DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

		ARE/MEDICAII TO BE COMPL						ID: DHZE Facility ID: 00381
MEDICARE/MEDICAID PROVIE (L1) 245628 2.STATE VENDOR OR MEDICAID (L2) 5. EFFECTIVE DATE CHANGE OF	NO.	3. NAME AND AD (L3) MN VETER. (L4) 45 BANKS B (L5) SILVER BAY	ANS HOME S BOULEVARD Y, MN	SILVER BA	(L6) 5	55614	4. TYPE OF ACTION 1. Initial 3. Termination 5. Validation 7. On-Site Visit	ON: 7 (L8) 2. Recertification 4. CHOW 6. Complaint 9. Other
(L9) 6. DATE OF SURVEY 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	02/2016 (L34) (L10)	01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	09 ESRD 10 NF 11 ICF/HD 12 RHC	13 PTIP 14 CORF 15 ASC 16 HOSPICE	22 CLIA	8. Full Survey After FISCAL YEAR END 06/30	
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	83 (L18) 83 (L17)	B. Not in Compl	e pased On:	am	2. Techi 3. 24 He 4. 7-Daj 5. Life \$	nical Personnel our RN y RN (Rural SN	The Following Requiren 6. Scope of S 7. Medical D F) 8. Patient Roo 9. Beds/Roon (L12)	ervices Limit irector om Size
14. LTC CERTIFIED BED BREAKD 18 SNF 18/19 SNF 83 (L37) (L38)		ICF (L42)	IID (L43)		15. FACILITY M 1861 (e) (1) or		(L15)	
16. STATE SURVEY AGENCY REM	MARKS (IF APPLICA	BLE SHOW LTC CA	NCELLATION I	DATE):				
17. SURVEYOR SIGNATURE Teresa Ament, Unit Su	upervisor	Date :	6/06/2016	(L19)	18. STATE SUR		APPROVAL Enforcement Speci	07/12/2010
PA	ART II - TO BE (COMPLETED B	BY HCFA RE		OFFICE OR	SINGLE ST	FATE AGENCY	(L20)
DETERMINATION OF ELIGIBLE 1. Facility is Eligible to 2. Facility is not Eligible	Participate		PLIANCE WITH	I CIVIL	2. O		icial Solvency (HCFA-25 I Interest Disclosure Stm :	
22. ORIGINAL DATE OF PARTICIPATION 10/20/2015 (L24)	23. LTC AGREEM BEGINNING (L41)	DATE	ENDING DAT		26. TERMINAT VOLUNTARY 01-Merger, Close 02-Dissatisfactio 03-Risk of Involu			(L30) NTARY Meet Health/Safety Meet Agreement
25. LTC EXTENSION DATE: (L27)		VE SANCTIONS of Admissions: aspension Date:	(L44) (L45)		04-Other Reason		OTHER	der Status Change
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS			
		00401						

(L31)

(L33)

DETERMINATION APPROVAL

32. DETERMINATION OF APPROVAL DATE

06/06/2016

31. RO RECEIPT OF CMS-1539

(L28)

(L32)



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 Weath

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



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 Weath

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

POST-CERTIFICATION REVISIT REPORT

				_	
PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building			DATE OF RE	VISIT
245628 _{Y1}	B. Wing		Y2	6/2/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
MN VETERANS HOME SILVER	R 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).

ITE Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4			DATE Y5
ID Prefix	F0282	Correction	ID Prefix F02	87	Correction	ID Prefix	F0323		Correction
Reg. #	483.20(k)(3)(ii)	Completed	Reg. # 483.5	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 F04	65	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			
REVIEWE STATE AC		REVIEWED BY (INITIALS) TA/mm	DATE 06/06/2016	SIGNATURE OF	SURVEYOR 29433		1	DATE 06/02	2/2016
REVIEWS CMS RO	ED BY	REVIEWED BY (INITIALS)	DATE	TITLE			ı	DATE	
FOLLOW 4/20/201		COMPLETED ON	CHECK FOUNCORR	OR ANY UNCORREC	CTED DEFICIEN ES (CMS-2567)	NCIES. WAS SENT TO TH	IE EA OU IT\/O	YE	s 🗆 NO

Form CMS - 2567B (09/92) EF (11/06)

Page 1 of 1

EVENT ID:

DHZE12

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building 01 - MN VETS HOME			DATE OF REV	ISIT
	B. Wing	,	Y2	5/27/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
MN VETERANS HOME SILVER	RBAY	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	DA	TE ITEM Y5 Y4	I DAT	
ID Prefix	Correction	ID Prefix	Corr	ection ID Pref	cx Corr	ection
Reg. # NFPA 101	Completed	Reg. #	Com	pleted Reg. #	Com	pleted
LSC K0062	04/27/2016	LSC		LSC		
ID Prefix	Correction	ID Prefix	Corr	rection ID Pref	ix Corr	ection
Reg. #	Completed	Reg. #	Com	pleted Reg. #	Com	pleted
LSC		LSC		LSC		
ID Prefix	Correction	ID Prefix	Corr	ection ID Pref	ix Corr	ection
Reg. #	Completed	Reg. #	Com	pleted Reg. #	Com	pleted
LSC		LSC		LSC		
ID Prefix	Correction	ID Prefix	Corr	rection ID Pref	ix Corr	ection
Reg. #	Completed	Reg. #	Com	pleted Reg. #	Com	pleted
LSC		LSC		LSC		
ID Prefix	Correction	ID Prefix	Corr	rection ID Pref	ix Corr	ection
Reg. #	Completed	Reg. #	Com	pleted Reg. #	Com	pleted
LSC		LSC		LSC	<u> </u>	
REVIEWED BY STATE AGENCY X	REVIEWED BY (INITIALS)TL/mm	DATE 06/06/2016	SIGNATURE OF SURV	EYOR 29433	DATE 05/27/201	6
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE		DATE	
FOLLOWUP TO SURVEY 4/26/2016	COMPLETED ON		R ANY UNCORRECTED CTED DEFICIENCIES (CI] NO

Form CMS - 2567B (09/92) EF (11/06)

Page 1 of 1

EVENT ID:

DHZE22

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	ARE/MEDICAID CERTIFICATION TO BE COMPLETED BY THE STA		ID: DHZE 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 I (L4) 45 BANKS BOULEVARD (L5) SILVER BAY, MN		4. TYPE OF ACTION: 2 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 6. DATE OF SURVEY 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC	7. PROVIDER/SUPPLIER CATEGORY 01 Hospital	14 CORF	8. Full Survey After Complaint FISCAL YEAR ENDING DATE: (L35) 06/30
2 AOA 3 Other 11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 83 (L18) 13.Total Certified Beds 83 (L17) 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF 83 (L37) (L38) (L39) 16. STATE SURVEY AGENCY REMARKS (IF APPLICATION)	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: ICF IID (L42) (L43) ABLE SHOW LTC CANCELLATION DATE):	And/Or Approved Waivers Of T 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNI 5. Life Safety Code * Code: B* 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	6. Scope of Services Limit 7. Medical Director
17. SURVEYOR SIGNATURE Teresa Ament, HFE NEII	Date : 05/23/2016 (L19)	18. STATE SURVEY AGENCY. Mark Type Enforcement Spe	ath
PART II - TO BE	COMPLETED BY HCFA REGIONA	L OFFICE OR SINGLE ST	
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 Finan2. Ownership/Control3. Both of the Above	Interest Disclosure Stmt (HCFA-1513)
22. ORIGINAL DATE OF PARTICIPATION 10/20/2015 (L24) 25. LTC EXTENSION DATE: 23. LTC AGREED BEGINNING (L41) 27. ALTERNATI	G DATE ENDING DATE (L25)	26. TERMINATION ACTION: VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimburse 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	05-Fail to Meet Health/Safety ment 06-Fail to Meet Agreement
(I 27)	(L44) uspension Date:		00-Active
28. TERMINATION DATE: 29). INTERMEDIARY/CARRIER NO.	30. REMARKS	
(L28)	06201 (L31)		

