DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: DHZE

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00381

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245628**
2.STATE VENDOR OR MEDICAID NO.
(L2)

3. NAME AND ADDRESS OF FACILITY
(L3) **MN VETERANS HOME SILVER BAY**
(L4) **45 BANKS BOULEVARD**
(L5) **SILVER BAY, MN** (L6) **55614**

4. TYPE OF ACTION: **7** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/02/2016** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
06/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **83** (L18)
13.Total Certified Beds **83** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	83			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Teresa Ament, Unit Supervisor 06/06/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 07/12/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
10/20/2015
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/06/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245628

July 12, 2016

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

Dear Ms. Gilbertson:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective May 30, 2016 the above facility is certified for:

83 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 83 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

June 6, 2016

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

RE: Project Number S5628001

Dear Ms. Gilbertson:

On May 6, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 20, 2016. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On June 2, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on May 27, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 20, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 30, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 20, 2016, effective May 30, 2016 and therefore remedies outlined in our letter to you dated May 6, 2016, will not be imposed.

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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

Enclosure(s)

cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245628 Y1	A. Building B. Wing Y2	6/2/2016 Y3

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

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0282	Correction	ID Prefix F0287	Correction	ID Prefix F0323	Correction
Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.20(f)	Completed	Reg. # 483.25(h)	Completed
LSC	05/30/2016	LSC	05/30/2016	LSC	05/30/2016
ID Prefix F0431	Correction	ID Prefix F0465	Correction	ID Prefix	Correction
Reg. # 483.60(b), (d), (e)	Completed	Reg. # 483.70(h)	Completed	Reg. #	Completed
LSC	05/30/2016	LSC	05/30/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒ X	TA/mm	06/06/2016	29433	06/02/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
4/20/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245628	A. Building 01 - MN VETS HOME B. Wing	5/27/2016

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

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0062	Correction Completed 04/27/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY [X]	**REVIEWED BY (INITIALS)** TL/mm	**DATE** 06/06/2016	**SIGNATURE OF SURVEYOR** 29433	**DATE** 05/27/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 4/26/2016	[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] **YES** [ ] **NO**			

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: DHZE

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00381

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245628**
2.STATE VENDOR OR MEDICAID NO.
(L2)

3. NAME AND ADDRESS OF FACILITY
(L3) **MN VETERANS HOME SILVER BAY**
(L4) **45 BANKS BOULEVARD**
(L5) **SILVER BAY, MN** (L6) **55614**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/20/2016** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
06/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **83** (L18)
13.Total Certified Beds **83** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	83			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Teresa Ament, HFE NEII 05/23/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 06/03/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
10/20/2015
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7013 3020 0001 8869 0947

May 6, 2016

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

RE: Project Number S5628001

Dear Ms. Gilbertson:

On April 20, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6

months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Christine Campbell
Quality Assurance
Minnesota Department of Health
Health Regulation Division
Licensing and Certification Program
Chris.Campbell@state.mn.us
Cell 218-206-3517

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 30, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within ten calendar days of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's PoC if the PoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable PoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A

Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by July 20, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human

Services that your provider agreement be terminated by October 20, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATE OF MINNESOTA DEPARTMENT OF VETERANS AFFAIRS

SILVER BAY VETERANS HOME

★ ★ ★

45 Banks Boulevard • Silver Bay, Minnesota 55614 • (218) 226-6300
Fax (218) 226-6336 • www.mvh.state.mn.us • 1-877-729-8387

May 18, 2016

Chris Campbell, Quality Assurance
Minnesota Department of Health
Health Regulation Division
Licensing and Certification Program
Chris.Campbell@state.mn.us
Cell 218-206-3517

Project Number: S5628001

Dear Ms Campbell,

Our Facility survey was completed on 4/20/2016. As always we look forward to review by our surveying teams. We know how hard surveyors work to assure that standards are made in our facilities. I have enclosed our plan of correction for our Federal and State citations.

All citations will be corrected by May 30, 2016. If you have any questions you may contact Pat Smedstad, DON or me @ 877-729-8387 or email us at one of our State of Minnesota email addresses.

Sincerely,

Carol Gilbertson

Carol Gilbertson, BSN, LNHA
Administrator Silver Bay Veterans Home
Carol.gilbertson@state.mn.us
218-353-8684

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245628	A. BUILDING _____ B. WING _____	04/20/2016

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) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	See attachments for all CMS tags. corrections	5/20/16
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the care plan regarding fall interventions for 2 of 3 residents (R50, R4) reviewed for falls. Findings include: R50's Admission record, dated 3/3/16, identified diagnoses that included Alzheimer's disease, anemia, type I diabetes mellitus, dementia, osteoarthritis, a history of hip fracture and repeated falls. R50's admission Minimum Data Set (MDS) dated 3/10/16, indicated R50 was cognitively impaired and exhibited wandering behaviors. The MDS further indicated that R50	F 282	OK with attachment POC 1 5-19-16 DC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carol Gilbertson | TITLE: Administrator | (X6) DATE: 5/19/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 282	Continued From page 1 required assistance with moving about in bed and extensive assistance with transfers from bed, chair and wheelchair. The MDS further indicated R50 required extensive assistance with dressing, toileting and ambulation. The MDS also indicated a history of orthostatic hypotension (drop in blood pressure when rising from a lying position to sitting or standing.) The MDS further indicated R50 was not steady and was only able to stabilize with staff assistance when moving from a seated to standing position, walking, turning around and facing the opposite direction, moving on and off the toilet and surface-to-surface transfer from bed and chair or wheelchair. R50's care area assessment (CAA) for falls dated 3/16/16, indicated R50 had a history of falls prior to admission,balance problems and was not steady with transfers or walking. The CAA for falls further indicated R50 had three falls the first week after admission. The CAA for falls also indicated safety interventions including hipsters at all times, safety skid socks when in bed, clip call light to clothing in bed and black anti-skid mat at side of bed. R50's care plan dated 4/15/16, directed staff R50 was to have the call light clipped to his clothing when in bed, to ensure a black anti-mat (non-slip,cushioned mat) is at the right side of his bed, to provide assistance with ambulation with walker or use a wheelchair if R50 appeared weak or unsteady, and R50 is to wear hipsters (a garment with impact absorbing pads over the hips to prevent hip fractures that can occur with a fall). R50's Fall Risk assessment dated 4/15/16, indicated multiple falls within the last six months, adequate vision, occasional bladder incontinence,	F 282		

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F 282	Continued From page 2 daily agitated behaviors, no orthostatic BP drop, use of assistive devices with walking and a loss of balance while standing. Review of the facility Post Incident Investigation Worksheets for Falls since 3/3/16, indicated R50 had six falls in the facility from 3/3/16, to 4/15/16. On 4/20/16, at 7:36 a.m., R50 was observed to get up from his bed and walk to the bathroom with no walker and no staff present. The call light was observed not attached to R50's clothing, no black mat was observed at the side of his bed, and R50 was not wearing a hipster garment. R50 was unsteady in the bathroom, holding on to toilet handle. Surveyor requested licensed practical nurse (LPN)-A to assist R50. R50's pants were observed to have a large wet spot in front, and the bathroom floor was observed to have a large puddle of urine. LPN-A assisted R50 to bed and changed R50's pants to clean clothing. At 7:56 a.m., LPN-A placed a black mat by the right side of R50's bed and assisted R50 in donning a hipster garment. On 4/20/16, at 7:51 a.m. LPN-A was interviewed and stated she knew R50 had at least two falls. LPN-A confirmed the black anti-mat was not at R50's bedside when R50 was up in the bathroom, R50 was not wearing a hipster garment and the call light was not clipped to R50's clothing. LPN-A stated changes in the residents' care plan were highlighted and placed on the communication board. On 4/20/16, the at 9:33 a.m. assistant director of nursing (ADON) was interviewed and stated R50 had recently had several falls. The ADON reviewed R50's care plan and stated R50 was to	F 282		

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F 282	Continued From page 3 have assistance of staff and a walker for ambulation and staff was to anticipate R50's needs. The ADON further confirmed R50 was to have the call light clipped to his clothing when in bed and the black anti-mat was not at R50's bedside at time of observation as directed by his care plan. The ADON stated changes in care plans are placed on the communication board, discussed in daily meetings and highlighted in care plan copies placed in the resident's closet space. On 4/20/16, at 12:49 p.m. the director of nursing (DON) was interviewed and confirmed R50's care plan included directives to place a black anti-mat next to R50's bed, clip the call light to R50's clothing when he is in bed, and to ensure R50 wears a hipster at all times. The DON confirmed changes in care plans are placed on the communication board, discussed in daily meetings and highlighted in care plan copies placed in the resident's closet space. The facility's Resident Assessment-Care plan Policy dated 11/5/15, indicated the facility will develop a plan of care for the resident with individualized focuses, goals and interventions in a resident centered format. The policy further directed the resident plan of care will be implemented on the day of admission. The policy also directed the resident's care plan was ongoing and adjusted by the resident's change of status. R4's face sheet dated 4/20/16, indicated R4's diagnoses included vascular dementia with behavioral disturbance, chronic iron deficiency anemia secondary to blood loss, hypothyroidism, delirium, Alzheimer's disease, glaucoma (increased pressure in the eyes, affecting vision),	F 282		

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F 282	Continued From page 4 history of transient ischemic attack (TIA), heart blocks and arrhythmia's. R4's Minimum Data Set (MDS) comprehensive assessment for a significant change dated 4/11/16, indicated R4 had highly impaired vision, short and long term memory impairment, moderately impaired cognitive skills for daily decision-making, and symptoms of delirium. The MDS further indicated R4's behaviors had worsened and included physical and verbal behaviors, and rejection of care 1 to 3 days of the assessment period. In addition, the MDS indicated R4 required extensive assistance of 2 staff for transfers, bed mobility, and toilet use, extensive assistance of one staff for ambulation, and required the assist of staff to stabilize due to impaired balance. The MDS indicated R4 used a walker and a wheelchair, and had 2 falls with no injury and one fall with an injury that was not major since the previous MDS assessment. The Care Area Assessment (CAA) dated 4/11/16, indicated R4 was at risk for falls and had several falls without major injury during the past review period. Safety interventions in place were identified in the CAA, including clipping the call light to R4's shirt when in bed and gripper socks or shoes to be worn at all times. R4's care plan revised 4/12/16, indicated R4 was at risk for falls, had a history of falls and was unaware of safety needs. The care plan directed staff to provide: stand-by assist with all ambulation, assist as needed gait belt at all times, standard wheelchair with anti-rollback brakes for long distance transportation	F 282		

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F 282	Continued From page 5 wear gripper socks or shoes at all times keep bed at transferable height remind to use front-wheeled walker wear hipsters as R4 allows clip call light to shirt to alert staff if he is getting up from bed set up an activity if wandering anticipate and meet needs Approach slowly from the front due to visual problems provide a bedtime snack Walk with human services technician twice daily, distance as tolerated R4's Bedside Kardex Report, located in R4's closet, identified all of the care plan interventions for safety, including clip call light to shirt when R4 goes to bed incase R4 forgets to push the call light to ask for assistance and gripper socks on while in bed. R4's Post-Incident Investigation Worksheets for Falls indicated R4 had 8 falls between 1/21/16 and 4/11/16. Each fall was reviewed and new interventions were initiated as were determined to be appropriate. On 4/20/16, at 7:54 a.m. R4 was lying in bed, sleeping. The call light cord was draped over R4's headboard with the call button on the back side of the headboard. On 4/20/16, at 8:00 a.m. human services technician (HST)-C stated R4's safety interventions included having his bed at transfer height, using his walker, and wheelchair as he needs. HST-C stated R4 required a gait belt as he needs, because he is unsteady at times. On 4/20/16, during an observation and interview	F 282		

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F 282	Continued From page 6 at 10:20 a.m. licensed practical nurse (LPN)-A read the closet care guide. R4 was lying in bed. LPN-A verified the call light was not clipped to R4's shirt and R4 did not have gripper socks on, but should have. LPN-A clipped the call light cord to R4's shirt and put some gripper socks on him. On 4/20/16, at 12:30 p.m. R4 was lying in bed, but was dressed. The call light was not clipped to his shirt, but was lying on the bed next to his right shoulder. HST-C verified it was not clipped to him and said it was clipped earlier. On 4/20/16, at 2:09 p.m. the director of nursing (DON) stated staff should refer to the bedside Kardex to implement safety interventions. The DON stated changes in resident cares or interventions are communicated to staff through daily report and through the bedside Kardex.	F 282		
F 287 SS=E	483.20(f) ENCODING/TRANSMITTING RESIDENT ASSESSMENT (1) Encoding Data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. (2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS	F 287	SEE ATTACHED POC	04/21/16

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F 287	Continued From page 7 System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. (3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i) Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on a resident that does not have an admission assessment. (4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to encode or transmit Minimum Data Set (MDS) data to the Center for Medicare/Medicaid (CMS) system timely for 57 of 80 residents.	F 287		

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F 287	Continued From page 8 Findings include: On 4/20/16, at 8:30 a.m. registered nurse (RN)-E was interviewed and stated the facility completed an MDS on all residents, however, due to an inaccurate facility identification number and problems with the facility software, the facility was unable to transmit the MDSs to CMS. RN-E stated the facility submitted the first batch of MDSs on 4/1/16, and they would continue to submit every Thursday. On 4/20/16, at 12:17 p.m. the administrator, the director of nursing (DON) and RN-E were interviewed. The administrator stated the facility had an incorrect identification number and software problems that left them unable to transmit MDS data. The administrator stated the facility became Medicare certified 10/20/15. RN-E verified 57 residents' MDS data had not been submitted to CMS. The facility was unable to provide a policy on transmission of MDSs to CMS.	F 287		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 323	SEE ATTACHED POC	05/30/16

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F 323	Continued From page 9 Based on observation, interview and document review, the facility failed to implement appropriate interventions to minimize the risk for falls for 2 of 3 residents (R50, R4). Findings include: R50's admission record, dated 3/3/16, identified diagnoses that included Alzheimer's disease, anemia, type I diabetes mellitus, dementia, osteoarthritis, and a history of hip fracture with repeated falls. R50's admission Minimum Data Set (MDS) dated 3/10/16, indicated R50 was cognitively impaired and exhibited wandering behaviors. The MDS further indicated that R50 required assistance with moving about in bed and extensive assistance with transfers from bed, chair and wheelchair. The MDS further indicated R50 required extensive assistance with dressing, toileting and ambulation. The MDS also indicated a history of orthostatic hypotension (drop in blood pressure when rising from a lying position to sitting or standing.) The MDS further indicated R50 was not steady and was only able to stabilize with staff assistance when moving from a seated to standing position, walking, turning around and facing the opposite direction, moving on and off the toilet and surface-to-surface transfer from bed and chair or wheelchair. R50's Care Area Assessment (CAA) for cognitive loss/dementia dated 3/15/16, indicated R50 had confusion, disorientation, forgetfulness and decreased ability to make self understood or to understand others. The CAA further indicated hearing and/or visual loss may have an impact on R50's ability to process information. The CAA for falls dated 3/16/16, indicated R50 had a history of falls prior to admission,. balance problems and	F 323		

