according to the facility's policy/procedure indicated R7 experienced increased pain due to the error. The incident was not reported to the CEP until 9/13/2010, at 5:45 p.m. The Administrator was notified within 24 hours. Although the incident was thoroughly investigated, and interventions were implemented, the investigation was not initiated until 9/13/2010.

At 9:20 a.m. on 10/28/2010, the RN Supervisor (RNS-B) confirmed the three VA incidents were not reported to the CEP within 24 hours. RNS-B stated he reported the incidents to the CEP within 24 hours after he was informed by facility staff, and initiated the investigations. RNS-B verified the staff did not appropriately internally report the incidents within 24 hours.

SUGGESTED METHOD FOR CORRECTION:
The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure all suspected or actual reports of resident maltreatment are reported to the appropriate external agency, and the Administrator immediately (within 24 hours). The Director of Nursing or designee could educate all the appropriate staff on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00381	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/28/2010
NAME OF PROVIDER OR SUPPLIER: **MN VETERANS HOME SILVER BAY**	STREET ADDRESS, CITY, STATE, ZIP CODE: **45 BANKS BOULEVARD SILVER BAY, MN 55614**		

(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
21980	Continued From page 41 polices/procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Seven (7) Days.	21980		
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 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 record review, policy review and interview, the facility failed to report 3 of 3 incidents of maltreatment to the appropriate external agency; and failed to report 3 of 6 alleged violations of maltreatment immediately (within 24 hours) to the appropriate external agency. Findings included: R9 and R16, who were cognitively impaired, were	21990		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00381	A. BUILDING ______ B. WING ______	10/28/2010

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21990	Continued From page 42	21990		

inappropriately touched in a sexual manner by another resident (R3), who was also cognitively impaired. The incidents of maltreatment were not reported according to the facility's "Vulnerable Adults Act" policy (not dated) to the Common Entry Point (CEP) immediately (within 24 hours).

R3 had a diagnosis of dementia. Review of an Orientation-Memory-Concentration Test dated 7/12/2010, indicated R3 had severe cognitive impairment. The admission Minimum Data Set (MDS) dated 7/19/2010, indicated R3 had short term memory problems with moderate cognitive impairment, was usually understood, and usually understood others.

R9's diagnoses included dementia with behavioral disturbance, dementia with lewy bodies, Alzheimer's disease, and anxiety. A Vulnerability/Risk Assessment dated 9/4/2010, indicated R9 was at risk for potential abuse/sexual abuse from other residents due to dementia, the behavior of yelling/screaming, living with other residents with impaired cognition, and the inability to move without assistance. The intervention noted was to separate residents immediately, and report any abuse to the RN. The quarterly Minimum Data Set (MDS) dated 9/30/2010, identified R9 had short and long term memory deficits with severely impaired cognition, was sometimes understood, and sometimes understood others.

R16's diagnoses included dementia with behavioral disturbance, and Alzheimer's disease. A Vulnerability/Risk Assessment dated 9/30/2010, indicated R16 was at risk for potential abuse/sexual abuse from other residents due to declining mental and physical health. The intervention noted was to remove R16 from a

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21990	Continued From page 43	21990		

situation and, notify the RN. The quarterly Minimum Data Set (MDS) dated 10/26/2010, identified R16 had short and long term memory deficits with severely impaired cognition, was rarely/never understood, and sometimes understood others.

Review of a progress note for R3 dated 8/7/2010, indicated staff observed R3 "groping under the shirt of a female resident" (R9). The Incident Report dated 8/7/2010, indicated the residents were separated to prevent further episodes, and R3 would be monitored closely around female residents. Possible medication interventions would be attempted after psychiatric review. A progress note dated 8/12/2010, indicated R3 was noted "touching" and "fondling" other female residents, and attempted to slap a male resident. The Incident Report dated 8/12/2010, indicated R3 fondled R16's "breasts and crotch" in the dining room before supper. R3 was removed from the area. The intervention noted was to not bring R3 to the dining room until meal trays arrive, and monitor closely around female residents. A progress note dated 8/29/2010, indicated R3 "brushed/groped" the "crotch" area of R16, and the residents were separated. The Incident Report dated 8/29/2010, indicated R3 wheeled a wheelchair to R16, and grabbed her "crotch" area as she was standing by chairs at the nursing station. The noted intervention was a psychiatric follow up, and to continue to monitor closely around female residents.

The medical records lacked any indication the incidents of maltreatment were externally reported to the CEP according to the facility's "Vulnerable Adults Act" policy.
The policy identified the definition of "Abuse" to include "any sexual contact or penetration

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NAME OF PROVIDER OR SUPPLIER: **MN VETERANS HOME SILVER BAY**	STREET ADDRESS, CITY, STATE, ZIP CODE: **45 BANKS BOULEVARD SILVER BAY, MN 55614**		

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21990	Continued From page 44	21990		

between facility staff person, or client of the facility", and directed that "any employee, volunteer, consultant, or other person providing services in the facility is required by law and this policy to report any situation of maltreatment (abuse, neglect, financial exploitation) of residents they have witnessed, been informed of, or believe that there is or has been maltreatment of a resident." The policy further directed the DON/OD or designee, as appointed by the Administrator, shall call the report to the "Common Entry Point within 24 hours."