32. DETERMINATION OF APPROVAL DATE

(L33)

DETERMINATION APPROVAL

(L32)

31. RO RECEIPT OF CMS-1539



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:

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

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

<u>Remedies</u> - 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

<u>Informal Dispute Resolution</u> - 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,

Kumalu 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

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 • <u>www.mvh.state.mn.us</u> • 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, BSN, LNHA

Administrator Silver Bay Veterans Home

Carol.gilbertson@state.mn.us

218-353-8684

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

(EACH DEFICIENCY REGULATORY OR LE NITIAL COMMENTE PROPERTIES PLAN (1985) PROPERTIES PROP	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) TS of correction (POC) will serve	A. BUILDING B. WING ST 45	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES OF CORRECTION SHOULD CROSS-REFERENCED TO THE APPROPRIES OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES OF CORRECTION OF CO	D BE COMPLET
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rour verification. 183.20(k)(3)(ii) SE PERSONS/PER C The services provi must be provided t	RVICES BY QUALIFIED ARE PLAN ded or arranged by the facility by qualified persons in	F 282		
by: Based on observative or the facility or the facility or the facility or garding fall inter (R50, R4) reviewe	ation, interview and document failed to follow the care plan ventions for 2 of 3 residents			
R50's Admission r diagnoses that inc anemia, type I dial osteoarthritis, a hi repeated falls. R5 Set (MDS) dated (eluded Alzheimer's disease, betes mellitus, dementia, story of hip fracture and O's admission Minimum Data 3/10/16, indicated R50 was ed and exhibited wandering	or or or or		(X6) DATE
EVENTO TOTAL FOR OUR	evisit of your facilialidate that substated alidate that substated are. Services provided in a cordance with earth are. This REQUIREMENT of the services provided in a cordance with earth are. This REQUIREMENT of the services are are. This REQUIREMENT of the services are are. This REQUIREMENT of the services are	evisit of your facility may be conducted to alidate that substantial compliance with the egulations has been attained in accordance with our verification. 83.20(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 are. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document eview, the facility failed to follow the care plan egarding 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	Prisit of your facility may be conducted to alidate that substantial compliance with the egulations has been attained in accordance with cour verification. 83.20(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 are. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document eview, the facility failed to follow the care plan egarding 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	evisit of your facility may be conducted to alidate that substantial compliance with the egulations has been attained in accordance with our verification. 83.20(k)(3)(ii) SERVICES BY QUALIFIED ERSONS/PER CARE PLAN The services provided or arranged by the facility nust be provided by qualified persons in accordance with each resident's written plan of are. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document eview, the facility failed to follow the care plan egarding 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, beteoarthritis, 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

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.

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	T		CONCEDICTION	(X3) DATE	SURVEY
STATEMENT AND PLAN O	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	COM	PLETED
		245628	B. WING			04/2	20/2016
	PROVIDER OR SUPPLIER	R BAY		45	REET ADDRESS, CITY, STATE, ZIP CODE BANKS BOULEVARD LVER BAY, MN 55614		
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 282	required assistance extensive assistance chair and wheelch R50 required extensive assistance and an ambust a history of orthost pressure when rist sitting or standing. R50 was not steastabilize with staff a seated to standing around and facing on and off the toile transfer from bed. R50's care area and dated 3/16/16, indeprior to admission steady with transfer further indicated fafter admission. The safety skirl socks.	age 1 e with moving about in bed and ce with transfers from bed, air. The MDS further indicated nsive assistance with dressing, lation. The MDS also indicated ratic hypotension (drop in blooding from a lying position to) The MDS further indicated dy and was only able to assistance when moving from a position, walking, turning the opposite direction, moving and surface-to-surface and chair or wheelchair. Assessment (CAA) for falls icated R50 had a history of falls also indicated had three falls the first week the CAA for falls also indicated his including hipsters at all times when in bed, clip call light to discontinuation.		282			
	was to have the cowhen in bed, to e (non-slip,cushion bed, to provide a walker or use a wor unsteady, and garment with imp to prevent hip fra	dated 4/15/16, directed staff R50 all light clipped to his clothing insure a black anti-mat ed mat) is at the right side of his ssistance with ambulation with theelchair if R50 appeared weak R50 is to wear hipsters (a act absorbing pads over the hip ctures that can occur with a fall) assessment dated 4/15/16, a falls within the last six months, occasional bladder incontinence	s s				

STATEMENT	STATEMENT OF DEFICIENCIES			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN O	FCORRECTION	IDENTIFICATION NOMBELS				04/6	20/2016
		245628	B. WING		REET ADDRESS, CITY, STATE, ZIP CODE	1 04/2	-0/2010
	PROVIDER OR SUPPLIER ERANS HOME SILVE	R BAY		45 [BANKS BOULEVARD VER BAY, MN 55614	,	
(X4) ID PREFIX TAG	SUMMARY ST.	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 282	daily agitated behause of assistive do of balance while so Review of the facil Worksheets for Fahad six falls in the On 4/20/16, at 7:3 get up from his bewith no walker and was observed not black mat was ob and R50 was not was unsteady in thandle. Surveyor nurse (LPN)-A to observed to have the bathroom floopuddle of urine. Lohanged R50's pa.m., LPN-A place of R50's bed and hipster garment. On 4/20/16, at 7: and stated she kilpn-A confirmed R50's bedside wilk R50 was not we call light was not stated changes in highlighted and place. On 4/20/16, the nursing (ADON)	aviors, no orthostatic BP drop, evices with walking and a loss		282			

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245628	B. WING			04/2	20/2016
	ROVIDER OR SUPPLIER			4!	TREET ADDRESS, CITY, STATE, ZIP CODE 5 BANKS BOULEVARD ILVER BAY, MN 55614		
(X4) ID PREFIX TAG	SUMMARY STA	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D RF	(X5) COMPLETION DATE
F 282	ambulation and staneeds. The ADON have the call light bed and the black bedside at time of care plan. The AD plans are placed of discussed in daily care plan copies papace. On 4/20/16, at 12: (DON) was interviplan included direnext to R50's bed clothing when he wears a hipster at changes in care prommunication be meetings and high placed in the residual placed in the residual control individualized for a resident center directed the residual control individual con	age 3 If staff and a walker for aff was to anticipate R50's further confirmed R50 was to clipped to his clothing when in anti-mat was not at R50's observation as directed by his ON stated changes in care on the communication board, meetings and highlighted in placed in the resident's closet 49 p.m. the director of nursing ewed and confirmed R50's care ctives to place a black anti-mat, clip the call light to R50's is in bed, and to ensure R50 all times. The DON confirmed plans are placed on the pard, discussed in daily hilighted in care plan copies dent's closet space. Ident Assessment-Care plan (15, indicated the facility will care for the resident with uses, goals and interventions in ed format. The policy further dent plan of care will be the day of admission. The policy resident's care plan was lated 4/20/16, indicated R4's ed vascular dementia with bance, chronic iron deficiency ry to blood loss, hypothyroidism	f	282			
	delirium, Alzheim	ner's disease, glaucoma cure in the eyes, affecting vision)	,				et Page 4 of