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F 323	Continued From page 10 was not steady with transfers or walking. The CAA for falls further indicated R50 had three falls the first week after admission. The CAA for falls also identified safety interventions including hipsters at all times, safety skid socks when in bed, clip call light to clothing in bed and black anti-skid mat at side of bed. R50's care plan dated 4/15/16, directed staff R50 was to have the call light clipped to his clothing when in bed, to ensure a black anti-mat (non-slip,cushioned mat) is at the right side of his bed, to provide assistance with ambulation with walker or use a wheelchair if R50 appeared weak or unsteady, and R50 was to wear a hipster (a garment with impact absorbing pads over the hips to prevent hip fractures that can occur with a fall). R50's Fall Risk assessment dated 4/15/16, indicated multiple falls within the last six months, adequate vision, occasional bladder incontinence, daily agitated behaviors, no orthostatic BP drop, use of assistive devices with walking and a loss of balance while standing. Review of the facility Post Incident Investigation Worksheets for Falls since 3/3/16, indicated the following: On 3/3/16, at 6:00 p.m. R50 fell when attempting to exit the facility locked unit door, slid down the door,hit his nose and sustained a cut to the bridge of his nose. Current care plan interventions in place were proper fitting foot wear, automatic locking bakes on wheelchair, escort for outside appointments and non-skid socks when in bed. New care intervention: Redirect resident from entranced/exit doors if trying to exit. The interdisciplinary team (IDT) met	F 323		

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F 323	Continued From page 11 on 3/4/16, and directed the following actions: Check orthostatic blood blood pressure (BP) x 7 days, one person assist with ambulation until he as oriented to his surroundings, anticipate his needs, hipsters at all times, redirect resident and provide one visit/activities if noted to be exit seeking. On 3/4/16, at 11:42 p.m. R50 was found on the bathroom floor with hands on sink. The falls investigation worksheet indicated no injury. Current care plan interventions were: one person assist with ambulation until R50 oriented to surroundings, hipsters at all times, proper foot wear, magnetic lock to right wrist (a wristband that will alert staff if a resident attempts to leave a secure unit), automatic locking brakes on wheelchair, escort for outside appointments, non-skid socks when in bed, and lying, sitting and standing BP measurements New care intervention: Clip call light to pajamas when R50 was in bed to alert staff if resident forgets to call for help. The IDT met on 3/7/16, and directed the resident is currently being monitored per MD order for orthostatic BP changes, elevated BP, calorie count and elevated glucose (blood sugar) readings. The IDT further directed the resident was to be seen 3/8/16 on MD rounds. On 3/5/16, at 7:31 a.m. R50 was found on the floor of his room with his head by the bathroom door with a blanket under his head. R50 said he slipped on a rug while trying to go to the bathroom, pointing to the blanket The worksheet documented no injury. The falls investigation worksheet indicated R50 had a 43 point drop in systolic blood pressure from a lying to standing position (orthostatic BP). The falls investigation worksheet also indicated R50 had a blood	F 323		

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F 323	Continued From page 12 glucose reading of 48 (normal blood glucose is 70-99). Current care plan interventions in place were one person assist with ambulation until R50 oriented to surroundings, hipsters at all times, anticipate R50's needs, proper foot wear, magnetic lock to right wrist, automatic locking brakes on wheelchair, escort for outside appointments, non-skid socks when in bed, and lying/sitting/ standing BP measurements. The IDT met on 3/7/16, and directed R50 was on a strict calorie count with blood glucose checks before meals and at bedtime, monitoring elevated BP and orthostatic BP. The IDT further directed R50 to be seen on MD rounds on 3/8/16. On 4/12/16, at 10:55 p.m. R50 fell on mat near bed. R50 stated he was trying to get something to eat. A 13.5 x 9 centimeter reddened area was noted on his right hip. The falls investigation worksheet indicated orthostatic BP was not applicable and lacked documentation of blood glucose. The IDT met on 4/13/16, and directed post void bladder scans x three days, a bedside commode at night and to try to move his bed closer to the lobby to allow staff monitoring when resident is in bed. A note in the falls investigation worksheet indicated all bladder scans were within accepted parameters. On 4/14/16, at 6:06 a.m. R50 was found on floor between wheelchair and a chair in the common resident area. The falls investigation worksheet lacked documentation of injury. The falls investigation worksheet indicated no orthostatic BP drop and lacked documentation of blood glucose. Post fall meeting staff met on 4/14/16, and directed staff to perform 30 minute checks until it was determined if R50 had a urinary tract infection. The team further directed staff to push	F 323		

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F 323	Continued From page 13 fluids and provide supervision if R50 had behaviors or was not redirectable. The physician was notified, and lab work ordered. On 4/15/16, at 3:45 p.m. R50 was found in the bathroom leaning against the wall between sink and wall. The falls investigation worksheet indicated no orthostatic BP drop or injury and lacked documentation of blood glucose. The falls investigation worksheet did not list care interventions in place on 4/15/16. The physician was called with a finding of an elevated C-reactive protein (CRP, an indication of infection) and ordered R50 to be transported to the emergency room. On 4/18/16, the IDT notes indicated R50 was diagnosed with pneumonia and bladder spasms; antibiotics were ordered and oxybutynin ordered for bladder spasms. On 4/20/16, at 7:36 a.m., R50 was observed to get up from his bed and walk to the bathroom with no walker and no staff present. The call light was observed not attached to R50's clothing, no black mat was observed at the side of his bed, and R50 was not wearing a hipster garment. R50 was unsteady in the bathroom, holding on to toilet handle. Surveyor requested licensed practical nurse (LPN)-A to assist R50. R50's pants were observed to have a large wet spot in front, and the bathroom floor was observed to have a large puddle of urine. LPN-A assisted R50 to bed and changed R50's pants to clean clothing. At 7:56 a.m., LPN-A placed a black mat by the right side of R50's bed and assisted R50 in donning a hipster garment. On 4/20/16, at 7:51 a.m. LPN-A was interviewed and stated she knew R50 had at least two falls. LPN-A confirmed the black anti-mat was not at	F 323		

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F 323	Continued From page 14 R50's bedside when R50 was up in the bathroom, R50 was not wearing a hipster garment and the call light was not clipped to R50's clothing. LPN-A stated changes in the residents' care plan are highlighted and placed on the communication board. On 4/20/16, at 9:33 a.m. the assistant director of nursing (ADON) was interviewed and stated R50 had several falls recently. The ADON reviewed R50's care plan and stated R50 was to have assistance of staff and a walker for ambulation and staff was to anticipate R50's needs. The ADON further confirmed R50 was to have the call light clipped to his clothing when in bed and the black anti-mat was not at R50's bedside at time of observation as directed by his care plan. The ADON stated changes in care plans were placed on the communication board, discussed in daily meetings and highlighted in care plan copies placed in the resident's closet space. On 4/20/16, at 12:49 p.m. the director of nursing (DON) was interviewed and confirmed R50's care plan included directives to place a black anti-mat next to R50's bed, clip the call light to R50's clothing when he is in bed, and to ensure R50 wore hipsters at all times. The DON confirmed changes in care plans were placed on the communication board, discussed in daily meetings and highlighted in care plan copies placed in the resident's closet space. The facility's Fall Prevention policy dated 5/15, directed floor mats to be placed at the resident's bedside for those residents who have fallen or at high risk for a fall from bed. The policy further directed additional approaches for fall prevention, including protective equipment such as hip pads.	F 323		

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F 323	Continued From page 15 R4's face sheet dated 4/20/16, indicated R4's diagnoses included vascular dementia with behavioral disturbance, chronic iron deficiency anemia secondary to blood loss, hypothyroidism, delirium, Alzheimer's disease, glaucoma (increased pressure in the eyes, affecting vision), history of transient ischemic attack (TIA), heart blocks and arrhythmia. R4's Minimum Data Set (MDS) comprehensive assessment for a significant change dated 4/11/16, indicated R4 had highly impaired vision, short and long term memory impairment, moderately impaired cognitive skills for daily decision-making, and symptoms of delirium. The MDS further indicated R4's behaviors had worsened and included physical and verbal behaviors, and rejection of care 1 to 3 days of the assessment period. R4 required extensive assistance of 2 staff for transfers, bed mobility, and toilet use, extensive assistance of one staff for ambulation, and required the assist of staff to stabilize due to impaired balance. The MDS indicated R4 used a walker and a wheelchair, and had 2 falls with no injury and one fall with an injury that was not major since the previous MDS assessment. The Care Area Assessment (CAA) dated 4/11/16, indicated R4 was at risk for falls and had several falls without major injury during the past review period. The CAA identified diagnoses and medications that were potential fall risk factors. Safety interventions in place were identified including clipping the call light to R4's shirt when in bed and gripper socks or shoes to be worn at all times.	F 323		

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F 323	Continued From page 16 R4's care plan revised 4/12/16, indicated R4 was at risk for falls, had a history of falls and was unaware of safety needs. The care plan directed staff to provide: stand-by assist with all ambulation, assist as needed gait belt at all times, standard wheelchair with anti-rollback brakes for long distance transportation wear gripper socks or shoes at all times keep bed at transferable height remind to use front-wheeled walker wear hipsters as R4 allows clip call light to shirt to alert staff if he is getting up from bed set up an activity if wandering anticipate and meet needs Approach slowly from the front due to visual problems provide a bedtime snack Walk with human services technician twice daily, distance as tolerated R4's Bedside Kardex Report, located in R4's closet, identified all of the care plan interventions for safety, including clip call light to shirt when R4 goes to bed in case R4 forgets to push the call light to ask for assistance and gripper socks on while in bed. R4's signed physician orders dated 3/28/16, included medications that had the potential to affect R4's falls, including verapamil (increased blood pressure), timolol eye drops for glaucoma, hydrochlorothiazide (diuretic), seroquel (antipsychotic), and omeprazole (gastro-esophageal reflux). A physician's progress note dated 3/28/16,	F 323		

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F 323	Continued From page 17 indicated R4 had frequent falls and physical therapy was noted to probably not be beneficial for R4. A physician's progress note dated 4/6/16, indicated R4 had a fall on 4/5/16, and was not moving as well. The physician identified contributing factors to R4's falls, including cognitive impairment and TIA's. R4's admission Fall Risk Assessment (FRA) darted 12/30/16, identified R4 as being at high risk for falls. R4's Post-Incident Investigation Worksheets for Falls indicated R4 had 8 falls between 1/21/16 and 4/11/16: On 1/21/16, at 8:30 p.m. R4 sat on the walker and tipped backwards to the floor. R4 had no injury. The interdisciplinary team (IDT) met on 1/22/16, and the new intervention was to put a "Do not sit" sign on the walker to remind R4 not to sit on top of the walker. On 2/12/16, at 2:30 p.m. R4 had an unwitnessed fall in the dining room, about 4 steps from where he had been sitting. R4 had a small abrasion on the back of the head. The IDT met on 2/16/16, and orthostatic blood pressures (blood pressures taken when lying, sitting and then standing) were checked for 3 days. R4 did not complain of being dizzy or light-headed. On 2/24/16, at 7:10 a.m. R4 was sitting on the floor beside the bed. R4's walker was tipped over on the floor next to R4, and R4 was stating he had to have a bowel movement. R4 had no injury. It was noted R4's blood pressure dropped from 133/72 while sitting, to 114/69 while standing. The IDT met and initiated the new intervention of offering toileting on last round of the shift. Orthostatic blood pressure checks following the incident, indicated R4 had no orthostasis.	F 323		

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F 323	Continued From page 18 On 3/4/16, at 4:50 p.m. R4 was witnessed walking without a walker and lost his balance and fell. R4 had no injury. The IDT met on 3/7/16, and the new intervention was to keep resident's walker close to him at all times. This intervention was no longer in the care plan or the bedside Kardex. On 3/18/16, at 3:15 p.m. R4 was walking out of a bathroom, lost his balance, the walker tipped over and R4 fell. R4 had a skin tear on the right elbow. During a post-fall meeting, the staff identified he needed to wear a gait belt at all times. The IDT met on 3/21/16 and indicated R4 needed to sleep-in in the morning, offered a bedtime snack, and required stand-by-assist with ambulation. On 3/23/16, at 10:10 p.m. R4 was found on the floor next to his roommates bed and had a bowel movement. R4 had no injury. The IDT met on 3/23/16, and approved new interventions that were initiated by staff during a post-fall review following the fall. These interventions included R4 was to wear hipsters to help prevent injury and the call light was to be clipped to R4's shirt at night when put to bed. On 4/5/16, at 7:40 p.m. R4 had walked into the living room and was standing along the wall with the walker. R4 appeared to side-step and fall to the right with the walker. The post-fall meeting was held on 4/5/16, and staff discussed different contributing factors and possible root cause for the fall. R4's physician reviewed medications and ordered lab work. The action initiated was to ambulate with stand-by assist at least twice daily at a distance as tolerated, and resident needed reminders to use the walker with assistance. On 4/11/16, at 8:30 p.m. R4 was running without his walker and tripped over another resident's foot. R4 was wearing someone else's shoes. R4	F 323		

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F 323	Continued From page 19 had no injury. The IDT met on 4/12/16, and the action was to locate R4's shoes and assist him with using the wheelchair if he is refusing to use the walker properly. Orthostatic blood pressures were checked and it was determined R4 did not have orthostasis. A FRA was completed after each fall. Each FRA included a review of risk factors, medications, vision, continence of bowel and bladder, behaviors, mobility, blood pressures, gait and balance. R4 was determined to be at moderate or high risk for falls with each FRA. On 4/20/16 at 7:54 a.m. R4 was lying in bed, sleeping. The call light cord was draped over R4's headboard with the call button on the back side of the headboard. On 4/20/16, at 8:00 a.m. human services technician (HST)-C stated R4's safety interventions included having his bed at transfer height, using his walker, and wheelchair as he needs. HST-C stated R4 required a gait belt as he needs, because he is unsteady at times. On 4/20/16, during an observation and interview at 10:20 a.m. with licensed practical nurse (LPN)-A the closet care guide was reviewed. R4 was lying in bed. LPN-A verified the call light was not clipped to R4's shirt and R4 did not have gripper socks on, but should have had both. LPN-A clipped the call light cord to R4's shirt and put some gripper socks on him. On 4/20/16, at 12:30 p.m. R4 was lying in bed, but was dressed. The call light was not clipped to his shirt, but was lying on the bed next to his right shoulder. HST-C verified it was not clipped to him and said it was clipped earlier. R4 had gripper socks on.	F 323		