At 2:15 p.m. on 10/27/2010, the Director of Nursing (DON) verified the incidents of maltreatment to R9 and R16 had not been reported to the CEP. The DON stated the incidents were not reported because all residents involved had dementia, and the incidents didn't affect R9 and R16.

In addition,

Three reported alleged violations of potential abuse/neglect were not reported to the CEP immediately (within 24 hours), and one of the three alleged violations was not reported to the Administrator within 24 hours.

On 10/28/2010, review of the facility's externally reported "Internal Notification Of Vulnerable Adult Report To The CEP" incidents noted as follows:

An incident which occurred at noon on 7/25/2010, regarding potential verbal abuse by a staff member to R2 was not reported until 7/29/2010, to the Administrator (9:35 a.m.) or CEP (1:35 p.m.). Although the incident was thoroughly investigated, and interventions were implemented, the investigation was not initiated

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NAME OF PROVIDER OR SUPPLIER: MN VETERANS HOME SILVER BAY	STREET ADDRESS, CITY, STATE, ZIP CODE: 45 BANKS BOULEVARD SILVER BAY, MN 55614		

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21990	Continued From page 45	21990		

until 7/29/2010.

An incident which occurred at 7:00 a.m. on 8/15/2010, regarding a 3.9cm x 1.9cm bruise next to R17's left eye was not reported to the CEP until 8/16/2010, at 2:30 p.m. (seven and a half hours over 24 hours). Although the incident was thoroughly investigated, and interventions were implemented, the investigation was not initiated until 8/16/2010. The Administrator was notified on 8/15/2010.

An incident which occurred on 9/10/2010, (time documented as "a.m./p.m.), regarding R7's pain medication being unavailable due to licensed nurses not obtaining the medication according to the facility's policy/procedure indicated R7 experienced increased pain due to the error. The incident was not reported to the CEP until 9/13/2010, at 5:45 p.m. The Administrator was notified within 24 hours. Although the incident was thoroughly investigated, and interventions were implemented, the investigation was not initiated until 9/13/2010.

At 9:20 a.m. on 10/28/2010, the RN Supervisor (RNS-B) confirmed the three VA incidents were not reported to the CEP within 24 hours. RNS-B stated he reported the incidents to the CEP within 24 hours after he was informed by facility staff, and initiated the investigations.

SUGGESTED METHOD FOR CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure all suspected or actual reports of resident maltreatment are reported to the appropriate external agency, and the Administrator immediately (within 24 hours).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00381	A. BUILDING ___ B. WING ___	10/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME SILVER BAY	45 BANKS BOULEVARD SILVER BAY, MN 55614

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21990	Continued From page 46 The Director of Nursing or designee could educate all the appropriate staff on the polices/procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Seven (7) Days.	21990		
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 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: INTERNAL REPORTING Based on record review, policy review and interview, the facility failed to internally report 3 of 3 alleged violations of maltreatment immediately (within 24 hours) to the appropriate facility staff; and 1 of 9 incidents of alleged maltreatment was not internally reported or thoroughly investigated by the facility. Findings included: Three reported alleged violations of potential abuse/neglect were not internally reported to the appropriate facility staff so an investigation could be initiated within 24 hours. On 10/28/2010, review of the facility's externally	21995		

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21995	Continued From page 47	21995		

reported "Internal Notification Of Vulnerable Adult Report To The CEP" incidents noted as follows:

An incident which occurred at noon on 7/25/2010, regarding potential verbal abuse by a staff member to R2 was not internally reported to the appropriate staff at the time of occurrence. The Incident Report and the investigation was not initiated until 7/29/2010.

An incident which occurred at 7:00 a.m. on 8/15/2010, regarding a 3.9cm x 1.9cm bruise next to R17's left eye was not internally reported to the appropriate staff at the time of occurrence. The Incident Report, and the investigation was not initiated until 31 and 1/2 hours later.

An incident which occurred on 9/10/2010, (time documented as "a.m./p.m.), regarding R7's pain medication being unavailable due to licensed nurses not obtaining the medication according to the facility's policy/procedure indicated R7 experienced increased pain due to the error. The incident was not internally reported to the appropriate staff at the time of occurrence. The Incident Report, and the investigation was not initiated until 9/13/2010, at 5:45 p.m.

Review of R3's nursing progress notes dated 7/20/2010, indicated R3 was sitting next to another resident, and started "touching" the other resident inappropriately. The medical records lacked any other information regarding the incident, and the facility was unable to provide an Incident Report or any further investigation to the surveyor.