STATEMENT	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
AND PLAN O	F CORRECTION					04	/20/2016	
	PROVIDER OR SUPPLIER		B. WING	STRE 45 B	EET ADDRESS, CITY, STATE, ZIP CO ANKS BOULEVARD VER BAY, MN 55614		20/2010	
(X4) ID PREFIX TAG	SUMMARY ST.	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 282	blocks and arrhythem At's Minimum Datassessment for a 4/11/16, indicated short and long termoderately impair decision-making, MDS further indicated and incidentated and incidentated R4 requists for transfers, extensive assista and required the impaired balance walker and a wheinjury and one falmajor since the particular of the particular of the particular of the Clight to R4's shirt or shoes to be with the R4's care plan reat risk for falls, hunaware of safet staff to provide: stand-by assist needed gait belt at all times.	tischemic attack (TIA), heart imia's. Ita Set (MDS) comprehensive significant change dated R4 had highly impaired vision, memory impairment, red cognitive skills for daily and symptoms of delirium. The ated R4's behaviors had luded physical and verbal fection of care 1 to 3 days of the id. In addition, the MDS irred extensive assistance of 2 bed mobility, and tollet use, nace of one staff for ambulation, assist of staff to stabilize due to the MDS indicated R4 used a relichair, and had 2 falls with no I with an injury that was not revious MDS assessment. Seessment (CAA) dated 4/11/16, at risk for falls and had several or injury during the past review erventions in place were CAA, including clipping the call when in bed and gripper socks		282		K continuation S		

		& MEDICAID SERVICES	(X9) MIII	TIPL.	E CONSTRUCTION	(X3) DATE	SURVEY
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COIVII	LECTED
,		245628	B. WING			04/3	20/2016
NAME OF F	ROVIDER OR SUPPLIER	2-10020	<u> </u>		TREET ADDRESS, CITY, STATE, ZIP CODE		
\		D DAV			5 BANKS BOULEVARD BILVER BAY, MN 55614		,
MN VETE	RANS HOME SILVE			-	I PROVIDER'S PLAN OF CORRECT	ION	(X5)
(X4) ID PREFIX TAG	ALYON DELICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	COMPLETION DATE
F 282	Continued From payear gripper socks keep bed at transferemind to use from wear hipsters as Figure call light to shift from bed set up an activity if anticipate and med Approach slowly froblems provide a bedtime Walk with human distance as toleral R4's Bedside Kard closet, identified a for safety, including goes to bed incast light to ask for asswhile in bed. R4's Post-Incidentified and 4/11/16. Each interventions were appropriate. On 4/20/16, at 7:3 sleeping. The cate R4's headboard with side of the headboard with the side of the side of the side of the headboard with the side of the side	age 5 s or shoes at all times erable height t-wheeled walker l4 allows rt to alert staff if he is getting up wandering et needs rom the front due to visual snack services technician twice daily, ted dex Report, located in R4's all of the care plan interventions ag clip call light to shirt when R4 e R4 forgets to push the call sistance and gripper socks on t Investigation Worksheets for had 8 falls between 1/21/16 th fall was reviewed and new e initiated as were determined to l1 light cord was draped over with the call button on the back		282			
	he needs, becau	se he is unsteady at times. ng an observation and interview					
	On 4/20/16, duri	ng all observation and interview	 7E11		Facility ID: 00381 If co	ntinuation sh	eet Page 6 of 2

CENTER	15 FUR MEDICANE	A WILDIOAID OLITATOLO	()(0) 14111	CIDLE:	CONSTRUCTION	(X3) DATE S	SURVEY
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	•		CONSTRUCTION	COMPL	ETED
		245628	B. WING			04/20)/2016
	PROVIDER OR SUPPLIER			45	REET ADDRESS, CITY, STATE, ZIP CODE BANKS BOULEVARD LVER BAY, MN 55614		
(X4) ID PREFIX TAG	SUMMARY STA	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) RF	(X5) COMPLETION DATE
F 282	at 10:20 a.m. licen read the closet car LPN-A verified the R4's shirt and R4 (but should have. It to R4's shirt and p On 4/20/16, at 12: but was dressed. his shirt, but was I shoulder. HST-C him and said it was completes a resident in the fact (i) Admission ass (ii) Annual assess (iii) Annual assess (iii) Annual assess (iii) Significant che (iv) Quarterly revi (v) A subset of ite reentry, discharge (vi) Background (is no admission as (2) Transmitting completes a resident in the fact (2) Transmitting (2) Transmitting (2) Transmitting (3) Transmitting (4) Transmitting (5) Transmitting (5) Transmitting (6) Transmitting (7) Transmitting (8) Transmitting (8) Transmitting (8) Transmitting (9) Transm	sed practical nurse (LPN)-A re guide. R4 was lying in bed. call light was not clipped to clid not have gripper socks on, LPN-A clipped the call light cord ut some gripper socks on him. 30 p.m. R4 was lying in bed, The call light was not clipped to ying on the bed next to his right verified it was not clipped to s clipped earlier. 9 p.m. the director of nursing f should refer to the bedside ent safety interventions. The ges in resident cares or communicated to staff through arough the bedside Kardex. UNG/TRANSMITTING ESSMENT a. Within 7 days after a facility following information for each cility: essment. sment updates. ange in status assessments. ew assessments. ew assessments. ems upon a resident's transfer, e, and death. fface-sheet) information, if there	F	282	SEE ATTACHED POC		04/21/16

PRINTED: 05/06/2016 FORM APPROVED OMB NO. 0938-0391 (x3) DATE SURVEY

	S FUR MEDICARL	A MEDIO IIB SELICIA	(X2) MUL	TIPLE CON	NSTRUCTION	(X3) DATE	LETED
STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ING			
MAD 1 FAIR O						04/0	0/2016
		245628	B, WING		T ADDRESS, CITY, STATE, ZIP CODE	1 04/2	0/2010
NAME OF F	ROVIDER OR SUPPLIER				NKS BOULEVARD		
*****	ERANS HOME SILVE	R BAY			R BAY, MN 55614		
MN VEIE				SILVE	PROVIDER'S PLAN OF CORRECT	ION	(X5)
(X4) ID PREFIX TAG	CAOU DEDOENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETION DATE
	Continued From p System informatio the MDS in a form record layouts and passes standardiz the State. (3) Transmittal red a facility complete facility must electr accurate, and con System, including (i) Admission ass (ii) Annual assess (iii) Significant con (v) Significant con assessment. (vi) Quarterly revi (vii) A subset of it reentry, discharg (viii) Background initial transmission does not have ar (4) Data format. the format specified commodities the format specified commodities commodities the format specified the format specified commodities the format specified commodities the format specified the format s	age 7 In for each resident contained in at that conforms to standard data dictionaries, and that are edits defined by CMS and quirements. Within 14 days after is a resident's assessment, a conically transmit encoded, inplete MDS data to the CMS the following: essment. It is an estatus assessment. It is ment. It is mot met as evidenced in a proved by CMS, in the by the State and approved by MENT is not met as evidenced in and document review, the encode or transmit Minimum Date in a contain the encode or transmit Minimum Date in a contain the encode or transmit Minimum Date in a contain the encode or transmit Minimum Date in a contain the encode or transmit Minimum Date in a contain the encode or transmit Minimum Date in a contain the encode or transmit Minimum Date in a contain the encode or transmit Minimum Date in a contain the encode or transmit Minimum Date in a contain the encode or transmit Minimum Date in a contain the encode or transmit Minimum Date in a contain the encode in the enc	t t	287	DEFICIENCY)		
	Set (MDS) data Medicare/Medic 80 residents.	to the Center for aid (CMS) system timely for 57 o	of			athurstin ch	eet Page 8 of
L		Event ID: DH	7F11	Facili	ly ID: 00381 If coi	nunuation sne	BELLAYE OU