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F 323	Continued From page 20 On 4/20/16, at 2:09 p.m. the director of nursing (DON) stated following a fall, a small post-fall meeting was held to discuss the fall and initiate immediate interventions. The IDT met for a follow-up meeting to assess effectiveness or decide if a new interventions should be initiated. The DON verified staff should refer to the bedside Kardex to implement safety interventions. The DON stated changes in resident cares or interventions are communicated to staff through daily report and through the bedside Kardex.	F 323		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked,	F 431	SEE ATTACHED POC	05/30/16

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F 431	Continued From page 21 permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to store medications at proper temperatures in 2 of 4 medication refrigerators reviewed. Findings include: On 4/19/16, at 3:52 p.m. the medication refrigerator on Maple unit was 34 degrees F (Fahrenheit). Trained medication assistant (TMA)-A verified this reading on the thermometer. On 4/20/16, at 12:20 p.m. the medication refrigerator on Maple unit was 34 degrees F. Registered nurse (RN)-F verified the thermometer reading. RN-F stated the night nurses checked the refrigerator temperature. RN-F also stated she did not know the range the temperature should be in but she usually saw the temperature in the refrigerator to be 34 degrees F. At 12:25 p.m. the assistant director of nursing (ADON) stated the medication refrigerator temperatures should be within 38-44 degrees Fahrenheit. The ADON verified the outside	F 431		

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F 431	Continued From page 22 thermometer of the refrigerator read 54 degrees and stated, "The thermometer is not accurate at all." The ADON stated she would get maintenance to fix it. The ADON stated staff was supposed to adjust the dial when the refrigerator temperature was out of range and then re-temp a hour later. The ADON verified the refrigerator temperatures since 4/4/16, had been running low 30 degrees F on 4/4/16, temperature was not read on 4/5/16, and 32 degrees F through 4/7/16. The ADON also verified temperatures on the log had read low off and on since 2/16/16, with a reading of 26 degrees on 2/16/16, 28 degrees F on 2/17-18/16, and 30 degrees and 32 degrees frequently from then on and through March and April 2016. The ADON stated the refrigerator temps log did not have a place for the readjustment or for the refrigerator temperature when rechecked after the adjustment. On 4/20/16 at 1:06 p.m. the medication refrigerator temperature on Maple unit read 32 degrees F. RN-F verified the reading on the thermometer and stated she would turn up the dial a little and would recheck the temperature on her shift. RN-F stated the vaccines in the refrigerator were used to administer to residents and staff. The refrigerator contained: a box of interferon beta-1a IM (intramuscular) medication a box of Risperdal Consta IM medication The inserts in the boxes indicated the medications should be stored 36-46 degrees. The sticker on the boxes indicated the medications should be refrigerated but not be frozen. 21 influenza vaccines	F 431		

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F 431	Continued From page 23 15 FluZone Quad vaccines 3 unopened vials of Lantus insulin 12 acetaminophen 650 mg (milligrams) suppositories On 4/20/16, at 1:21 p.m. the ADON sitting with the director of nursing (DON) stated they were working on a correction for this. The ADON stated the Minneapolis pharmacy said the medication refrigerator temperatures should be maintained within 36-46 degrees F. At 1:27 p.m. the DON stated, "I will call the pharmacy." At approximately 1:52 p.m. the DON stated, "I talked to pharmacy, they said it is borderline, the medications might still be good." On 4/20/16, at 1:45 p.m. the medication refrigerator on the Blue Spruce unit was 31 degrees F. The refrigerator temperature log indicated the refrigerator temperature readings had been consistently 30 to 32 degrees F since 4/4/16. Prior to 4/4/16, the temperature log indicated the temperatures recorded had been 30-32 degrees F, 14 of 98 readings since 1/1/16, with intermittent readings of 36 degrees F or above. Licensed practical nurse (LPN)-D verified the refrigerator temperature was below 36 degrees F and the temperature log readings had been below 36 degrees F. The refrigerator contained: one opened one milliliter (ml) vial of Tuberculin solution with approximately 0.5 milliliters remaining. two unopened 10 ml vials of Lantus insulin two unopened ml vials of human NPH insulin one unopened one vial of hepatitis B vaccine The package inserts for these medications	F 431		

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F 431	Continued From page 24 indicated they should be stored in a refrigerator between 36 and 46 degrees F, and should not be frozen. The package insert for the Tuberculin solution indicated it should be stored between 35 and 46 degrees F. On 4/20/16, at 1:59 p.m. the DON verified the medication refrigerator temperature range should be between 36 and 46 degrees. The DON stated the facility would contact the pharmacy for direction regarding medications in the refrigerators. The policy provided by the facility dated 8/13/15, Medication Storage and Security indicated: "All prescription, nonprescription medications and biologicals are to be kept safe, orderly, secure and accessible to authorized nursing personnel only. Whenever there are biologicals stored in the refrigerator the temperature must be monitored at least twice daily as close to 12 hour intervals as possible. Biologicals drugs include antibodies, interleukins, and vaccines. Refrigerator Temperatures: A range of 36 to 46 degrees Fahrenheit."	F 431		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a clean and	F 465	SEE ATTACHED POC	05/30/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245628	A. BUILDING _____ B. WING _____	04/20/2016

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) COMPLETION DATE
F 465	Continued From page 25 homelike environment was maintained in 4 of 31 resident rooms (203, 211, 225, 226) and the Blue Spruce household dining room. Findings include: On 4/19/16, beginning at 3:30 p.m. during an environmental tour, the maintenance director (MD) and a maintenance staff member (MS) verified the following environmental findings: Room 203: on the wall next to the bathroom was an area approximately 6 inches by 4 inches of chipped and missing sheet rock on the bottom of the wall creating a rough, uncleanable surface. The other side of the wall corner was covered with an unpainted, uncleanable board that was approximately 4 feet long and 6 inches wide. Room 211: the heat register had several areas of paint scratched off. The corner molding between the sink and the bathroom at the bottom was broken off approximately 3 inches by 4 inches creating a rough, uncleanable surface. Room 225: had a dime sized hole in the ceramic tile in the bathroom wall by toilet creating an uncleanable area. Room 226: had an approximately 4 inch by 1 inch chipped area in the ceramic tile on the bathroom wall causing a rough and uncleanable surface. The Blue Spruce dining room the corner edge of the wall between the two rooms had two chipped areas with missing and exposed sheet rock. The areas measured approximately 4 inches by 2 inches and 1 inch by 1 inch causing a rough and uncleanable surface. In addition the molding	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245628	A. BUILDING _____ B. WING _____	04/20/2016

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) COMPLETION DATE
F 465	Continued From page 26 under the window ledge was missing and exposed the sheet rock. On 4/19/16, at 3:50 p.m. the MD stated a painter for resident room worked one weekend a month to repair and paint resident rooms and another painter worked every third weekend to repair and paint hallways and other areas. The MS stated there was not a schedule or log of what had been done or what needed to be done. The MD further stated the facility had a computer system in which staff could notify maintenance of areas needing repair. The system was checked daily. The facility's Maintenance Service policy dated 2015, indicated the maintenance department was responsible for maintaining the buildings, grounds and equipment in a safe and operable manner. The functions performed by maintenance included maintaining the building in good repair and free from hazards. Provide routine scheduled maintenance to all areas. The policy further indicated painting and room maintenance would be done in a three to four week cycle.	F 465		

CMS STATE HOME INSPECTION (2016)

SURVEY CLASS	SURVEY YEAR			
Annual Survey	2016			
NAME OF FACILITY	**STREET ADDRESS**	**CITY**	**STATE**	**ZIP CODE**
Silver Bay Veterans Home	45 Banks Blvd	Silver Bay	MN	55614

SURVEYED BY

STANDARDS FOR NURSING HOME CARE	RATING	EXPLANATORY STATEMENTS	FACIILITY CITATION ACTION	PREVENTION	MONITORING PLAN	CORRECTION DATE
F282 483.20(k)(3)(ii) **Services by qualified persons per care plan.** The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. MN RULE 4658.0405 SUBP. 3. A comprehensive plan of care must be used by all personnel involved in the care of the resident. F282 483.20(k)(3)(ii)	D	Based on observation, interview and document review, the facility failed to follow the care plan regarding fall interventions for 2 of 3 residents (R50 & R4) reviewed for falls	Staff were provided education regarding the facility policy on fall prevention and following the plan of care. **Completed on 5/5/16, 5/11/16 and 5/16/16. See attachments.** A falling leaf board that identifies high fall risk residents has been posted in the documentation centers; to enhance cross departmental employee awareness. **Initiated on 4/26/16** RN and LPN staff will round during each shift on their household to check that care planned safety devices are in place. Just in time education will be provided as appropriate. **Initiated on 4/26/16** The facility will continue the practice of a post fall huddle, weekday incident reviews and post incident interventions. **Reviewed & updated on 4/26/16** • Licensed staff will utilize the **Checklist for Assessing Fall Risk and Post-fall Review** to assist them in determining potential interventions. **Initiated on 5/9/16 See attachment.** • The IDT will meet, assess and implement further interventions	Supervisors will conduct audits that check for the following: Safety devices are in place, staff awareness of the falling leaf program, nursing verbalization on fall prevention policy and on fall risk resident care planned awareness, interventions and where to locate the plan. Just in time education will be provided as appropriate. **Initiated on 5/16/16**	Supervisor, MDS Nurse audits will be monitored through our QAPI program. Monitoring will occur monthly until 100% compliance is achieved. When 100% compliance is achieved reports will be submitted quarterly x 3 months to assure on going compliance.	CORRECTED ON 5/30/16

CMS STATE HOME INSPECTION (2016)

SURVEY CLASS	SURVEY YEAR			
Annual Survey	2016			
NAME OF FACILITY	**STREET ADDRESS**	**CITY**	**STATE**	**ZIP CODE**
Silver Bay Veterans Home	45 Banks Blvd	Silver Bay	MN	55614

SURVEYED BY

STANDARDS FOR NURSING HOME CARE	RATING	EXPLANATORY STATEMENTS	FACIILITY CITATION ACTION	PREVENTION	MONITORING PLAN	CORRECTION DATE
Services by qualified persons per care plan. CONTINUED			for residents with continued falls. **Initiated 4/22/16.** Staff complete care plan reviews on a scheduled rotation. Staff will continue reviews with an increased focus on reviewing and updating safety interventions. **Initiated 4/26/16** RCA's were completed for residents cited in the deficiency. **R50 completed on 4/22/16 and R4 on 5/2/16.**	MDS Nurses and/or Designee will audit care plan's interventions when residents trigger as a fall risk, are having continual falls and/or as appropriate. Interventions shall occur and just in time education shall be provided as appropriate. **Initiated on 5/18/16** RCA recommendations for R4 and R50 were implemented as appropriate **by 5/18/16.**	Resident R50 and R4's fall interventions compliance will be monitored through the QAPI program. Monitoring will occur monthly until 100% compliance is achieved. When 100% compliance is achieved reports will be submitted quarterly x 3 months to assure on going compliance. **QAPI reporting will begin in June 2016.**	

CMS STATE HOME INSPECTION (2016)

SURVEY CLASS	SURVEY YEAR			
Annual Survey	2016			
NAME OF FACILITY	**STREET ADDRESS**	**CITY**	**STATE**	**ZIP CODE**
Silver Bay Veterans Home	45 Banks Blvd	Silver Bay	MN	55614

SURVEYED BY

STANDARDS FOR NURSING HOME CARE	RATING	EXPLANATORY STATEMENTS	FACIILITY CITATION ACTION	PREVENTION	MONITORING PLAN	CORRECTION DATE
F287 483.20(f) **Encoding/Transmitting Resident Assessment** (1) Encoding data. Wilthin 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment (ii) Annual assessment updates (iii) Significant change in status assessments (iv) Quarterly review assessments (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background information, if there is no admission assessment.	E	Based on interview and document review, the facility failed to encode or transmit Minimum Data Set (MDS) data to the Cetner for Medicare/Medicaid (CMS) system timely for 57 of 80 residents.	Our facility is a newly certified CMS facility. All documents were completed on time. Transmission occurred timely to the Federal VA system. We had difficulty submitting to the CMS system related to system complexities. In addition we made multiple attempts to submit to the CMS system without success. During our survey we were provided with a State contact who assisted us in transmitted the 57 MDS's noted previously. The 57 residents that were affected by the deficient practice were submitted to CMS **on 4/21/2016.**	The MDS nurse prior to closing the MDS is now coding A0410 as a 3 (Federal Required Submission) this coding began on 4/1/16. MDS transmission policy shall be followed. MDS's will continue to be submitted as appropriate. **See attachment.**	The MDS Coordinator and/or designee will monitor submission for timelines will be monitored through the QAPI program. Monitoring will occur monthly until 100% compliance is achieved. When 100% compliance is achieved reports will be submitted quarterly x 3 months to assure on going compliance. **QAPI reporting will begin in June 2016.**	CORRECTED ON 4/21/16

CMS STATE HOME INSPECTION (2016)

SURVEY CLASS	SURVEY YEAR			
Annual Survey	2016			
NAME OF FACILITY	**STREET ADDRESS**	**CITY**	**STATE**	**ZIP CODE**
Silver Bay Veterans Home	45 Banks Blvd	Silver Bay	MN	55614

SURVEYED BY

STANDARDS FOR NURSING HOME CARE	RATING	EXPLANATORY STATEMENTS	FACIILITY CITATION ACTION	PREVENTION	MONITORING PLAN	CORRECTION DATE
F323 483.25(h) **Free of Accident Hazards/Supervision/ Devices** The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. MN Rule 4658.0520 subp.1 A resident must receive nursing care and treatment, personal care and supervision based on individual needs and preferences.	D	Based on observation, interview and document review, the facility failed to follow the care plan regarding fall interventions for 2 of 3 residents (R50 & R4) reviewed for falls	Staff were provided education regarding the facility policy on fall prevention. **Completed on 5/5/16, 5/11/16** and 5/16/16. **See attachments** A falling leaf board that identifies high fall risk residents has been posted in the documentation centers; to enhance cross departmental employee awareness. **Initiated on 4/26/16** RN and LPN staff will round during each shift on their household to check that care planned safety devices are in place. Just in time education will be provided as appropriate. **Initiated on 4/26/16** The facility will continue the post fall huddles, weekday incident reviews and post incident interventions. **Reviewed & updated on 4/26/16** • Licensed staff will utilize the **Checklist for Assessing Fall Risk and Post-fall Review** to assist them in determining potential interventions. **Initiated on 5/9/16 see attachment.** • The IDT will meet, assess and implement further interventions for residents with continued falls. 4/22/16.	Supervisors will conduct audits that check for the following: Safety devices are in place, staff awareness of the falling leaf program, nursing verbalization on fall prevention policy and on fall risk resident care planned awareness, interventions and where to locate the plan. Just in time education will be provided as appropriate. **Initiated on 5/16/16.**	Supervisor, MDS Nurse audits will be monitored through our QAPI program. Monitoring will occur monthly until 100% compliance is achieved. When 100% compliance is achieved reports will be submitted quarterly x 3 months to assure on going compliance. **QAPI reporting will begin in June 2016.**	CORRECTED ON 5/30/16