The facility's "Vulnerable Adults Act" policy (not dated), directed the facility staff to immediately notify supervisory staff of any suspected and/or

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NAME OF PROVIDER OR SUPPLIER: MN VETERANS HOME SILVER BAY	STREET ADDRESS, CITY, STATE, ZIP CODE: 45 BANKS BOULEVARD SILVER BAY, MN 55614		

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21995	Continued From page 48 observed maltreatment, complete an Incident Report prior to the employee going off duty on the date of the incident, and submit it to the department supervisor. The RN Supervisor should inform the Director of Nursing (DON) and Administrator of any serious incident/injuries and suspected/actual VA situations. At 9:20 a.m. on 10/28/2010, the RN Supervisor (RNS-B) stated he initiated the Incident Reports and investigations of the three externally reported incidents when the facility staff informed him. RNS-B verified the facility staff did not appropriately internally report or document the incidents. At 12:20 p.m. on 10/28/2010, the DON stated she was unable to find any further documentation regarding R3's innapropriate touching incident on 7/20/2010. The DON stated the progress note was vague, and didn't really tell what happened. The DON verified the incident should have been internally reported and investigated further. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure all suspected or actual reports of resident maltreatment are immediately internally reported to the appropriate facility staff, and documented/investigated according to the Vulnerable Adults Act, Sec. 22, 626.5572. The Director of Nursing or designee could educate all the appropriate staff on the polices/procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Seven (7) Days.	21995		

Minnesota Department of Health

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 SILVER BAY	**45 BANKS BOULEVARD SILVER BAY, MN 55614**

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Office of Financial Management, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D.C. 20503.

Provider/Supplier Number	Provider/Supplier Name
	MN VETERANS HOME SILVER BAY

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)
Team Leader 1. 25479	10-25-2010	10-28-2010	2.25	1.00	27.25	2.00	3.00	5.00
2. 28595	10-25-2010	10-28-2010	0.00	1.00	28.00	2.00	3.00	5.00
3. 29433	10-25-2010	10-28-2010	0.00	1.00	27.25	2.00	3.00	8.50
4. 29435	10-25-2010	10-28-2010	0.00	1.00	27.25	0.00	3.00	11.50
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours 4.00

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

RECEIVED
DEC 6 2010
COMPLIANCE MONITORING DIVISION
LICENSE AND CERTIFICATION

PROVIDER: Mn Veterans Home Silver Bay
45 Banks Boulevard
Silver Bay, MN 55614

DATE OF SURVEY: October 25, 2010 through October 28, 2010

BEDS LICENSED:

HOSP: _____ NH: 87 BCH: _____ SLFA: _____ SLFB: _____

CENSUS:
HOSP: _____ NH: 78 BCH: _____ SLF: _____

BEDS CERTIFIED:
SNF/18: _____ SNF 18/19: _____ NFI: _____ NFII: _____ ICF/MR: _____ OTHER: 0

NAME(S) AND TITLE(S) OF PERSONS INTERVIEWED:
Carol Gilbertson, Administrator; Pat Smedstad, RN/DON; Chad Burginger, RN Supervisor; Larry Gomer, RN Supervisor; Julia Alvarez, RN; Bozena Frericks, RN; Susan Cone, RN; Katie Aldinger, RN; Jessica Redfield, LPN; Heidi Nelson, LPN; Constance Haldorson, LPN; Donna Stauss, LPN; Jessica Dehnhoff, LPN; Crystal Peterson, LPN; Linda Heath, HST; Alisha Brown, HST; Pat Hale, HST; Tanya Starkovich, HST; Grace Rabold, HST; Al Davis, HST; Andy Johnson, HST; Kelly Wahl, HST; Darlene Williams, HST; Aaron LeDoux, HST; Heidi Barnard, Cook Supervisor; Tammy Nikula, Cook; Cara Curry, Food Service Worker; Shannon Highland, LSW; Chris Bonander, BSW; Bob McGlaughlin, Building Maintenance Foreman; Gina Thompson, Personnel Officer

SUBJECT: 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.

The exit conference was tape recorded.

SL00381019

Minnesota Department of Health
Licensing and Certification Program

FACILITY MN VETERANS HOME SILVER BAY DATE 10/28/10

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
Cheryl Johnson	HFE Nursing Evaluator II
Terri Ament	HFE Nursing Evaluator II
DeeAnn Haganson	HFE Nursing Evaluator II
Cindy Green	HFE Nursing Evaluator II

Exit Conference Attendees

SIGNATURE	TITLE
[illegible] /RNS	RN Supervisor
[illegible]	Administrator
Pat Smedstad	DON
Gina Thompson	Personnel Officer
Heidi [illegible]	Dietary Manager
Lindsey [illegible]	Personnel Aide
[illegible]	RN Senior
[illegible]	RN Supervisor
[illegible]	BMF

MDH LTC 3201

SENDER: *COMPLETE THIS SECTION*

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Ms. Carol Gilbertson, Administrator
Minnesota Veterans Home – Silver Bay
45 Banks Boulevard
Silver Bay, Minnesota 55614

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Lisa A DeRosier ☐ Agent ☐ Addressee

B. Received by (*Printed Name*) Lisa A DeRosier

C. Date of Delivery 11/10/10

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

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

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

7008 1830 0003 8091 9009

Please return within 5 days

PS Form 3811, February 2004 Domestic Return Receipt 5L0038109 C 102595-02-M-1540