		& MEDICAID SERVICES	(Va) MI II	TIDI E	CONSTRUCTION	(X3) DATE	SURVEY
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COMP	LETED
AND FLANC	Officerion		, ,, , , , , , , , , , , , , , , , , , ,				
		245628	B, WING			04/2	0/2016
NAME OF P	ROVIDER OR SUPPLIER		,		REET ADDRESS, CITY, STATE, ZIP CODE		
MANI VETE	RANS HOME SILVE	R BAY		1	BANKS BOULEVARD LVER BAY, MN 55614		Ì
WIIN VEIL					PROVIDER'S PLAN OF CORRECTIO	N	(X5) COMPLETION
(X4) ID PREFIX	ICACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	JBE (DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)		
F 287	Continued From pa	age 8	F	287	•		
. =0.	Findings include:	i	l	-			
		o wastered purpo (DN) E			·		
	On 4/20/16, at 8:30	0 a.m. registered nurse (RN)-E nd stated the facility completed					
	an MDS on all resi	idents, however, due to an					
	inaccurate facility i	identification number and					
	problems with the	facility software, the facility was the MDSs to CMS. RN-E					
	stated the facility s	submitted the first batch of					
	MDSs on 4/1/16, a	and they would continue to					
	submit every Thur	'sday.					
	On 4/20/16, at 12:	17 p.m. the administrator, the					
	director of nursing	(DON) and RN-E were administrator stated the facility					
	had an incorrect in	dentification number and					
	software problems	s that left them unable to					
	transmit MDS dat	a. The administrator stated the edicare certified 10/20/15. RN-E				•	,
	verified 57 resider	nts' MDS data had not been					
ĺ	submitted to CMS	.					
	The facility was III	nable to provide a policy on					
	transmission of M	IDSs to CMS.					
F 323	483,25(h) FREE (OF ACCIDENT	F	323	SEE ATTACHED POC		05/30/16
SS=D	HAZARDS/SUPE	RVISION/DEVICES			SEL ATTACHED FOC		03/30/10
	The facility must	ensure that the resident					
	environment rem	ains as free of accident hazards					
	as is possible; an	nd each resident receives ision and assistance devices to					
	prevent accidents	S.					
	I .	IENT is not met as evidenced					
	by:						

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245628	B. WING				/20/2016	
	PROVIDER OR SUPPLIER			45 B	ET ADDRESS, CITY, STATE, ZIP CODE ANKS BOULEVARD /ER BAY, MN 55614			
(X4) ID PREFIX TAG	JEACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 323	Based on observer review, the facility interventions to mid 3 residents (R50, Findings include: R50's admission rediagnoses that includes anemia, type I diacosteoarthritis, and repeated falls. R5 Set (MDS) dated a cognitively impaire behaviors. The Middle of the cognitively impaired behaviors. The Middle of the cognitive of the cognitively impaired behaviors. The Middle of the cognitive of the cognitiv	ation, interview and document failed to implement appropriate nimize the risk for falls for 2 of		323				
,	loss/dementia da confusion, disorie decreased ability understand other hearing and/or vis R50's ability to pr	Assessment (CAA) for cognitive ted 3/15/16, indicated R50 had entation, forgetfulness and to make self understood or to s. The CAA further indicated sual loss may have an impact or ocess information. The CAA for 6, indicated R50 had a history ossion, balance problems and	1					

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE (CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	IDENTIFICATION NUMBER:					
		245628	B. WING			04/	20/2016
	PROVIDER OR SUPPLIER			45 E	REET ADDRESS, CITY, STATE, ZIP CODE BANKS BOULEVARD VER BAY, MN 55614		
(X4) ID PREFIX	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
TAG	TIEGOD II O II O				DEI IOIERO I		
F 323	was not steady with CAA for falls further the first week after also identified safe hipsters at all time bed, clip call light anti-skid mat at side R50's care pland was to have the combed, to provide a walker or use a wor unsteady, and garment with impact to prevent hip fract R50's Fall Risk as indicated multiple adequate vision, daily agitated behuse of assistive dof balance while stated.	th transfers or walking. The er indicated R50 had three falls admission. The CAA for falls by interventions including as, safety skid socks when in to clothing in bed and black de of bed. Lated 4/15/16, directed staff R50 all light clipped to his clothing as at the right side of his esistance with ambulation with heelchair if R50 appeared weak R50 was to wear a hipster (a lact absorbing pads over the hipstures that can occur with a fall). Essessment dated 4/15/16, falls within the last six months, occasional bladder incontinence laviors, no orthostatic BP drop, levices with walking and a loss standing.		323			
	Review of the fac Worksheets for F following:	ility Post Incident Investigation falls since 3/3/16, indicated the					
	to exit the facility door, hit his nose bridge of his nos interventions in pwear, automatic escort for outside socks when in be Redirect residen	0 p.m. R50 fell when attempting locked unit door, slid down the and sustained a cut to the e. Current care plan blace were proper fitting foot locking bakes on wheelchair, e appointments and non-skid ed. New care intervention: t from entranced/exit doors if e interdisciplinary team (IDT) me					

CENTER	S FOR MEDICARE	& MEDICAID SERVICES			CONCEDUCTION	(X3) DATE	SURVEY	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COMP		
		245628	B, WING		· · · · · · · · · · · · · · · · · · ·	04/20/20		
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 5 BANKS BOULEVARD			
MN VETE	RANS HOME SILVE	R BAY			ILVER BAY, MN 55614			
(X4) ID PREFIX TAG	/EACH DESIGNENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BF	(X5) COMPLETION DATE	
	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.		F	323				
	bathroom floor with investigation works. Current care plant assist with ambula surroundings, hips wear, magnetic look that will alert staff secure unit), autor wheelchair, escort non-skid socks what standing BP measintervention: Clip of was in bed to alert for help. The IDT resident is current order for orthostaticalorie count and readings. The IDT was to be seen 3/	2 p.m. R50 was found on the h hands on sink. The falls sheet indicated no injury, interventions were: one person ation until R50 oriented to sters at all times, proper foot ck to right wrist (a wristband if a resident attempts to leave a matic locking brakes on for outside appointments, nen in bed, and lying, sitting and surements New care call light to pajamas when R50 to staff if resident forgets to call met on 3/7/16, and directed the cly being monitored per MD tic BP changes, elevated BP, elevated glucose (blood sugar) further directed the resident (8/16 on MD rounds.)						
	door with a blanker slipped on a rug verbathroom, pointing documented no in worksheet indicate systolic blood prespection (orthostal)	et under his head. R50 said he while trying to go to the g to the blanket The worksheet njury. The falls investigation led R50 had a 43 point drop in ssure from a lying to standing tic BP). The falls investigation adicated R50 had a blood						