CMS STATE HOME INSPECTION (2016)

SURVEY CLASS	SURVEY YEAR
Annual Survey	2016

NAME OF FACILITY	STREET ADDRESS	CITY	STATE	ZIP CODE
Silver Bay Veterans Home	45 Banks Blvd	Silver Bay	MN	55614

SURVEYED BY

STANDARDS FOR NURSING HOME CARE	RATING	EXPLANATORY STATEMENTS	FACIILITY CITATION ACTION	PREVENTION	MONITORING PLAN	CORRECTION DATE
F323 483.25(h) **Free of Accident Hazards/Supervision/ Devices** **CONTINUED**			Staff complete care plan reviews on a scheduled rotation. Staff will continue reviews with an increased focus on reviewing and updating safety interventions. **Initiated 4/26/16** RCA's were completed for residents cited in the deficiency. **R50 completed on 4/22/16 and R4 on 5/2/16.**	MDS Nurses and/or Designee will audit care plan's interventions when residents trigger as a fall risk, are having continual falls and/or as appropriate. Interventions shall occur and just in time education shall be provided as appropriate. **Initiated on 5/18/16** RCA recommendations for R4 and R50 were all implemented by **5/18/16.**	Resident R50 and R4's fall interventions compliance will be monitored through the QAPI program. Monitoring will occur monthly until 100% compliance is achieved. When 100% compliance is achieved reports will be submitted quarterly x 3 months to assure on going compliance. **QAPI reporting will begin in June 2016.**	

CMS STATE HOME INSPECTION (2016)

SURVEY CLASS	SURVEY YEAR
Annual Survey	2016

NAME OF FACILITY	STREET ADDRESS	CITY	STATE	ZIP CODE
Silver Bay Veterans Home	45 Banks Blvd	Silver Bay	MN	55614

SURVEYED BY

STANDARDS FOR NURSING HOME CARE	RATING	EXPLANATORY STATEMENTS	FACILITY CITATION ACTION	PREVENTION	MONITORING PLAN	CORRECTION DATE
F431 483.60(b),(d),(e) **Drug Records, Label/store Drugs & Biologicals** In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys. MN RULE 4658.1340 Subp.1	E	Based on observation, interview and document review the facility failed to store medication at proper temperatures in 2 of 4 medication refrigerators reviewed.	On 4/20/16 the pharmacy contacted and medications that could not be verified as stable were destroyed and replacements obtained. On 4/20/16 staff were trained on proper refrigerator temperature for medication storage and temperatures adjusted on that date. Further education on the Medication storage policy occurred on 4/26/16, 5/5/16 and 5/16/16. **See attachments** Implemented temperature monitoring form that identifies temperature range, when to adjust and requirement for rechecking when temperature not in range. **Implemented on 4/20/16**	RN Supervisors and/or designees will be conducting audits to monitor for temperature recording, proper range, and temperature adjustments and rechecking of temperatures as appropriate. **Initiated on 5/7/16**	Supervisor and/ or designee refrigerator temperature audits will be monitored through our QAPI program. Monitoring will occur monthly until 100% compliance is achieved. When 100% compliance is achieved reports will be submitted quarterly x 3 months to assure on going compliance. **QAPI reporting will begin in June 2016.**	CORRECTED ON 5/30/16

CMS STATE HOME INSPECTION (2016)

SURVEY CLASS	SURVEY YEAR			
Annual Survey	2016			
NAME OF FACILITY	**STREET ADDRESS**	**CITY**	**STATE**	**ZIP CODE**
Silver Bay Veterans Home	45 Banks Blvd	Silver Bay	MN	55614

SURVEYED BY

STANDARDS FOR NURSING HOME CARE	RATING	EXPLANATORY STATEMENTS	FACIILITY CITATION ACTION	PREVENTION	MONITORING PLAN	CORRECTION DATE
F465 483.70(h) **Safe/Functional/ Sanitary/Comfortable Environment** The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. MN Rule 4658.1415 Subp.2 The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety and well-being of the residents according to a written routine maintenance and repair program	E	Based on observation interview and documentation review the facility failed to ensure a clean and homelike environment was maintained in 4 of 31 resident rooms (203, 211, 225, and 226) and the Blue Spruce household dining room.	Staff were provided education regarding the facility policy on Maintenance Service. **Initiated on 5/17/16 See attached Policy.** Repairs were made to resident rooms (203, 211, 225, 226) and the Blue Spruce household dining room as identified in this survey on 4/19 and 4/20 2016. Our facility utilizes the Archibus System (preventative maintenance program) to log and maintain our building in good repair. The Archibus system is used to identify/prompt repair cycles. We will continue to paint and repair walls on a monthly cycle. The Archibus system is used to log daily request by all employees. Areas requiring maintenance are logged into this system. We will continue to use this system.	Archibus reports will be audited to assure compliance with logging cyclic repairs as noted in our Maintenance Service Policy. **Implemented in May for reporting in June 2016.** The Maintenance Manager and/or Housekeeping Supervisor or designee's shall conduct monthly rounds to identify areas that require repair. The rounding documents shall be audited to determine program compliance. **Implemented in May for reporting in June 2016.**	The Maintenance Manager and/or Housekeeping Supervisor will conduct various monthly audits as identified. The audits will be monitored through our QAPI program. Monitoring will occur monthly until 100% compliance is achieved. When 100% compliance is achieved reports will be submitted quarterly x 3 months to assure on going compliance. **QAPI reporting will begin in June 2016.**	CORRECTED BY 5/30/16

Checklist for Assessing Fall Risk and Post-fall Review

Factors	Fall Risk	After a Fall
Falls history	☐ Review history of previous falls	☐ Review history of previous falls
Underlying illnesses and problems	☐ Assess for presence of underlying medical condition that predispose to falls ☐ Assess for presence of orthostatic hypotension and conditions predisposing to it ☐ Assess for presence of underlying medical conditions affecting balance, causing dizziness or vertigo ☐ Assess for presence of underlying medical conditions that increase injury risk from falls	☐ Review the status of any medical conditions that predispose to falls ☐ Assess for presence of orthostatic hypotension and manage predisposing conditions ☐ Review status of any underlying medical conditions affecting balance, causing dizziness or vertigo ☐ Assess status of underlying medical conditions that increase injury risk from falls
Medications	☐ Review for medications that could predispose to falls; especially, diuretics, cardiovascular medications, anti-hypertensives, antipsychotics, antianxiety agents, sleeping medications, anti-depressants ☐ Reduce dosages or eliminate such medications	☐ Review for presence of medications that could predispose to falls; adjust dosage or stop medication as indicated ☐ Review for recent changes in medication regimen
Functional status	☐ Review for impaired mobility, standing or sitting balance ☐ Review for impaired ability to use ambulatory assistive device (cane, walker, etc.) ☐ Review situation related to restraints ☐ Review activity tolerance, possible deconditioning ☐ Review bowel and bladder continence status ☐ Assess footwear utilization	☐ Reassess mobility, standing and sitting balance ☐ Reassess use of ambulatory assistive device (cane, walker, etc.), modify as indicated ☐ Review situation related to restraints ☐ Review activity tolerance, possible deconditioning ☐ Review bowel and bladder continence status ☐ Assess footwear used at time of fall
Sensory status	☐ Look for conditions (cataracts, glaucoma, macular degeneration) reducing vision	☐ Review status of conditions affecting vision ☐ Reassess visual and auditory impairments
Psychological status	☐ Assess for presence of depression ☐ Review for impaired cognition, judgement, memory, safety awareness, decision making capacity	☐ Assess for symptoms of depression ☐ Reassess cognition, judgement, memory, safety awareness, decision making capacity as indicated
Environmental status	☐ Assess for environmental factors that could cause or contribute to falls	☐ Review and modify environmental factors that could have caused or contributed to fall

MINNESOTA VETERANS' HOME – SILVER BAY PROCEDURE: 02-173_____
NURSING PROCEDURES

TITLE: FALL PREVENTION

PURPOSE: The fall reduction program will identify risk factors related to falls and reduce the potential, incidence and morbidity of falls through development and implementation of individualized approaches to the resident's plan of care.

The Incident Review Committee is an interdisciplinary team that meets week days to review all falls and other types of resident incidents that have occurred since the previous meeting to review interventions put in place at the time of the fall and need for additional interventions to reduce falls. A second group the Fall Reduction committee is an interdisciplinary group can be contacted to complete a secondary review process to attempt to determine further interventions when a specific resident continues to have issues with falls. This group utilizes a Root Cause Analysis process to determine a potential cause not previously realized and the interventions to attempt to prevent future falls.

Definition of a fall for the purpose of this committee is an unintentional change in position whether it is witnessed or unwitnessed.

An initial At Risk to Fall Assessment form is done by the RN on admission to reduce the risk of falling upon entering the home. (See Attachment A, At Risk to Fall Assessment). A score of 9 or greater on the assessment tool indicates a risk of falling. Risk factors are identified and immediate preventive actions are taken to reduce or eliminate the potential for falls. Individualized precautions are then defined and incorporated into the resident's plan of care. Interventions include but are not limited to changes in the environment, and internal or external forces. Additional assessment indicators for a resident's risk for falls are the Minimum Data Set.

Those residents who have the potential for additional falls or are at risk of an initial fall are suggested when the following has been triggered by the MDS:

*Fall in the past 30 days
*Fall in the past 31-180 days

The resident who has not fallen can be at high risk for falls when one or more of the following triggers from the MDS are present:

*Use of psychoactive drugs
*Impaired sense of balance
*Bedfast
*Hemi Quadriplegia or poor leg control

Problem areas for the resident are identified and preventive measures are taken. The resident's evaluation of their physical abilities will be done within one week of admission by PT as appropriate. Upon admission the nurse will assess ambulation/gait, positioning, mobility and side rails and address through care planning, incorporating the resident's strengths and limitations. Residents will be routinely assessed for falls risk on admission, quarterly, and with significant change in condition.

One hour rounding: nursing staff will walk through the household every hour to check on residents and redirect at risk behaviors. This has been demonstrated to be the best way to prevent falls as staff is there to intervene in risky behavior.

How to do rounding:

Rounding is when a member of the care giving team physically makes contact with a resident on a consistent set time frame. When this is practiced residents become more certain that a nurse will be available for immediate needs (assistance to the bathroom, pain interventions, or in addressing questions about care and other needs). Rounding is usually conducted every 1 hour and includes addressing the "4Ps" which encompass the assessment of the following items :

1. Positioning. Make sure the resident is comfortable and assess the risk of pressure ulcer.

2. Personal needs. Schedule resident trips for toileting to avoid unsafe conditions. This avoids residents trying to get up by themselves who are not able or not strong enough.

3. Pain. Ask the resident to describe their pain level on a scale of zero to 10, then act upon findings for whatever is needed.

4. Presence. Promotes trust, safety and certainty of available care giver.

A resident incident report is to be completed each time a resident has fallen or is found on the floor.

Monthly falls analysis will be tabulated to look for trends, class of injury and patterns related to types of falls. The outcome of the analysis will be reported on a quarterly basis at the Quality Assurance meeting.

Fall Prevention Measures

All preventive fall approaches are identified in the resident's individualized care plan, , and in progress notes.

Low Beds

Low beds are appropriate for a resident to reduce the potential for injury by decreasing the distance from the bed to the floor. Beds will not be placed in a low position for residents still able to independently transfer as this could increase fall risk.

Floor Mats

Floor mats are placed at the resident's bedside for those residents who have fallen or are at high risk for a fall from bed. Housekeeping will clean the mats on a daily basis, (Policy #09-22, Cleaning Mat on Floor). Precautions need to be taken when implementing a mat on the floor to avoid creating a possible hazard for the resident or roommate.

Additional Approaches to Falls:

Contour mattress
Non-slip mat at bedside
Colored toilet seat
Check postural hypotension
Referral to PT/OT

MINNESOTA DEPARTMENT OF VETERANS AFFAIRS

POLICY: Medication Storage and Security

Division:	Veterans Health Care	**Effective:**	August 13, 2015
Subdivision:	Health Care Administrative	**Revised:**	August 13, 2015
Approver:	Deputy Commissioner VHC	**Created:**	August 13, 2015
Approved:	Robin L Carnahan	**Date:**	October 22, 2015

APPLICABILITY: Veterans Health Care

PURPOSE: To ensure that all medications are stored in accordance with Minnesota Department of Health Rule 4658.1340.

POLICY: All prescription, nonprescription medications and biologicals are to be kept safe, orderly, secure and accessible to authorized nursing personnel only.

PROCEDURES:

A. All medication storage areas (carts, medication rooms, cabinets and individual resident medication supply areas) are locked whenever the nurse is not in direct sight of the medication storage area.

B. All drugs and biologicals are retained in the prescription container that it was dispensed in until the time of administration.

C. All medication storage areas are well-illuminated.

Pain management program
Calcium, Vit D, Miacalcin, Estrogen, Fosomax, etc.
Decreasing medications that put residents at risk for a fall
Non-slip shoes or gripper-socks
Change toileting schedule
Check more frequently when in the room
Wheelchair pedals off
Protective equipment, i.e. hip or knee pads
Less time in bed
Keep resident in public place when up in the wheelchair
Sign, posted reminders
To put to bed earlier or later
Alternative seating
Mobility aids
Positioning wedges
Anti-tippers on wheelchair, anti-lock brakes
Structured activities program
Good lighting
Make sure pathway is clear
Make sure glasses/hearing aids are in place
Customize wheelchair
Identify fall pattern high risk times
Use of assistive devices, i.e. reachers, walker, wheelchair
Participation in daily exercise
Restorative rehabilitation program

ATTACHMENTS:

Regulatory Reference:
Survey Tag:
Other Resources:
Related Documents:
Review: 5/16

O. The pharmacy works in collaboration with the nursing staff to provide recommendations on proper medication storage and security issues.

DEFINITIONS:

Biological Drug: A substance that is made from a living organism or its products and is used in the prevention, diagnosis, or treatment of cancer and other diseases. Biological drugs include antibodies, interleukins, and vaccines. Also called biologic agent and biological agent.

Room Temperature: A range of 68 to 79 degrees Fahrenheit with an acceptable variation from 59 to 86 degrees.

Refrigerator Temperatures: A range of 36 to 46 degrees Fahrenheit.

FORMS AND ATTACHMENTS:

None

REFERENCES:

Centers for Medicare and Medicaid Services (CMS) F-Tag 431
Minnesota Rule 4658.1340

Maintenance Service – Silver Bay Veterans Home

Highlights

Responsibility of Maintenance Service

Functions

Policy Statement

Maintenance service shall be provided to all areas of the building, grounds, and equipment.

Policy Interpretation and Implementation

1. The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times.

2. The following functions are performed by maintenance, but are not limited to:

   a. Maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines.
   b. Maintaining the building in good repair and free from hazards.
   c. Maintaining the fire alarm system and emergency generator system in good working order.
   d. Maintaining the heat/cooling system, plumbing fixtures, wiring, etc., in good working order.
   e. Maintaining lighting levels that are comfortable, and assuring that exit lights are in good working order.
   f. Establishing priorities in providing repair service.
   g. Maintaining the paging system in good working order.
   h. Maintaining the grounds, sidewalks, parking lots, etc., in good order.
   i. Providing routinely scheduled maintenance service to all areas. See Preventative Manuals (PM), Archibus and painting/room repair are scheduled and prn.
      - Painting – Monthly cycle review (call in painter if needed)
      - Room maintenance – Monthly cycle review (call in extra assistance if needed).
   j. Others that may become necessary or appropriate.

References		
OBRA Regulatory Reference Numbers	483.15(h)(l)-(7); 483.70(a)-(h)(4); Life Safety Code (2000 Edition)	
Survey Tag Numbers	F252-F258; F454-F469	
Related Documents		
Policy Revised	Date: 2015	By: Robert Mclaughlin, Plant Director
	Date: 5/2016	By: Robert Mclaughlin, Plant Director
	Date:_____	By:_____
	Date:_____	By:_____

MINNESOTA VETERAN'S HOME- SILVER BAY

POLICY: MDS AUTOMATED DATA PROCESSING POLICY

PURPOSE : ENSURE ALL MDS'S ARE ENCODED AND TRANSMITTED TO THE STATE OF MINNESOTA AND FEDERAL VETERANS AFFAIRS TIMELY.

PROCEDURE:

1. WITHIN 7 DAYS AFTER THE FACILITY COMPLETES A RESIDENT'S ASSESSMENT, THE FACILITY MUST ENCODE THE FOLLOWING INFORMATION FOR EACH RESIDENT IN THE FACILITY:
   - **(I)** ADMISSION ASSESSMENT
   - **(II)** ANNUAL ASSESSMENT UPDATES.
   - **(III)** SIGNIFICANT CHANGE IN STATUS ASSESSMENTS
   - **(IV)** QUARTERLY REVIEW ASSESSMENTS
   - **(V)** A SUBSET OF ITEMS UPON A RESIDENT'S TRANSFER, REENTRY, DISCHARGE, AND DEATH.

2. TRANSMITTAL REQUIREMENTS. WITHIN 14 DAYS AFTER A FACILITY COMPLETES A RESIDENTS' ASSESSMENT, A FACILITY MUST ELECTRONICALLY TRANSMIT ENCODED, ACCURATE, AND COMPLETE MDS DATA TO THE CMS SYSTEM, INCLUDING THE LISTED ABOVE.

Policy Revised	Date: 04/1/2015	By: Jill Reineccius
	Date:_____	By:_____
	Date:_____	By:_____
	Date:_____	By:_____

ATTACHMENTS:

OBRA/Regulatory Reference: §483.20(b)(2)(i) – (iii); §483.20(c); §483.20(f)(1) – (f)(4)
Survey Tag: F287
Other Resources: Minnesota Regulation:
Related Documents:
Review: 4/14

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

F5628001

PRINTED: 05/06/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245628	A. BUILDING **01 - MN VETS HOME** B. WING _____	**04/26/2016**

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) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, MN Veterans Home - Silver Bay was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145	K	APPROVED Tom Linhoff By Tom Linhoff at 8:04 am, May 23, 2016 See attachments for K tag citation corrections. RECEIVED MAY 23 2016 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carol Gilbertson — TITLE: Administrator — (X6) DATE: 5/19/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245628	A. BUILDING **01 - MN VETS HOME** B. WING _____	**04/26/2016**

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) COMPLETION DATE
K 000	Continued From page 1 ST. PAUL, MN 55101-5145, or By e-mail to both: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Minnesota Veterans Home-Silver Bay is a one story building, partial basement original year of construction 1960's, and it was converted into a nursing home in the early 1990's. The original building and additions are all Type II(111) construction. The building is fully sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 83 beds and had a census of 80 the time of the survey.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245628	A. BUILDING **01 - MN VETS HOME** B. WING _____	**04/26/2016**

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) COMPLETION DATE
K 000	Continued From page 2 The requirement at 42 CFR Subpart 483.70(a) is NOT MET.	K 000		
K 062 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on documentation review and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00), Section 19.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, (98). This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect 83 of 80 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 1:30 PM to 4:30 PM on 04/26/2016, a review of documentation and an interview with the Maintenance Supervisor revealed that at the time of the inspection the facility could not provide any documentation for the annual fire sprinkler testing and for 2 of 4 quarterly fire sprinkler flow test verifying that they have been completed.	K 062	See Attached POC	04/27/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245628	A. BUILDING **01 - MN VETS HOME** B. WING _____	**04/26/2016**

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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K 062	Continued From page 3 This deficient condition was verified by a Maintenance Supervisor.	K 062		

CMS STATE HOME INSPECTION (2016)

SURVEY CLASS	SURVEY YEAR			
Annual Survey	2016			
NAME OF FACILITY	**STREET ADDRESS**	**CITY**	**STATE**	**ZIP CODE**
Silver Bay Veterans Home	45 Banks Blvd	Silver Bay	MN	55614

SURVEYED BY

STANDARDS FOR NURSING HOME CARE	RATING	EXPLANATORY STATEMENTS	FACILITY CITATION ACTION	PREVENTION	MONITORING PLAN	CORRECTION DATE
K 062 - NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler system are continuously maintained		Facility did not provide documentation for the annual fire sprinkler testing for 2 of 4 quarterly sprinkler flow tests verifying that they were completed.	Documentation for 2 of the 4 quarterly sprinkler flow tests verifying compliance were obtained on 4/27/2016. This information was also provided to the Fire Marshall. **See attachments.** The Building Services Manager will ensure full documentation is maintained on site and is provided on date of annual inspection as appropriate.	The Building Services Manager and/or designee shall review quarterly fire sprinkler flow testing documents to assure all documents are available for review monthly. The monthly reviews shall be submitted to QAPI as monthly audits.	Supervisor and/ or designee audits will be monitored through our QAPI program. Monitoring will occur monthly until 100% compliance is achieved. When 100% compliance is achieved reports will be submitted quarterly x 3 months to assure on going compliance. **QAPI reporting will begin in June 2016.**	CORRECTED ON 4/27/2016.

A. G. O'BRIEN • FIRE PROTECTION
4907 LIGHTNING DRIVE • HERMANTOWN, MN 55811
PHONE (218) 729-9662

REPORT OF INSPECTION

Property Name: MN VETS HOME Date: 7/17/2015
Address: 45 BANKS BLVD Contract No.: 85786
SILVER BAY, MN Inspector: HILDEN

OWNER'S SECTION (To be answered by Owner or Occupant)

A. Explain any occupancy hazard changes since the previous inspection NONE
B. Describe fire protection modifications made since last inspection NONE
C. Describe any fires since last inspection NONE
D. When was the system piping last checked for stoppage, corrosion or foreign material? NOT KNOWN
E. When was the dry piping system last checked for proper pitch? NA
F. Are dry valves adequately protected from freezing? NA

INSPECTOR'S SECTION (All responses reference current inspection.)

	Y	N	N/A
1. GENERAL			
a. Is the building occupied?	X		
b. Are all systems in service?	X		
c. Is there a minimum of 18" (457 m) clearance between top of storage and sprinkler deflector?	X		
d. In areas protected by a wet system, does the building appear to be properly heated in all areas, including blind attics and perimeter areas, where accessible. AT TIME OF INSPECTION	X		
Do all exterior openings appear to be protected against freezing?			X
e. Does the hand hose on the sprinkler system appear to be satisfactory?			X
2. CONTROL VALVES (See Item 14)			
a. Are all sprinkler system control valves and all other valves in the appropriate or closed position?	X		
b. Are all control valves in the open position, locked sealed or equipped with a tamper switch?	X		
3. WATER SUPPLIES (See Item 15)			
a. Was a water flow test of the main drain made at the sprinkler riser? TO STATIC 65 PSI	X		
4. TANKS, PUMPS, FIRE DEPARTMENT CONNECTIONS:			
a. Are fire pumps, gravity tanks, reservoirs and pressure tanks in good condition and properly maintained?			X
b. Are fire department connections in satisfactory condition, coupling free, caps in place and check valves tight?	X		
Are they accessible and visible?	X		
5. WET SYSTEMS (See Item 13)			
a. Are cold water weather valves (OS&Y) in the appropriate open or closed position?			X
b. Have antifreeze system solutions been tested?			X
c. Were the antifreeze test results satisfactory?			X
6. DRY SYSTEMS (See Items 10 to 14)			
a. Is the dry valve in service?	X		
b. Are the air pressure and water level in accordance with the manufacturer's instructions?	X		
c. Has the operation of the air or nitrogen supply been tested?	X		
Is it in service?	X		
d. Were low points drained during this inspection? ALL KNOWN	X		
e. Did quick opening devices operate satisfactorily?			X
f. Did the dry valve trip properly during the trip pressure test?	X		
g. Did the heating equipment in the dry pipe valve room operate at the time of the inspection?			X
7. SPECIAL SYSTEMS – as defined in Section 1-3 (See Item 16)			
a. Did the deluge or pre-action valves operate properly during testing?			X
b. Did the heat responsive devices operate properly during testing?			X
c. Did the supervisory devices operate during testing?			X
8. ALARMS			
a. Did motor and gang test satisfactorily?			X
b. Did electric alarm test satisfactorily?	X		
c. Did supervisory alarm service test satisfactorily?	X		
SPRINKLERS			
a. Are all sprinklers free from corrosion, loading or obstruction to spray discharge?	X		
b. Are sprinklers over 50 years old, thus requiring sample testing? NOT OVER 50 YEARS			X
c. Is stock of spare sprinklers available?	X		
d. Does the exterior condition of the sprinkler system appear to be satisfactory?	X		
e. Are sprinklers of proper temperature ratings for their locations?	X		

10. Date dry pipe valve trip tested (control valve partially open) ____

11. Date dry pipe valve trip tested (control valve fully open) X (See trip test table below)

12. Date quick opening device tested X (See trip test table below)

13. Date deluge or pre-action valve tested X (See trip test table below)

14. Review Control Valve Maintenance (See valve maintenance table below)

TRIP TEST TABLE

	DRY VALVE MAKE	DRY VALVE MODEL	DRY VALVE SERIAL NO.	C.O.D. MAKE	C.O.D. MODEL	C.O.D. SERIAL NO.
	CENTRAL	A6		X	X	X

DRY PIPE OPERATING TEST		TIME TO TRIP THRU TEST CONNECTION MIN.	TIME TO TRIP THRU TEST CONNECTION SEC.	WATER PRESSURE PSI	AIR PRESSURE PSI	TRIP POINT AIR PRESSURE PSI	TIME WATER REACHED TEST OUTLET MIN.	TIME WATER REACHED TEST OUTLET SEC.	ALARM OPERATED PROPERLY YES	ALARM OPERATED PROPERLY NO
	WITHOUT Q.O.D.	X	11	75	39	7	X	X	YES	
	WITH Q.O.D.									
	IF NO, EXPLAIN									

DELUGE & PREACTION								
OPERATION	☐ PNEUMATIC	☐ ELECTRIC	☐ HYDRAULIC					
PIPING SUPERVISED	☐ YES	☐ NO	DETECTING MEDIA SUPERVISED	☐ YES	☐ NO			
DOES VALVE OPERATE FROM THE MANUAL TRIP AND/OR REMOTE CONTROL STATIONS				☐ YES	☐ NO			
IS THERE AN ACCESSIBLE FACILITY IN EACH CIRCUIT FOR TESTING? YES	NO	IF NO, EXPLAIN						
MAKE	MODEL	DOES EACH CIRCUIT OPERATE SUPERVISION LOSS ALARM YES	DOES EACH CIRCUIT OPERATE SUPERVISION LOSS ALARM NO	DOES EACH CIRCUIT OPERATE VALVE RELEASE YES	DOES EACH CIRCUIT OPERATE VALVE RELEASE NO	MAXIMUM TIME TO OPERATE RELEASE MIN.	MAXIMUM TIME TO OPERATE RELEASE SEC.	