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD	TIPLE CONSTRUCTION ING	COM	(X3) DATE SURVEY COMPLETED 04/20/2016		
	PROVIDER OR SUPPLIER	245628 R BAY	B. WING	STREET ADDRESS, CITY, STA 45 BANKS BOULEVARD SILVER BAY, MN 55614		/20/2016		
(X4) ID PREFIX TAG	/EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION EACTION SHOULD BE I TO THE APPROPRIATE DIENCY)	(X5) COMPLETION DATE		
F 323	70-99). Current ca were one person a oriented to surrour anticipate R50's not magnetic lock to ribrakes on wheelch appointments, nor lying/sitting/ standimet on 3/7/16, and calorie count with meals and at bedt and orthostatic BF to be seen on MD On 4/12/16, at 10: bed. R50 stated heat. A 13.5 x 9 cel noted on his right worksheet indicat applicable and lac glucose. The IDT post void bladder commode at night closer to the lobby resident is in bed.	48 (normal blood glucose is re plan interventions in place assist with ambulation until R50 addings, hipsters at all times, seeds, proper foot wear, ght wrist, automatic locking nair, escort for outside askid socks when in bed, and ang BP measurements. The IDT didirected R50 was on a strict blood glucose checks before ime, monitoring elevated BP and and ang BP for the IDT further directed R50 arounds on 3/8/16. 55 p.m. R50 fell on mat near e was trying to get something to entimeter reddened area was hip. The falls investigation ed orthostatic BP was not exceed documentation of blood met on 4/13/16, and directed scans x three days, a bedside t and to try to move his bed y to allow staff monitoring when A note in the falls investigation ed all bladder scans were within		323				
	between wheelch resident area. The lacked document investigation world BP drop and lack glucose, Post fall and directed staff until it was determined.	06 a.m. R50 was found on floor air and a chair in the common ne falls investigation worksheet ation of injury. The falls asheet indicated no orthostatic ed documentation of blood meeting staff met on 4/14/16, if to perform 30 minute checks mined if R50 had a urinary tract am further directed staff to push				David 10 of		

STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED .		
		245628	B. WING			04/2	0/2016	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP 45 BANKS BOULEVARD SILVER BAY, MN 55614		LVER BAY, MN 55614			
(X4) ID PREFIX TAG	(CACH DESIGNENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BF	(X5) COMPLETION DATE	
F 323	fluids and provide behaviors or was rate was notified, and I. On 4/15/16, at 3: bathroom leaning and wall. The falls indicated no ortho lacked documenta investigation work interventions in play was called with a corrective protein infection) and order the emergency roundicated R50 was and bladder spass and oxybutynin or On 4/20/16, at 7:3 get up from his be with no walker and was observed not black mat was observed not black mat was observed not was unsteady in the handle. Surveyor nurse (LPN)-A to observed to have the bathroom floopuddle of urine. LPN-A assisted Figure 1 pants to clean cloplaced a black mand assisted R50 on 4/20/16, at 7: and stated she keep the control of the control	supervision if R50 had not redirectable. The physician	t	323				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245628	B. WING_		04	/20/2016	
	PROVIDER OR SUPPLIER ERANS HOME SILVE			STREET ADDRESS, CITY, STATE, ZIP CO 45 BANKS BOULEVARD SILVER BAY, MN 55614	DDE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 323	R50's bedside when R50 was not weard call light was not of stated changes in thighlighted and platholder. On 4/20/16, at 9:33 nursing (ADON) was had several falls re R50's care plan and assistance of staff and staff was to an ADON further confilight clipped to his oblack anti-mat was observation as dire ADON stated changen the communicate meetings and highlighaced in the reside clothing when he is wore hipsters at all changes in care placed communication board meetings and highlighaced in the reside. The facility's Fall Prodirected floor mats bedside for those residence.	in R50 was up in the bathroom, ing a hipster garment and the ipped to R50's clothing. LPN-A he residents' care plan are ced on the communication B a.m. the assistant director of as interviewed and stated R50 cently. The ADON reviewed d stated R50 was to have and a walker for ambulation ticipate R50's needs. The irmed R50 was to have the call clothing when in bed and the not at R50's bedside at time of ceted by his care plan. The ges in care plans were placed ion board, discussed in daily lighted in care plan copies ent's closet space. B p.m. the director of nursing wed and confirmed R50's care tives to place a black anti-mat clip the call light to R50's in bed, and to ensure R50 times. The DON confirmed ans were placed on the ard, discussed in daily lighted in care plan copies ent's closet space. The placed at the resident's esidents who have fallen or at	F 32	23			
	high risk for a fall fr directed additional	esidents who have fallen or at com bed. The policy further approaches for fall prevention, equipment such as hip pads.					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		OATE SURVEY OMPLETED
		245628	B. WING	•		04/20/2016
	PROVIDER OR SUPPLIER	R BAY		STREET ADDRESS, CITY, 45 BANKS BOULEVARI SILVER BAY, MN 55	D	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	(EACH CORRECT CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	diagnoses included behavioral disturba anemia secondary delirium, Alzheimer (increased pressur history of transient blocks and arrhythicks and long term moderately impaired decision-making, and MDS further indica worsened and inclubehaviors, and rejeassessment period assistance of 2 sta and toilet use, exterior ambulation, and stabilize due to impindicated R4 used had 2 falls with no injury that was not assessment. The Care Area Assindicated R4 was a falls without major period. The CAA i medications that we Safety intervention including clipping to the care and the car	ted 4/20/16, indicated R4's invascular dementia with since, chronic iron deficiency to blood loss, hypothyroidism, r's disease, glaucoma e in the eyes, affecting vision), ischemic attack (TIA), heart	F	323		

STATEM	ENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	TIPLE CONSTRUCTION DING	(X3) DAT	COMPLETED		
		245628	B, WING			/20/2016		
	OF PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIF 45 BANKS BOULEVARD SILVER BAY, MN 55614				
(X4) PREF	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL I LSC IDENTIFYING INFORMATION)	ID PREF TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
F3	at risk for falls, ha unaware of safety staff to provide: stand-by assist v needed gait belt at all tim anti-rollback brak transportation wear gripper sockeep bed at transremind to use frowear hipsters as clip call light to sl from bed set up an activity anticipate and m Approach slowly problems provide a bedtim Walk with humar distance as toler R4's Bedside Ka closet, identified for safety, included for safety, included for safety, included for safety, included medical affect R4's falls, blood pressure) hydrochlorothiaz (antipsychotic), (gastro-esophage)	vised 4/12/16, indicated R4 was ad a history of falls and was a needs. The care plan directed with all ambulation, assist as es, standard wheelchair with res for long distance as ferable height nt-wheeled walker R4 allows nirt to alert staff if he is getting up if wandering eet needs from the front due to visual e snack a services technician twice daily, ated ated at the care plan interventions ing clip call light to shirt when R4 ase R4 forgets to push the call esistance and gripper socks on sician orders dated 3/28/16, tions that had the potential to including verapamil (increased, timolol eye drops for glaucoma, and omeprazole		323				