CONTROL VALVE MAINTENANCE TABLE

CONTROL VALVES	NO.	TYPE	OPEN	SECURED	CLOSED	SIGNS	EXPLAIN ABNORMAL CONDITION
CITY CONNECTION CONTROL VALVES							
TANK CONTROL VALVES							
PUMP CONTROL VALVES							
SECTIONAL CONTROL VALVES	1	3" BFV	YES	YES	—	YES	
SYSTEM CONTROL VALVES	2	4" BFV	YES	YES	—	YES	
OTHER CONTROL VALVES	1	2½" BFV	YES	YES	—	YES	

15. WATER FLOW TEST AT SPRINKLER RISER

WATER SUPPLY SOURCE (CITY) TANK PUMP LAST WATER FLOW TEST 75-65

DATE 7/17/2015 TEST PIPE LOCATION RISER SIZE TEST PIPE 2" STATIC PSI 75 RESIDUAL (FLOW) PRESSURE 65 THIS WATER FLOW TEST 75-65

17. ADJUSTMENTS OR CORRECTIONS MADE DURING THIS INSPECTION: NONE

18. ALTHOUGH THESE COMMENTS ARE NOT THE RESULT OF AN ENGINEERING REVIEW, THE FOLLOWING DESIRABLE IMPROVEMENTS ARE RECOMMENDED: NONE

A.G. O'Brien Fire Protection
4907 Lightning Drive Hermantown, MN 55811
(218) 729-9662 phone
(218) 729-9774 fax

Quarterly Report of Inspections & Tests

Property Name: MN. VETS HOME
Address: 45 BANKS BLVD SILVER BAY MN

Date: 7-17-15

Inspector: A HILDEN

	Y	N	N/A
Main Drain Test Record the static pressure on the control riser guage and residual pressure once the Two Inch main drain valve is fully opened. Static: 75 Residual: 60	✓		
Fire Department Connections Verify that the connection is visible,not damaged, caps are in place, identification sign is in place, and ball drip is working satisfactorily.	✓		
Wet Pipe System Flow Alarm Test water-flow alarms by opening the inspector's test valve. (Notify alarm company to avoid false alarms)	✓		
Dry Pipe Valve Priming Level Check dry priming water level by opening the test valve and checking for a small amount of water discharge. If no water flows out of the test line, add priming water.	✓		
Dry Pipe System Low-Air-Pressure Alarm Close the water supply valve and slowly open the test valve to reduce air pressure. (Do not reduce air pressure enough to trip the dry pipe valve) Confirm operation of the low air pressure alarm, record air pressure at which the alarm activated, close the test valve, allow air pressure to rise to normal, then open the water supply control valve.			✓
Dry Pipe System Flow Alarm p.s.i. NA Open the alarm bypass valve. (Notify alarm company to avoid false alarms)	✓		
Quick Opening Device Test in accordance with manufacturers instructions.			✓
Preaction System Flow Alarm Open the alarm bypass valve. (Notify alarm company to avoid false alarms)			✓
Deluge System Flow Alarm Open the alarm bypass valve. (Notify alarm company to avoid false alarms)			✓

Notes:

ALARMS + TAMPERS OK

A.G. O'Brien Fire Protection
4907 Lightning Drive Hermantown, MN 55811
(218) 729-9662 phone
(218) 729-9774 fax

Quarterly Report of Inspections & Tests

Property Name: MAI WETS HOME
Address: 45 RANGE BLVD
SILVER BAY MN

Date: 10-16-14

Inspector: A. O'BRIEN

	Y	N	N/A
Main Drain Test Record the static pressure on the control riser guage and residual pressure once the Two Inch main drain valve is fully opened. Static: 72 Residual: 66	✓		
Fire Department Connections Verify that the connection is visible,not damaged, caps are in place, identification sign is in place, and ball drip is working satisfactorily.	✓		
Wet Pipe System Flow Alarm Test water-flow alarms by opening the inspector's test valve. (Notify alarm company to avoid false alarms)	✓		
Dry Pipe Valve Priming Level Check dry priming water level by opening the test valve and checking for a small amount of water discharge. If no water flows out of the test line, add priming water.	✓		
Dry Pipe System Low-Air-Pressure Alarm Close the water supply valve and slowly open the test valve to reduce air pressure. (Do not reduce air pressure enough to trip the dry pipe valve) Confirm operation of the low air pressure alarm, record air pressure at which the alarm activated, close the test valve, allow air pressure to rise to normal, then open the water supply control valve. p.s.i. N/A			✓
Dry Pipe System Flow Alarm Open the alarm bypass valve. (Notify alarm company to avoid false alarms)	✓		
Quick Opening Device Test in accordance with manufacturers instructions.			✓
Preaction System Flow Alarm Open the alarm bypass valve. (Notify alarm company to avoid false alarms)			✓
Deluge System Flow Alarm Open the alarm bypass valve. (Notify alarm company to avoid false alarms)			✓

Notes:

ALL ALARMS + TAMPERS OK

A.G. O'Brien Fire Protection
4907 Lightning Drive Hermantown, MN 55811
(218) 729-9662 phone
(218) 729-9774 fax

Quarterly Report of Inspections & Tests

Property Name: MN VETS HOME
Address: 45 BANKS
SILVER BAY MN

Date: 1-23-15

Inspector: AHLDEN

	Y	N	N/A
Main Drain Test Record the static pressure on the control riser guage and residual pressure once the Two inch main drain valve is fully opened. Static: 75 Residual: 65	✓		
Fire Department Connections Verify that the connection is visible,not damaged, caps are in place, identification sign is in place, and ball drip is working satisfactorily.	✓		
Wet Pipe System Flow Alarm Test water-flow alarms by opening the inspector's test valve. (Notify alarm company to avoid false alarms)	✓		
Dry Pipe Valve Priming Level Check dry priming water level by opening the test valve and checking for a small amount of water discharge. If no water flows out of the test line, add priming water.	✓		
Dry Pipe System Low-Air-Pressure Alarm Close the water supply valve and slowly open the test valve to reduce air pressure. (Do not reduce air pressure enough to trip the dry pipe valve) Confirm operation of the low air pressure alarm, record air pressure at which the alarm activated, close the test valve, allow air pressure to rise to normal, then open the water supply control valve. p.s.i. N/A			✓
Dry Pipe System Flow Alarm Open the alarm bypass valve. (Notify alarm company to avoid false alarms)	✓		
Quick Opening Device Test in accordance with manufacturers instructions.			✓
Preaction System Flow Alarm Open the alarm bypass valve. (Notify alarm company to avoid false alarms)			✓
Deluge System Flow Alarm Open the alarm bypass valve. (Notify alarm company to avoid false alarms)			✓

Notes:

ALARMS + TAMPERS OK

A.G. O'Brien Fire Protection
4907 Lightning Drive Hermantown, MN 55811
(218) 729-9662 phone
(218) 729-9774 fax

Quarterly Report of Inspections & Tests

Property Name: MN VETS HOME
Address: 45 RANKS BLVD SILVER BAY MN. 55614

Date: 4-30-15

Inspector: ANTINEN

	Y	N	N/A
Main Drain Test Record the static pressure on the control riser guage and residual pressure once the Two inch main drain valve is fully opened. Static: 75 Residual: ✓	✓		
Fire Department Connections Verify that the connection is visible,not damaged, caps are in place, identification sign is in place, and ball drip is working satisfactorily.	✓		
Wet Pipe System Flow Alarm Test water-flow alarms by opening the inspector's test valve. (Notify alarm company to avoid false alarms)	✓		
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Dry Pipe System Flow Alarm Open the alarm bypass valve. (Notify alarm company to avoid false alarms)	✓		
Quick Opening Device Test in accordance with manufacturers instructions.			✓
Preaction System Flow Alarm Open the alarm bypass valve. (Notify alarm company to avoid false alarms)			✓
Deluge System Flow Alarm Open the alarm bypass valve. (Notify alarm company to avoid false alarms)			✓

Notes:

ALARMS + TAMPERS OK. SET OFF HORN STROBES

A.G. O'Brien Fire Protection
4907 Lightning Drive Hermantown, MN 55811
(218) 729-9902 phone
(218) 729-9774 fax

Quarterly Report of Inspections & Tests

Property Name: MN VETS HOME
Address: 45 BOATS BLVD SILVER BAY

Date: 10-30-15

Inspector: AHTIEN

	Y	N.	N/A
Main Drain Test Record the static pressure on the control riser guage and residual pressure once the Two inch main drain valve is fully opened. Static: 75 Residual: 65	✓		
Fire Department Connections Verify that the connection is visible,not damaged, caps are in place, identification sign is in place, and ball drip is working satisfactorily.	✓		
Wet Pipe System Flow Alarm Test water-flow alarms by opening the inspector's test valve. (Notify alarm company to avoid false alarms)	✓		
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Dry Pipe System Flow Alarm Open the alarm bypass valve. (Notify alarm company to avoid false alarms)	✓		
Quick Opening Device Test in accordance with manufacturers instructions.			✓
Preaction System Flow Alarm Open the alarm bypass valve. (Notify alarm company to avoid false alarms)			✓
Deluge System Flow Alarm Open the alarm bypass valve. (Notify alarm company to avoid false alarms)			✓

Notes:

ALARMS + TAMPERS OK

A.G. O'Brien Fire Protection
4907 Lightning Drive Hermantown, MN 55811
(218) 720-9662 phone
(218) 729-9774 fax

Quarterly Report of Inspections & Tests

Property Name: MN. VETS HOME
Address: 456 BANKS BLVD
SILVERBAY MN.

Date: 1-19-16

Inspector: ATTLESEY

	Y	N	N/A
Main Drain Test Record the static pressure on the control riser guage and residual pressure once the Two Inch main drain valve is fully opened. Static: 75 Residual: 65	✓		
Fire Department Connections Verify that the connection is visible,not damaged, caps are in place, identification sign is in place, and ball drip is working satisfactorily.	✓		
Wet Pipe System Flow Alarm Test water-flow alarms by opening the inspector's test valve. (Notify alarm company to avoid false alarms)	✓		
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Dry Pipe System Flow Alarm Open the alarm bypass valve. (Notify alarm company to avoid false alarms)	✓		
Quick Opening Device Test in accordance with manufacturers instructions.			✓
Preaction System Flow Alarm Open the alarm bypass valve. (Notify alarm company to avoid false alarms)			✓
Deluge System Flow Alarm Open the alarm bypass valve. (Notify alarm company to avoid false alarms)			✓

Notes:

ALARMS + TAMPERS OK

A.G. O'Brien Fire Protection
4907 Lightning Drive Hermantown, MN 55811
(218) 729-9662 phone
(218) 729-9774 fax

Quarterly Report of Inspections & Tests

Property Name: MAIVETS HOME
Address: 45 BANKS BLVD
SILVER BAY MN

Date: 4-7-16

Inspector: AHLDEN

	Y	N	N/A
Main Drain Test Record the static pressure on the control riser guage and residual pressure once the Two inch main drain valve is fully opened. Static: 75 Residual: 65	✓		
Fire Department Connections Verify that the connection is visible,not damaged, caps are in place, identification sign is in place, and ball drip is working satisfactorily.	✓		
Wet Pipe System Flow Alarm Test water-flow alarms by opening the inspector's test valve. (Notify alarm company to avoid false alarms)	✓		
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Dry Pipe System Flow Alarm Open the alarm bypass valve. (Notify alarm company to avoid false alarms)	✓		
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Deluge System Flow Alarm Open the alarm bypass valve. (Notify alarm company to avoid false alarms)			✓

Notes:

ALARMS + TAMPERS OK

MDH
Minnesota
Department
of Health

Protecting, maintaining and improving the health of all Minnesotans

Electronically submitted
May 6, 2016

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5628001

Dear Ms. Gilbertson:

The above facility was surveyed on April 18, 2016 through April 20, 2016 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, Health Regulation 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.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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 contact Christine Campbell at 218-206-3517.

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,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00381	A. BUILDING: _____ B. WING _____	04/20/2016

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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2 000	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 4/18/2016, through 4/20/2016, 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	See attachments for all State citation Plans of correction. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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2 000	Continued From page 1 Certification Program; 11 East Superior Street, Suite 290, Duluth, MN 55802.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." 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 evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	
2 565	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 document review, the facility failed to follow the care plan regarding fall interventions for 2 of 3 residents (R50, R4) reviewed for falls. Findings include: R50's Admission record, dated 3/3/16, identified diagnoses that included Alzheimer's disease, anemia, type I diabetes mellitus, dementia, osteoarthritis, a history of hip fracture and repeated falls. R50's admission Minimum Data Set (MDS) dated 3/10/16, indicated R50 was cognitively impaired and exhibited wandering behaviors. The MDS further indicated that R50 required assistance with moving about in bed and extensive assistance with transfers from bed, chair and wheelchair. The MDS further indicated R50 required extensive assistance with dressing, toileting and ambulation. The MDS also indicated a history of orthostatic hypotension (drop in blood pressure when rising from a lying position to sitting or standing.) The MDS further indicated R50 was not steady and was only able to	2 565		

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2 565	Continued From page 2	2 565		

stabilize with staff assistance when moving from a seated to standing position, walking, turning around and facing the opposite direction, moving on and off the toilet and surface-to-surface transfer from bed and chair or wheelchair.

R50's care area assessment (CAA) for falls dated 3/16/16, indicated R50 had a history of falls prior to admission,balance problems and was not steady with transfers or walking. The CAA for falls further indicated R50 had three falls the first week after admission. The CAA for falls also indicated safety interventions including hipsters at all times, safety skid socks when in bed, clip call light to clothing in bed and black anti-skid mat at side of bed.

R50's care plan dated 4/15/16, directed staff R50 was to have the call light clipped to his clothing when in bed, to ensure a black anti-mat (non-slip,cushioned mat) is at the right side of his bed, to provide assistance with ambulation with walker or use a wheelchair if R50 appeared weak or unsteady, and R50 is to wear hipsters (a garment with impact absorbing pads over the hips to prevent hip fractures that can occur with a fall).

R50's Fall Risk assessment dated 4/15/16, indicated multiple falls within the last six months, adequate vision, occasional bladder incontinence, daily agitated behaviors, no orthostatic BP drop, use of assistive devices with walking and a loss of balance while standing.

Review of the facility Post Incident Investigation Worksheets for Falls since 3/3/16, indicated R50 had six falls in the facility from 3/3/16, to 4/15/16.

On 4/20/16, at 7:36 a.m., R50 was observed to get up from his bed and walk to the bathroom

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2 565	Continued From page 3	2 565		

with no walker and no staff present. The call light was observed not attached to R50's clothing, no black mat was observed at the side of his bed, and R50 was not wearing a hipster garment. R50 was unsteady in the bathroom, holding on to toilet handle. Surveyor requested licensed practical nurse (LPN)-A to assist R50. R50's pants were observed to have a large wet spot in front, and the bathroom floor was observed to have a large puddle of urine. LPN-A assisted R50 to bed and changed R50's pants to clean clothing. At 7:56 a.m., LPN-A placed a black mat by the right side of R50's bed and assisted R50 in donning a hipster garment.

On 4/20/16, at 7:51 a.m. LPN-A was interviewed and stated she knew R50 had at least two falls. LPN-A confirmed the black anti-mat was not at R50's bedside when R50 was up in the bathroom, R50 was not wearing a hipster garment and the call light was not clipped to R50's clothing. LPN-A stated changes in the residents' care plan were highlighted and placed on the communication board.

On 4/20/16, the at 9:33 a.m. assistant director of nursing (ADON) was interviewed and stated R50 had recently had several falls. The ADON reviewed R50's care plan and stated R50 was to have assistance of staff and a walker for ambulation and staff was to anticipate R50's needs. The ADON further confirmed R50 was to have the call light clipped to his clothing when in bed and the black anti-mat was not at R50's bedside at time of observation as directed by his care plan. The ADON stated changes in care plans are placed on the communication board, discussed in daily meetings and highlighted in care plan copies placed in the resident's closet space.

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2 565	Continued From page 4 On 4/20/16, at 12:49 p.m. the director of nursing (DON) was interviewed and confirmed R50's care plan included directives to place a black anti-mat next to R50's bed, clip the call light to R50's clothing when he is in bed, and to ensure R50 wears a hipster at all times. The DON confirmed changes in care plans are placed on the communication board, discussed in daily meetings and highlighted in care plan copies placed in the resident's closet space. The facility's Resident Assessment-Care plan Policy dated 11/5/15, indicated the facility will develop a plan of care for the resident with individualized focuses, goals and interventions in a resident centered format. The policy further directed the resident plan of care will be implemented on the day of admission. The policy also directed the resident's care plan was ongoing and adjusted by the resident's change of status. R4's face sheet dated 4/20/16, indicated R4's diagnoses included vascular dementia with behavioral disturbance, chronic iron deficiency anemia secondary to blood loss, hypothyroidism, delirium, Alzheimer's disease, glaucoma (increased pressure in the eyes, affecting vision), history of transient ischemic attack (TIA), heart blocks and arrhythmia's. R4's Minimum Data Set (MDS) comprehensive assessment for a significant change dated 4/11/16, indicated R4 had highly impaired vision, short and long term memory impairment, moderately impaired cognitive skills for daily decision-making, and symptoms of delirium. The MDS further indicated R4's behaviors had worsened and included physical and verbal	2 565		

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2 565	Continued From page 5 behaviors, and rejection of care 1 to 3 days of the assessment period. In addition, the MDS indicated R4 required extensive assistance of 2 staff for transfers, bed mobility, and toilet use, extensive assistance of one staff for ambulation, and required the assist of staff to stabilize due to impaired balance. The MDS indicated R4 used a walker and a wheelchair, and had 2 falls with no injury and one fall with an injury that was not major since the previous MDS assessment. The Care Area Assessment (CAA) dated 4/11/16, indicated R4 was at risk for falls and had several falls without major injury during the past review period. Safety interventions in place were identified in the CAA, including clipping the call light to R4's shirt when in bed and gripper socks or shoes to be worn at all times. R4's care plan revised 4/12/16, indicated R4 was at risk for falls, had a history of falls and was unaware of safety needs. The care plan directed staff to provide: stand-by assist with all ambulation, assist as needed gait belt at all times, standard wheelchair with anti-rollback brakes for long distance transportation wear gripper socks or shoes at all times keep bed at transferable height remind to use front-wheeled walker wear hipsters as R4 allows clip call light to shirt to alert staff if he is getting up from bed set up an activity if wandering anticipate and meet needs Approach slowly from the front due to visual problems provide a bedtime snack Walk with human services technician twice daily,	2 565		

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2 565	Continued From page 6 distance as tolerated R4's Bedside Kardex Report, located in R4's closet, identified all of the care plan interventions for safety, including clip call light to shirt when R4 goes to bed incase R4 forgets to push the call light to ask for assistance and gripper socks on while in bed. R4's Post-Incident Investigation Worksheets for Falls indicated R4 had 8 falls between 1/21/16 and 4/11/16. Each fall was reviewed and new interventions were initiated as were determined to be appropriate. On 4/20/16, at 7:54 a.m. R4 was lying in bed, sleeping. The call light cord was draped over R4's headboard with the call button on the back side of the headboard. On 4/20/16, at 8:00 a.m. human services technician (HST)-C stated R4's safety interventions included having his bed at transfer height, using his walker, and wheelchair as he needs. HST-C stated R4 required a gait belt as he needs, because he is unsteady at times. On 4/20/16, during an observation and interview at 10:20 a.m. licensed practical nurse (LPN)-A read the closet care guide. R4 was lying in bed. LPN-A verified the call light was not clipped to R4's shirt and R4 did not have gripper socks on, but should have. LPN-A clipped the call light cord to R4's shirt and put some gripper socks on him. On 4/20/16, at 12:30 p.m. R4 was lying in bed, but was dressed. The call light was not clipped to his shirt, but was lying on the bed next to his right shoulder. HST-C verified it was not clipped to him and said it was clipped earlier.	2 565		

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2 565	Continued From page 7 On 4/20/16, at 2:09 p.m. the director of nursing (DON) stated staff should refer to the bedside Kardex to implement safety interventions. The DON stated changes in resident cares or interventions are communicated to staff through daily report and through the bedside Kardex. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure care plans are followed for all residents. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.	2 830		

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2 830	Continued From page 8 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement appropriate interventions to minimize the risk for falls for 2 of 3 residents (R50, R4). Findings include: R50's Admission record, dated 3/3/16, identified diagnoses that included Alzheimer's disease, anemia, type I diabetes mellitus, dementia, osteoarthritis, and a history of hip fracture with repeated falls. R50's admission Minimum Data Set (MDS) dated 3/10/16, indicated R50 was cognitively impaired and exhibited wandering behaviors. The MDS further indicated that R50 required assistance with moving about in bed and extensive assistance with transfers from bed, chair and wheelchair. The MDS further indicated R50 required extensive assistance with dressing, toileting and ambulation. The MDS also indicated a history of orthostatic hypotension (drop in blood pressure when rising from a lying position to sitting or standing.) The MDS further indicated R50 was not steady and was only able to stabilize with staff assistance when moving from a seated to standing position, walking, turning around and facing the opposite direction, moving on and off the toilet and surface-to-surface transfer from bed and chair or wheelchair. R50's care area assessment (CAA) for cognitive loss/dementia dated 3/15/16, indicated R50 had confusion, disorientation, forgetfulness and decreased ability to make self understood or to understand others. The CAA further indicated hearing and/or visual loss may have an impact on R50's ability to process information. The CAA for	2 830		

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2 830	Continued From page 9 falls dated 3/16/16, indicated R50 had a history of falls prior to admission,balance problems and was not steady with transfers or walking. The CAA for falls further indicated R50 had three falls the first week after admission. The CAA for falls also identified safety interventions including hipsters at all times, safety skid socks when in bed, clip call light to clothing in bed and black anti-skid mat at side of bed. R50's care plan dated 4/15/16, directed staff R50 was to have the call light clipped to his clothing when in bed, to ensure a black anti-mat (non-slip,cushioned mat) is at the right side of his bed, to provide assistance with ambulation with walker or use a wheelchair if R50 appeared weak or unsteady, and R50 was to wear a hipster (a garment with impact absorbing pads over the hips to prevent hip fractures that can occur with a fall). R50's Fall Risk assessment dated 4/15/16, indicated multiple falls within the last six months, adequate vision, occasional bladder incontinence, daily agitated behaviors, no orthostatic BP drop, use of assistive devices with walking and a loss of balance while standing. Review of the facility Post Incident Investigation Worksheets for Falls since 3/3/16, indicated the following: On 3/3/16, at 6:00 p.m. R50 fell when attempting to exit the facility locked unit door, slid down the door,hit his nose and sustained a cut to the bridge of his nose. Current care plan interventions in place were proper fitting foot wear, automatic locking bakes on wheelchair, escort for outside appointments and non-skid socks when in bed. New care intervention: Redirect resident from entranced/exit doors if	2 830		

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2 830	Continued From page 10 trying to exit. The interdisciplinary team (IDT) met on 3/4/16, and directed the following actions: Check orthostatic blood blood pressure (BP) x 7 days, one person assist with ambulation until he as oriented to his surroundings, anticipate his needs, hipsters at all times, redirect resident and provide one visit/activities if noted to be exit seeking. On 3/4/16, at 11:42 p.m. R50 was found on the bathroom floor with hands on sink. The falls investigation worksheet indicated no injury. Current care plan interventions were: one person assist with ambulation until R50 oriented to surroundings, hipsters at all times, proper foot wear, magnetic lock to right wrist (a wristband that will alert staff if a resident attempts to leave a secure unit), automatic locking brakes on wheelchair, escort for outside appointments, non-skid socks when in bed, and lying, sitting and standing BP measurements New care intervention: Clip call light to pajamas when R50 was in bed to alert staff if resident forgets to call for help. The IDT met on 3/7/16, and directed the resident is currently being monitored per MD order for orthostatic BP changes, elevated BP, calorie count and elevated glucose (blood sugar) readings. The IDT further directed the resident was to be seen 3/8/16 on MD rounds. On 3/5/16, at 7:31 a.m. R50 was found on the floor of his room with his head by the bathroom door with a blanket under his head. R50 said he slipped on a rug while trying to go to the bathroom, pointing to the blanket The worksheet documented no injury. The falls investigation worksheet indicated R50 had a 43 point drop in systolic blood pressure from a lying to standing position (orthostatic BP). The falls investigation worksheet also indicated R50 had a blood	2 830		

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2 830	Continued From page 11 glucose reading of 48 (normal blood glucose is 70-99). Current care plan interventions in place were one person assist with ambulation until R50 oriented to surroundings, hipsters at all times, anticipate R50's needs, proper foot wear, magnetic lock to right wrist, automatic locking brakes on wheelchair, escort for outside appointments, non-skid socks when in bed, and lying/sitting/ standing BP measurements. The IDT met on 3/7/16, and directed R50 was on a strict calorie count with blood glucose checks before meals and at bedtime, monitoring elevated BP and orthostatic BP. The IDT further directed R50 to be seen on MD rounds on 3/8/16. On 4/12/16, at 10:55 p.m. R50 fell on mat near bed. R50 stated he was trying to get something to eat. A 13.5 x 9 centimeter reddened area was noted on his right hip. The falls investigation worksheet indicated orthostatic BP was not applicable and lacked documentation of blood glucose. The IDT met on 4/13/16, and directed post void bladder scans x three days, a bedside commode at night and to try to move his bed closer to the lobby to allow staff monitoring when resident is in bed. A note in the falls investigation worksheet indicated all bladder scans were within accepted parameters. On 4/14/16, at 6:06 a.m. R50 was found on floor between wheelchair and a chair in the common resident area. The falls investigation worksheet lacked documentation of injury. The falls investigation worksheet indicated no orthostatic BP drop and lacked documentation of blood glucose. Post fall meeting staff met on 4/14/16, and directed staff to perform 30 minute checks until it was determined if R50 had a urinary tract infection. The team further directed staff to push fluids and provide supervision if R50 had	2 830		

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2 830	Continued From page 12	2 830		

behaviors or was not redirectable. The physician was notified, and lab work ordered.

On 4/15/16, at 3:45 p.m. R50 was found in the bathroom leaning against the wall between sink and wall. The falls investigation worksheet indicated no orthostatic BP drop or injury and lacked documentation of blood glucose. The falls investigation worksheet did not list care interventions in place on 4/15/16. The physician was called with a finding of an elevated C-reactive protein (CRP, an indication of infection) and ordered R50 to be transported to the emergency room. On 4/18/16, the IDT notes indicated R50 was diagnosed with pneumonia and bladder spasms; antibiotics were ordered and oxybutynin ordered for bladder spasms.

On 4/20/16, at 7:36 a.m., R50 was observed to get up from his bed and walk to the bathroom with no walker and no staff present. The call light was observed not attached to R50's clothing, no black mat was observed at the side of his bed, and R50 was not wearing a hipster garment. R50 was unsteady in the bathroom, holding on to toilet handle. Surveyor requested licensed practical nurse (LPN)-A to assist R50. R50's pants were observed to have a large wet spot in front, and the bathroom floor was observed to have a large puddle of urine.
LPN-A assisted R50 to bed and changed R50's pants to clean clothing. At 7:56 a.m., LPN-A placed a black mat by the right side of R50's bed and assisted R50 in donning a hipster garment.

On 4/20/16, at 7:51 a.m. LPN-A was interviewed and stated she knew R50 had at least two falls. LPN-A confirmed the black anti-mat was not at R50's bedside when R50 was up in the bathroom, R50 was not wearing a hipster garment and the

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2 830	Continued From page 13 call light was not clipped to R50's clothing. LPN-A stated changes in the residents' care plan are highlighted and placed on the communication board. On 4/20/16, at 9:33 a.m. the assistant director of nursing (ADON) was interviewed and stated R50 had several falls recently. The ADON reviewed R50's care plan and stated R50 was to have assistance of staff and a walker for ambulation and staff was to anticipate R50's needs. The ADON further confirmed R50 was to have the call light clipped to his clothing when in bed and the black anti-mat was not at R50's bedside at time of observation as directed by his care plan. The ADON stated changes in care plans were placed on the communication board, discussed in daily meetings and highlighted in care plan copies placed in the resident's closet space. On 4/20/16, at 12:49 p.m. the director of nursing (DON) was interviewed and confirmed R50's care plan included directives to place a black anti-mat next to R50's bed, clip the call light to R50's clothing when he is in bed, and to ensure R50 wore hipsters at all times. The DON confirmed changes in care plans were placed on the communication board, discussed in daily meetings and highlighted in care plan copies placed in the resident's closet space. The facility's Fall Prevention policy dated 5/15, directed floor mats to be placed at the resident's bedside for those residents who have fallen or at high risk for a fall from bed. The policy further directed additional approaches for fall prevention, including protective equipment such as hip pads. R4's face sheet dated 4/20/16, indicated R4's diagnoses included vascular dementia with	2 830		

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2 830	Continued From page 14 behavioral disturbance, chronic iron deficiency anemia secondary to blood loss, hypothyroidism, delirium, Alzheimer's disease, glaucoma (increased pressure in the eyes, affecting vision), history of transient ischemic attack (TIA), heart blocks and arrhythmia. R4's Minimum Data Set (MDS) comprehensive assessment for a significant change dated 4/11/16, indicated R4 had highly impaired vision, short and long term memory impairment, moderately impaired cognitive skills for daily decision-making, and symptoms of delirium. The MDS further indicated R4's behaviors had worsened and included physical and verbal behaviors, and rejection of care 1 to 3 days of the assessment period. R4 required extensive assistance of 2 staff for transfers, bed mobility, and toilet use, extensive assistance of one staff for ambulation, and required the assist of staff to stabilize due to impaired balance. The MDS indicated R4 used a walker and a wheelchair, and had 2 falls with no injury and one fall with an injury that was not major since the previous MDS assessment. The Care Area Assessment (CAA) dated 4/11/16, indicated R4 was at risk for falls and had several falls without major injury during the past review period. The CAA identified diagnoses and medications that were potential fall risk factors. Safety interventions in place were identified including clipping the call light to R4's shirt when in bed and gripper socks or shoes to be worn at all times. R4's care plan revised 4/12/16, indicated R4 was at risk for falls, had a history of falls and was unaware of safety needs. The care plan directed staff to provide:	2 830		

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2 830	Continued From page 15 stand-by assist with all ambulation, assist as needed gait belt at all times, standard wheelchair with anti-rollback brakes for long distance transportation wear gripper socks or shoes at all times keep bed at transferable height remind to use front-wheeled walker wear hipsters as R4 allows clip call light to shirt to alert staff if he is getting up from bed set up an activity if wandering anticipate and meet needs Approach slowly from the front due to visual problems provide a bedtime snack Walk with human services technician twice daily, distance as tolerated R4's Bedside Kardex Report, located in R4's closet, identified all of the care plan interventions for safety, including clip call light to shirt when R4 goes to bed in case R4 forgets to push the call light to ask for assistance and gripper socks on while in bed. R4's signed physician orders dated 3/28/16, included medications that had the potential to affect R4's falls, including verapamil (increased blood pressure), timolol eye drops for glaucoma, hydrochlorothiazide (diuretic), seroquel (antipsychotic), and omeprazole (gastro-esophageal reflux). A physician's progress note dated 3/28/16, indicated R4 had frequent falls and physical therapy was noted to probably not be beneficial for R4. A physician's progress note dated 4/6/16, indicated R4 had a fall on 4/5/16, and was not	2 830		