<u> </u>	AS FUR MEDICARE	A MEDICAID SELVICES				(VS) DATE	SUBVEY
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245628	B. WING			04/2	20/2016
	PROVIDER OR SUPPLIER	R BAY		45	TREET ADDRESS, CITY, STATE, ZIP CODE 5 BANKS BOULEVARD ILVER BAY, MN 55614		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	OBE	(X5) COMPLETION DATE
F 323	therapy was noted for R4. A physician's progrindicated R4 had a moving as well. The contributing factors cognitive impairmed R4's admission Fadarted 12/30/16, idrisk for falls. R4's Post-Incident Falls indicated R4 and 4/11/16: On 1/21/16, at 8:30 and tipped backwainjury. The interdis 1/22/16, and the ne"Do not sit" sign or sit on top of the wa On 2/12/16, at 2:30 fall in the dining rohe had been sitting the back of the head orthostatic blotaken when lying, checked for 3 days dizzy or light-head On 2/24/16, at 7:1 floor beside the beon the floor next to had to have a bow injury. It was note from 133/72 while standing. The IDT intervention of offer the shift. Orthosta	requent falls and physical to probably not be beneficial ress note dated 4/6/16, and was not he physician identified at to R4's falls, including ent and TIA's. Il Risk Assessment (FRA) lentified R4 as being at high Investigation Worksheets for had 8 falls between 1/21/16 O p.m. R4 sat on the walker ards to the floor. R4 had no ciplinary team (IDT) met on ew intervention was to put a he the walker to remind R4 not to alker. O p.m. R4 had an unwitnessed om, about 4 steps from where g. R4 had a small abrasion on ad. The IDT met on 2/16/16, nod pressures (blood pressures sitting and then standing) were s. R4 did not complain of being		323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DA COI	(X3) DATE SURVEY COMPLETED		
		245628	B. WING			/20/2016		
NAME OF PROVIDER OR SUPPLIER MN VETERANS HOME SILVER BAY				STREET ADDRESS, CITY, STAT 45 BANKS BOULEVARD SILVER BAY, MN 55614				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION EACTION SHOULD BE TO THE APPROPRIATE HENCY)	(X5) COMPLETION DATE		
F 323	On 3/4/16, at 4:5 walking without a fell. R4 had no in the new intervent walker close to h was no longer in Kardex. On 3/18/16, at 3: bathroom, lost hi and R4 fell. R4 helbow. During a identified he nee times. The IDT in needed to sleepbedtime snack, ambulation. On 3/23/16, at 10 floor next to his movement. R4 his yas to wear and the call light night when put to On 4/5/16, at 7: living room and the walker. R4 at the right with the was held on 4/5/contributing fact the fall. R4's phordered lab worl ambulate with stat a distance as reminders to use On 4/11/16, at 8 his walker and the walker and the sall worl ambulate with stat a distance as reminders to use On 4/11/16, at 8 his walker and the sall w	D p.m. R4 was witnessed walker and lost his balance and jury. The IDT met on 3/7/16, and ion was to keep resident's im at all times. This intervention the care plan or the bedside 15 p.m. R4 was walking out of a salance, the walker tipped over nad a skin tear on the right post-fall meeting, the staff ded to wear a gait belt at all net on 3/21/16 and indicated R4 in in the morning, offered a and required stand-by-assist with 0:10 p.m. R4 was found on the commates bed and had a bowel nad no injury. The IDT met on proved new interventions that staff during a post-fall review These interventions included hipsters to help prevent injury was to be clipped to R4's shirt at		323				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED		
MN VETERANS HOME SILVER BAY (X3) D FREETIX TAG F323 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 wheelchalr 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 shifted and R4 did not have			245628	B, WING			04/2	0/2016	
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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	PRÉFIX	/EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	(X6) COMPLETION DATE	
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	F 323	had no injury. The action was to locat with using the whe the walker properly were checked and have orthostasis. A FRA was comple included a review ovision, continence behaviors, mobility balance. R4 was or high risk for falls On 4/20/16 at 7:54 sleeping. The call R4's headboard w side of the headboard w side of the headboard wide of the headboard wi	IDT met on 4/12/16, and the e R4's shoes and assist him elchair if he is refusing to use and assist him elchair if he is refusing to use and assist him elchair if he is refusing to use and assist him elchair if he is refusing to use and assist him elchair if he is refusing to use and assist him elchair each FRA of risk factors, medications, of bowel and bladder, and bladder, and bladder, and bladder, and bladder, and and determined to be at moderate with each FRA. I a.m. R4 was lying in bed, light cord was draped over ith the call button on the back bard. O a.m. human services C stated R4's safety ded having his bed at transfer walker, and wheelchair as he ted R4 required a gait belt as e he is unsteady at times. I g an observation and interview licensed practical nurse that care guide was reviewed. R4 LPN-A verified the call light was as shirt and R4 did not have but should have had both. It is call light cord to R4's shirt and socks on him. I so p.m. R4 was lying in bed, and the call light was not clipped to lying on the bed next to his right.		323				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMI	SURVEY PLETED
		245628	B. WING			04/2	20/2016
	PROVIDER OR SUPPLIER	R BAY		4	TREET ADDRESS, CITY, STATE, ZIP CODE 5 BANKS BOULEVARD ILVER BAY, MN 55614		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	(DON) stated follow	p.m. the director of nursing ving a fall, a small post-fall	F	323			
F 431 SS⊨E	immediate intervent follow-up meeting to decide if a new intervention of the DON verified so Kardex to impleme DON stated change interventions are condaily report and through the decided by (d), (d), (e) [o discuss the fall and initiate tions. The IDT met for a o assess effectiveness or reventions should be initiated. taff should refer to the bedside nt safety interventions. The es in resident cares or ommunicated to staff through ough the bedside Kardex. DRUG RECORDS, EUGS & BIOLOGICALS	F4	131	SEE ATTACHED POC		05/30/16
	a licensed pharmad of records of receip controlled drugs in accurate reconciliar records are in orde	nploy or obtain the services of cist who establishes a system of and disposition of all sufficient detail to enable an tion; and determines that drug r and that an account of all maintained and periodically					
	labeled in accordar professional princip appropriate access	als used in the facility must be nce with currently accepted bles, and include the ory and cautionary e expiration date when					
	facility must store a locked compartment	State and Federal laws, the all drugs and biologicals in ants under proper temperature it only authorized personnel to keys.					
	The facility must pr	ovide separately locked,					

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				TO(O) DATE	CLIDVEV
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUP		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY GOMPLETED	
		245628	B, WING			04/2	0/2016
NAME OF PROVIDER OR SUPPLIER			_	ı	REET ADDRESS, CITY, STATE, ZIP CODE B BANKS BOULEVARD		
MN VETE	ERANS HOME SILVE	R BAY		s	ILVER BAY, MN 55614		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	1	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 431	controlled drugs lis Comprehensive Di Control Act of 1976 abuse, except whe	d compartments for storage of sted in Schedule II of the rug Abuse Prevention and and other drugs subject to an the facility uses single unit ribution systems in which the minimal and a missing dose can		431			
	by: Based on observative review, the facility	eNT is not met as evidenced ation, interview and document failed to store medications at es in 2 of 4 medication wed.					
	Findings include:				·		
	refrigerator on Ma (Fahrenheit). Trair	2 p.m. the medication ple unit was 34 degrees F ned medication assistant nis reading on the thermometer.					
	refrigerator on Ma Registered nurse thermometer read nurses checked th RN-F also stated temperature shou	20 p.m. the medication ple unit was 34 degrees F. (RN)-F verified the ling. RN-F stated the night ne refrigerator temperature. she did not know the range the ld be in but she usually saw the e refrigerator to be 34 degrees					
	(ADON) stated the temperatures sho	assistant director of nursing e medication refrigerator uld be within 38-44 degrees DON verified the outside					

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY	
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NAME OF PROVIDER OR SUPPLIER MN VETERANS HOME SILVER BAY				STREET ADDRESS, CITY, STATE, ZIP CODE 45 BANKS BOULEVARD SILVER BAY, MN 55614				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE	
F 431	thermometer of the and stated, "The the and stated, "The the all." The ADON state maintenance to fix supposed to adjust temperature was consumed to the additional temperatures since and a state of the ADON also we had read low off at reading of 26 degron 2/17-18/16, and frequently from the April 2016. The AD temps log did not readjustment or for when rechecked as	e refrigerator read 54 degrees nermometer is not accurate at atted she would get it. The ADON stated staff was at the dial when the refrigerator out of range and then re-temp a ON verified the refrigerator e 4/4/16, had been running low /4/16, temperature was not d 32 degrees F through 4/7/16. Frified temperatures on the log and on since 2/16/16, with a rees on 2/16/16, 28 degrees F d 30 degrees and 32 degrees en on and through March and DON stated the refrigerator have a place for the or the refrigerator temperature after the adjustment.	F					
	refrigerator temper degrees F. RN-F thermometer and dial a little and wo her shift. RN-F strefrigerator were and staff. The refrigerator of a box of interferor medication a box of Risperda The inserts in the medications show sticker on the box	n beta-1a IM (intramuscular) Il Consta IM medication boxes indicated the Ild be stored 36-46 degrees. The ces indicated the medications rated but not be frozen.						