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2 830	Continued From page 16	2 830		

moving as well. The physician identified contributing factors to R4's falls, including cognitive impairment and TIA's.
R4's admission Fall Risk Assessment (FRA) darted 12/30/16, identified R4 as being at high risk for falls.
R4's Post-Incident Investigation Worksheets for Falls indicated R4 had 8 falls between 1/21/16 and 4/11/16:
On 1/21/16, at 8:30 p.m. R4 sat on the walker and tipped backwards to the floor. R4 had no injury. The interdisciplinary team (IDT) met on 1/22/16, and the new intervention was to put a "Do not sit" sign on the walker to remind R4 not to sit on top of the walker.
On 2/12/16, at 2:30 p.m. R4 had an unwitnessed fall in the dining room, about 4 steps from where he had been sitting. R4 had a small abrasion on the back of the head. The IDT met on 2/16/16, and orthostatic blood pressures (blood pressures taken when lying, sitting and then standing) were checked for 3 days. R4 did not complain of being dizzy or light-headed.
On 2/24/16, at 7:10 a.m. R4 was sitting on the floor beside the bed. R4's walker was tipped over on the floor next to R4, and R4 was stating he had to have a bowel movement. R4 had no injury. It was noted R4's blood pressure dropped from 133/72 while sitting, to 114/69 while standing. The IDT met and initiated the new intervention of offering toileting on last round of the shift. Orthostatic blood pressure checks following the incident, indicated R4 had no orthostasis.
On 3/4/16, at 4:50 p.m. R4 was witnessed walking without a walker and lost his balance and fell. R4 had no injury. The IDT met on 3/7/16, and the new intervention was to keep resident's walker close to him at all times. This intervention was no longer in the care plan or the bedside

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2 830	Continued From page 17 Kardex. On 3/18/16, at 3:15 p.m. R4 was walking out of a bathroom, lost his balance, the walker tipped over and R4 fell. R4 had a skin tear on the right elbow. During a post-fall meeting, the staff identified he needed to wear a gait belt at all times. The IDT met on 3/21/16 and indicated R4 needed to sleep-in in the morning, offered a bedtime snack, and required stand-by-assist with ambulation. On 3/23/16, at 10:10 p.m. R4 was found on the floor next to his roommates bed and had a bowel movement. R4 had no injury. The IDT met on 3/23/16, and approved new interventions that were initiated by staff during a post-fall review following the fall. These interventions included R4 was to wear hipsters to help prevent injury and the call light was to be clipped to R4's shirt at night when put to bed. On 4/5/16, at 7:40 p.m. R4 had walked into the living room and was standing along the wall with the walker. R4 appeared to side-step and fall to the right with the walker. The post-fall meeting was held on 4/5/16, and staff discussed different contributing factors and possible root cause for the fall. R4's physician reviewed medications and ordered lab work. The action initiated was to ambulate with stand-by assist at least twice daily at a distance as tolerated, and resident needed reminders to use the walker with assistance. On 4/11/16, at 8:30 p.m. R4 was running without his walker and tripped over another resident's foot. R4 was wearing someone else's shoes. R4 had no injury. The IDT met on 4/12/16, and the action was to locate R4's shoes and assist him with using the wheelchair if he is refusing to use the walker properly. Orthostatic blood pressures were checked and it was determined R4 did not have orthostasis. A FRA was completed after each fall. Each FRA	2 830		

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2 830	Continued From page 18 included a review of risk factors, medications, vision, continence of bowel and bladder, behaviors, mobility, blood pressures, gait and balance. R4 was determined to be at moderate or high risk for falls with each FRA. On 4/20/16 at 7:54 a.m. R4 was lying in bed, sleeping. The call light cord was draped over R4's headboard with the call button on the back side of the headboard. On 4/20/16, at 8:00 a.m. human services technician (HST)-C stated R4's safety interventions included having his bed at transfer height, using his walker, and wheelchair as he needs. HST-C stated R4 required a gait belt as he needs, because he is unsteady at times. On 4/20/16, during an observation and interview at 10:20 a.m. with licensed practical nurse (LPN)-A the closet care guide was reviewed. R4 was lying in bed. LPN-A verified the call light was not clipped to R4's shirt and R4 did not have gripper socks on, but should have had both. LPN-A clipped the call light cord to R4's shirt and put some gripper socks on him. On 4/20/16, at 12:30 p.m. R4 was lying in bed, but was dressed. The call light was not clipped to his shirt, but was lying on the bed next to his right shoulder. HST-C verified it was not clipped to him and said it was clipped earlier. R4 had gripper socks on. On 4/20/16, at 2:09 p.m. the director of nursing (DON) stated following a fall, a small post-fall meeting was held to discuss the fall and initiate immediate interventions. The IDT met for a follow-up meeting to assess effectiveness or decide if a new interventions should be initiated. The DON verified staff should refer to the bedside	2 830		

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2 830	Continued From page 19 Kardex to implement safety interventions. The DON stated changes in resident cares or interventions are communicated to staff through daily report and through the bedside Kardex. UGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to fall interventions are implemented assessed and revised as needed for all residents. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to store medications at proper temperatures in 2 of 4 medication refrigerators reviewed. Findings include: On 4/19/16, at 3:52 p.m. the medication	21610		

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refrigerator on Maple unit was 34 degrees F (Fahrenheit). Trained medication assistant (TMA)-A verified this reading on the thermometer.

On 4/20/16, at 12:20 p.m. the medication refrigerator on Maple unit was 34 degrees F. Registered nurse (RN)-F verified the thermometer reading. RN-F stated the night nurses checked the refrigerator temperature. RN-F also stated she did not know the range the temperature should be in but she usually saw the temperature in the refrigerator to be 34 degrees F.

At 12:25 p.m. the assistant director of nursing (ADON) stated the medication refrigerator temperatures should be within 38-44 degrees Fahrenheit. The ADON verified the outside thermometer of the refrigerator read 54 degrees and stated, "the thermometer was not accurate at all." The ADON stated she would get maintenance to fix it. The ADON stated staff was supposed to adjust the dial when the refrigerator temperature was out of range and then re-temp a hour later. The ADON verified the refrigerator temperatures since 4/4/16, had been running low 30 degrees F on 4/4/16, temperature was not read on 4/5/16, and 32 degrees F through 4/7/16. The ADON also verified temperatures on the log had read low off and on since 2/16/16, with a reading of 26 degrees on 2/16/16, 28 degrees F on 2/17-18/16, and 30 degrees and 32 degrees frequently from then on and through March and April 2016. The ADON stated the Refrigerator Temps log did not have a place for the readjustment or for the refrigerator temperature when rechecked after the adjustment.

On 4/20/16 at 1:06 p.m. the medication refrigerator temperature on Maple unit read 32

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degrees F. RN-F verified the reading on the thermometer and stated she would turn up the dial a little and would recheck the temperature on her shift. RN-F stated the vaccines in the refrigerator were used to administer to residents and staff.

The refrigerator contained:

a box of interferon beta-1a IM (intramuscular) medication
a box of Risperdal Consta IM medication
The inserts in the boxes indicated the medications should be stored 36-46 degrees. The sticker on the boxes indicated the medications should be refrigerated but not be frozen.
21 influenza vaccines
15 FluZone Quad vaccines
3 unopened vials of Lantus insulin
12 acetaminophen 650 mg (milligrams) suppositories

On 4/20/16, at 1:21 p.m. the ADON sitting with the director of nursing (DON) stated, "We were working on a correction" for this. The ADON stated the Minneapolis pharmacy said the medication refrigerator temperatures should be maintained within 36-46 degrees F. At 1:27 p.m. the DON stated, "I will call the pharmacy." At approximately 1:52 p.m. the DON stated, "I talked to pharmacy, they said it is borderline, the medications might still be good."

On 4/20/16, at 1:45 p.m. the medication refrigerator on the Blue Spruce unit was 31 degrees F. The refrigerator temperature log indicated the refrigerator temperature readings had been consistently 30 to 32 degrees F since 4/4/16. Prior to 4/4/16, the temperature log indicated the temperatures recorded had been

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21610	Continued From page 22 30-32 degrees F, 14 of 98 readings since 1/1/16, with intermittent readings of 36 degrees F or above. Licensed practical nurse (LPN)-D verified the refrigerator temperature was below 36 degrees F and the temperature log readings had been below 36 degrees F. The refrigerator contained: one opened one milliliter (ml) vial of Tuberculin solution with approximately 0.5 milliliters remaining. two unopened 10 ml vials of lantus insulin two unopened ml vials of human NPH insulin one unopened one vial of hepatitis B vaccine The package inserts for these medications indicated they should be stored in a refrigerator between 36 and 46 degrees F, and should not be frozen. The package insert for the Tuberculin solution indicated it should be stored between 35 and 46 degrees F. On 4/20/16, at 1:59 p.m. the DON verified the medication refrigerator temperature range should be between 36 and 46 degrees. The DON stated the facility would contact the pharmacy for direction regarding medications in the refrigerators. The policy provided by the facility dated 8/13/15, Medication Storage and Security indicated "All prescription, nonprescription medications and biologicals are to be kept safe, orderly, secure and accessible to authorized nursing personnel only. Whenever there are biologicals stored in the refrigerator the temperature must be monitored at least twice daily as close to 12 hour intervals as possible. Biologicals drugs include antibodies, interleukins, and vaccines. Refrigerator Temperatures: A range of 36 to 46 degrees	21610		

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	00381	A. BUILDING: _____ B. WING _____	04/20/2016

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21610	Continued From page 23 Fahrenheit." SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure medication is stored at the proper temperature. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21610		
21670	MN Rule 4658.1405 A.B.C.D. Resident Units The following items must be provided for each resident: A. A bed of proper size and height for the convenience of the resident, a clean, comfortable mattress, and clean bedding, appropriate for the weather and resident's comfort, that are in good condition. Each bed must have a clean bedspread. A moisture-proof mattress or mattress cover must be provided for all residents confined to bed and for other beds as necessary. Rollaway type beds, cots, or folding beds must not be used. B. A chair or place for the resident to sit other than the bed. C. A place adjacent or near the bed to store personal possessions, such as a bedside table with a drawer. D. Clean bath linens provided daily or more often as needed. E. A bed light conveniently located and of an	21670		

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21670	Continued From page 24 intensity to meet the needs of the resident while in bed or in an adjacent chair This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a chair or place to sit, other than the bed, was provided for 3 of 35 residents (R21, R80, R18). Findings include: On 4/18/16, at 6:00 p.m. R21 was observed lying on the bed. R21 did not have a chair or a place to sit other than the bed. R21 stated he had to sit on the bed if he wanted a place to sit. "It would be nice to have a chair in here, it would be something different to sit on." From 4/18/16, at 6:00 p.m. through 4/20/16, at 1:00 p.m. R21 was observed to ambulate independently in his room and about the facility. R21's Communication care plan dated 4/12/16, indicated R21 had clear speech and was able to make his needs known. The Mobility care plan dated 4/11/16, indicated R21 ambulated and transferred independently without a device. On 4/19/16, at 9:35 a.m. R80, was observed sitting on the bed. R80 did did not have a chair or a place to sit other than the bed. From 419/16, at 9:35 a.m. through 4/20/16, at 1:00 p.m. R80 was observed to ambulate independently with a walker in his room and about the facility. R80's Mobility care plan dated 4/8/16, indicated R80 transferred and ambulated independently with a walker. The Cognition care plan dated 4/18/16, indicated R80 had impaired cognitive	21670		

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21670	Continued From page 25 function. On 4/20/16, at approximately 9:00 a.m. the director of nursing (DON) verified R21 and R80 did not have a chair or a place to sit other than the bed in their rooms and a chair was placed in R21 and R80 rooms. The DON stated residents should have a chair in their room or a place to sit on other than just the bed. The DON stated in the handbook it stated a chair would be provided at the resident's request and some residents choose not to have a chair due to limited space. The DON further stated if a resident was unable to request a chair one would be provided. The facility's Resident and Family Handbook (not dated) indicated a chair would be provided at the resident's request and some residents may choose not to have a chair due to limited space. On 4/19/16, at 10:15 a.m., R18 was observed sitting on his bed. The room lacked any seating other than the bed. R18 stated he had a recliner previously that he enjoyed sitting in, but the recliner was removed from his room by the facility. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure resident's rooms had a chair or a place to sit other than a bed. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one	21670		

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21670	Continued From page 26 (21) days.	21670		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a clean and homelike environment was maintained in 4 of 31 resident rooms (203, 211, 225, 226) and the Blue Spruce household dining room. Findings include: On 4/19/16, beginning at 3:30 p.m. during an environmental tour, the maintenance director (MD) and a maintenance staff member (MS) verified the following environmental findings: Room 203: on the wall next to the bathroom was an area approximately 6 inches by 4 inches of chipped and missing sheet rock on the bottom of the wall creating a rough, uncleanable surface. The other side of the wall corner was covered with an unpainted, uncleanable board that was approximately 4 feet long and 6 inches wide. Room 211: the heat register had several areas of paint scratched off. The corner molding between	21685		

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21685	Continued From page 27 the sink and the bathroom at the bottom was broken off approximately 3 inches by 4 inches creating a rough, uncleanable surface. Room 225: had a dime sized hole in the ceramic tile in the bathroom wall by toilet creating an uncleanable area. Room 226: had an approximately 4 inch by 1 inch chipped area in the ceramic tile on the bathroom wall causing a rough and uncleanable surface. The Blue Spruce dining room the corner edge of the wall between the two rooms had two chipped areas with missing and exposed sheet rock. The areas measured approximately 4 inches by 2 inches and 1 inch by 1 inch causing a rough and uncleanable surface. In addition the molding under the window ledge was missing and exposed the sheet rock. On 4/19/16, at 3:50 p.m. the MD stated a painter for resident room worked one weekend a month to repair and paint resident rooms and another painter worked every third weekend to repair and paint hallways and other areas. The MS stated there was not a schedule or log of what had been done or what needed to be done. The MD further stated the facility had a computer system in which staff could notify maintenance of areas needing repair. The system was checked daily. The facility's Maintenance Service policy dated 2015, indicated the maintenance department was responsible for maintaining the buildings, grounds and equipment in a safe and operable manner. The functions performed by maintenance included maintaining the building in good repair and free from hazards. Provide routine scheduled maintenance to all areas. The policy further	21685		

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21685	Continued From page 28 indicated painting and room maintenance would be done in a three to four week cycle. SUGGESTED METHOD OF CORRECTION: The Director of Maintenance or designee could develop, review, and/or revise policies and procedures to ensure resident rooms and common areas were maintained in a clean and homelike environment. The Director of Maintenance or designee could educate all appropriate staff on the policies and procedures. The Director of Maintenance or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21685		