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245628	B. WING	i		04/	/20/2016	
NAME OF PROVIDER OR SUPPLIER MN VETERANS HOME SILVER BAY					STREET ADDRESS, CITY, STATE, ZIP CODE 45 BANKS BOULEVARD SILVER BAY, MN 55614		20,20	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL GC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 431	the director of nursing working on a correct the Minneapolis phase refrigerator temperativithin 36-46 degree stated, "I will call the 1:52 p.m. the DON states they said it is border still be good." On 4/20/16, at 1:45 refrigerator on the Bedgrees F. The refrigerator on the Bedgrees F. The refrigerated the refrigerated the temperature above. Licensed professional pro	p.m. the ADON sitting with a gracines (DON) stated they were tion for this. The ADON stated armacy said the medication attures should be maintained as F. At 1:27 p.m. the DON pharmacy." At approximately stated, "I talked to pharmacy, dine, the medication situe Spruce unit was 31 gerator temperature log rator temperature readings and the temperature log ratures recorded had been at of 98 readings since 1/1/16, dings of 36 degrees F or actical nurse (LPN)-D verified perature was below 36 amperature log readings had been the following since 1/1/16, dings of 36 degrees F or actical nurse (LPN)-D verified perature was below 36 amperature log readings had bees F.	F	131				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		<u> </u>
	245628		B. WING			04/20/2016	
NAME OF PROVIDER OR SUPPLIER MN VETERANS HOME SILVER BAY				STREET ADDRESS, CITY, STATE, ZIP CODE 45 BANKS BOULEVARD SILVER BAY, MN 55614	<u>, , , , , , , , , , , , , , , , , , , </u>	1/20/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFI TAG		DBE	(X5) COMPLETION DATE	_
	between 36 and 46 frozen. The package solution indicated it and 46 degrees F. On 4/20/16, at 1:59 medication refrigeration be between 36 and 46 frozen.	d be stored in a refrigerator degrees F, and should not be insert for the Tuberculin should be stored between 35 o.m. the DON verified the for temperature range should 6 degrees. The DON stated tact the pharmacy for	F 4	31	,		
F 465 SS=E E	Medication Storage a prescription, nonpressible to be and accessible to autonly. Whenever there refrigerator the tempeleast twice daily as classible. Biologicals interleukins, and vacce Temperatures: A rangeant renheit." 483.70(h) SAFE/FUNCTIONAL, E ENVIRON The facility must provice anitary, and comfortations and the confortations.	SANITARY/COMFORTABL ide a safe, functional, able environment for	F 46	SEE ATTACHED POC		05/30/16	

STATEMEN AND PLAN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED	
		245628	B. WING		04	/20/2016	
NAME OF PROVIDER OR SUPPLIER MN VETERANS HOME SILVER BAY				STREET ADDRESS, CITY, STATE, ZIP CODE 45 BANKS BOULEVARD SILVER BAY, MN 55614		, — , — —	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
	resident rooms (203 Spruce household d Findings include: On 4/19/16, beginning environmental tour, to (MD) and a maintenate verified the following Room 203: on the water an area approximate chipped and missing the wall creating a room spruce of the second spruc	ent was maintained in 4 of 31 , 211, 225, 226) and the Blue	F 46	55			
i i	with an unpainted, ur approximately 4 feet approximately 4 feet Room 211: the heat repaint scratched off. The sink and the bath broken off approximatereating a rough, uncoreating a rough, uncome 225: had a diminate in the bathroom wuncleanable area. Room 226: had an appropriate approach a sure as with missing an areas measured approaches and 1 inch by the reas with missing and the sure as measured approaches and 1 inch by the sure as measured approaches and 1 inch by the sure as measured approaches and 1 inch by the sure as measured approaches and 1 inch by the sure as measured approaches and 1 inch by the sure as measured approaches and 1 inch by the sure as measured approaches and 1 inch by the sure as measured approaches and 1 inch by the sure as measured approaches and 1 inch by the sure as measured approaches and 1 inch by the sure as measured approaches and 1 inch by the sure as measured approaches and 1 inch by the sure as measured approaches and 1 inch by the sure as measured approaches and 1 inch by the sure as measured approaches and 1 inch by the sure as measured approaches and 1 inch by the sure as measured approaches and 1 inch by the sure as measured approaches and 1 inch by the sure as measured approaches and 1 inch by the sure as measured approaches and 1 inch by the sure as measured approaches and 1 inch by the sure as measured approaches and 1 inch by the sure as measured approaches and 1 inch by the sure as measured approaches and 1 inch by the sure as measured approaches and 1 inch by the sure as measured approaches and 1 inch by the sure as measured approaches and 1 inch by the sure as measured approaches and 1 inch by the sure as measured approaches and 1 inch by the sure as measured approaches and 1 inch by the sure as measured approaches and 1 inch by the sure as measured approaches and 1 inch by the sure as measured approaches and 1 inch by the sure as measured approaches and 1 inch by the sure as measured approaches and 1 inch by the sure as a su	register had several areas of the corner molding between room at the bottom was tely 3 inches by 4 inches					

STATEMEN AND PLAN	FATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		<u> </u>
NAME OF	T. D. D. W. T.	245628	B. WINC	B. WING		04/20/2016		
MN VET	NAME OF PROVIDER OR SUPPLIER MN VETERANS HOME SILVER BAY				TREET ADDRESS, CITY, STATE, ZIP CODE 5 BANKS BOULEVARD SILVER BAY, MN 55614		<u> </u>	
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL			IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	4
	under the window le exposed the sheet re On 4/19/16, at 3:50 pfor resident room wo to repair and paint repainter worked every paint hallways and of there was not a schedone or what needed stated the facility had staff could notify main repair. The system where the stated the maintenance to all are maintenance to all are stated the facility's Mainten 2015, indicated the maintenance to all are maintenance to all are stated the from hazards maintenance to all are stated the system where stated the maintenance to all are stated the system where stated the maintenance to all are stated the system where stated the maintenance to all are stated the system where system where system where system where system where systems where	dge was missing and ock. p.m. the MD stated a painter orked one weekend a month esident rooms and another of third weekend to repair and ther areas. The MS stated edule or log of what had been to be done. The MD further if a computer system in which entenance of areas needing ras checked daily. ance Service policy dated enaintenance department was aining the buildings, grounds afe and operable manner. The building in good repair is. Provide routine scheduled eas. The policy further is room maintenance would in the paintenance would in the state of the stat	FZ	165				

SURVEY CLASS

SURVEY YEAR 2016

Annual Survey

NAME OF FACILITY Silver Bay Veterans Home

STREET ADDRESS 45 Banks Blvd

<u>CITY</u> Silver Bay

STATE MN

ZIP CODE 55614

STANDARDS FOR NURSING HOME CARE	RATING	EXPLANATORY STATEMENTS	FACIILITY CITATION ACTION	PREVENTION	MONITORING PLAN	CORRECTION DATE
dervices 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.		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

SURVEY CLASS

 $\frac{\textbf{SURVEY YEAR}}{2016}$

Annual Survey

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Silver Bay Veterans Home

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STATE MN

ZIP CODE 55614

STANDARDS FOR NURSING HOME CARE	RATING	EXPLANATORY STATEMENTS	FACIILITY CITATION ACTION	PREVENTION	MONITORING PLAN	CORRECTION DATE
		1		NADC N		1
Services by qualified			for residents with continued	MDS Nurses and/or Designee will	Resident R50 and R4's	
			falls. Initiated 4/22/16.	audit care plan's interventions	fall interventions	
persons per care plan.			Staff complete care plan reviews on a	when residents trigger as a fall risk,	compliance will be	
			scheduled rotation. Staff will continue	are having continual falls and/or as	monitored through the	
CONTINUED		•	reviews with an increased focus on	appropriate. Interventions shall	QAPI program.	
			reviewing and updating safety	occur and just in time education	Monitoring will occur	
			interventions. Initiated 4/26/16	shall be provided as appropriate.	monthly until 100%	
			interventions. Initiated 4/20/10	Initiated on 5/18/16	compliance is achieved.	
					When 100%	
					compliance is achieved	
				RCA recommendations for R4 and	reports will be	
	•			R50 were implemented as	submitted quarterly x 3	
			RCA's were completed for residents cited	appropriate by 5/18/16.	months to assure on	
			in the deficiency. R50 completed on		going compliance. QAPI	
			4/22/16 and R4 on 5/2/16.		reporting will begin in	
	1		,, ==, == === == = = = = = = = = = = =		lune 2016	

SURVEY CLASS Annual Survey

SURVEY YEAR 2016

NAME OF FACILITY
Silver Bay Veterans Home

STREET ADDRESS 45 Banks Blvd

CITY Silver Bay

STATE MN

ZIP CODE 55614

STANDARDS FOR NURSING HOME CARE	RATING	EXPLANATORY STATEMENTS	FACILITY 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

SURVEY CLASS

SURVEY YEAR 2016

Annual Survey

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STANDARDS FOR NURSING HOME CARE	RATING	EXPLANATORY STATEMENTS	FACILITY 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

SURVEY CLASS

SURVEY YEAR 2016

Annual Survey

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CITY Silver Bay

STATE MN

ZIP CODE 55614

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.	

SURVEY CLASS

SURVEY YEAR

Annual Survey

2016

NAME OF FACILITY
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STREET ADDRESS 45 Banks Blvd <u>CITY</u> Silver Bay STATE MN

ZIP CODE 55614

STANDARDS FOR NURSING	RATING	EXPLANATORY	FACILITY CITATION ACTION	PREVENTION	MONITORING PLAN	CORRECTION
HOME CARE		STATEMENTS			MONTONING FLAN	DATE
	1	J	L			
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

SURVEY CLASS Annual Survey

SURVEY YEAR 2016

NAME OF FACILITY
Silver Bay Veterans Home

STREET ADDRESS 45 Banks Blvd

CITY Silver Bay STATE MN

ZIP CODE 55614

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 histo	ry	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 tatus	 □ 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
ensory atus	☐ Look for conditions (cataracts, glaucoma, macular degeneration) reducing vision	 ☐ Review status of conditions affecting vision ☐ Reassess visual and auditory impairments
sychologic 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
vironmen 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 NURSING PROCEDURES

PROCEDURE: 02-173____

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

*Bedfast

*Impaired sense of balance

*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.

MINNESOTA VETERANS' HOME – SILVER BAY NURSING PROCEDURES

PROCEDURE:	02-173
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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 Caustal

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.

MINNESOTA VETERANS' HOME – SILVER BAY NURSING PROCEDURES

PROCEDURE: 02-173____

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

ΑТ	ΨΓΛ	α	MCN	rra.
77.1	17	.CHN	MDIN	10:

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	Policy Statement
	Maintenance service shall be provided to all areas of the building, grounds, and equipment.
X	Policy Interpretation and Implementation
Responsibility of Maintenance Service	1. The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times.
Functions	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.

	Refe	rences					
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:	By: Robert Mclaughlin, Plant Director By: Robert Mclaughlin, Plant Director By: By: 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.

	Date: <u>04/1/2015</u>	By: Jill Reineccius	
Policy	Date:	Ву:	
Revised	Date:	Ву:	- 1
	Date:	Ву:	
ATTACHMENTS	:		
OBRA/Regu	latory Reference: §483.20(b)((2)(i) – (iii); §483.20(c); §483.20(f)(1) – (f)(4)	
Survey Tag:			
Other Resou	urces: Minnesota Regulation	,	
Related Doc	cuments:		
Review: 4/1	4		\dashv

PRINTED: 05/06/2016 5628001 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MN VETS HOME 245628 04/26/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 45 BANKS BOULEVARD MN VETERANS HOME SILVER BAY SILVER BAY, MN 55614 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) K 000 | INITIAL COMMENTS **APPROVED** By Tom Linhoff at 8:04 am, May 23, 2016 FIRE SAFETY See attachments for Ktay actation 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. MAY 23 2016 PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY MN DEPT. OF PUBLIC SAFETY **DEFICIENCIES (K TAGS) TO:** STATE FIRE MARSHAL DIVISION

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

HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145

TITLE

(X6) DATE

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.

MINISTER

AND FLAN C	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION NG 01 - MN VETS HOME	(X3) DATE SURVEY COMPLETED			
		245628	B. WING		04/	26/2016		
	PROVIDER OR SUPPLIER ERANS HOME SILVER			STREET ADDRESS, CITY, STATE, ZIP CODE 45 BANKS BOULEVARD SILVER BAY, MN 55614				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO ((EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE		
*	ST. PAUL, MN 5510 By e-mail to both: Marian.Whitney@st and Angela.Kappenman THE PLAN OF COF DEFICIENCY MUST FOLLOWING INFORM 1. A description of we to correct the deficient 2. The actual, or proceed of the correct of the deficient of the correct of the deficient of the defici	ate.mn.us @state.mn.us @state.mn.us RECTION FOR EACH INCLUDE ALL OF THE RMATION: hat has been, or will be, done ency. posed, completion date. title of the person ection and monitoring to ence of the deficiency Home-Silver Bay is a one basement original year of and it was converted into a early 1990's. The original s are all Type II(111) sprinkler protected. The te fire alarm system with the corridors and spaces that is monitored for	K 00	00				

). 0938-039
STATEMEN ND PLAN (F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG 01 - MN VETS HOME	(X3) DA	TE SURVEY MPLETED
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K 062	The requirement a NOT MET.	age 2 t 42 CFR Subpart 483.70(a) is FETY CODE STANDARD	K 06			04/27/16
	continuously maintage condition and are in periodically. 19.7 9.7.5 This STANDARD is Based on docume with staff, the facilita and maintain the autocordance with NF Section 19.7.6, and of Sprinkler System for the Inspection, The Water Based Fire Fedeficient practice desprinkler system is fully operational in the negatively affect 83 undetermined number facility. Findings include: On facility tour betwo 04/26/2016, a review interview with the Morevealed that at the facility could not prothe annual fire sprintage.	c sprinkler systems are ained in reliable operating ispected and tested 7.6, 4.6.12, NFPA 13, NFPA 25, is not met as evidenced by: intatlon review and interview y has failed to properly inspect atomatic sprinkler system in FPA 101 Life Safety Code (00), 4.6.12, NFPA 13 Installation is (99), and NFPA 25 Standard festing and Maintenance of Protection Systems, (98). This is increased the event of a fire and could of 80 residents as well as an interval of staff, and visitors to the event of the inspection the vide any documentation for kler testing and for 2 of 4 for flow test verifying that they are the staff in the property in the p				

STATEMEN	IT OF DEFICIENCIES	AND SERVICES			OWR VC) <u>. 0938-039</u>
AND PLAN	MENT OF DEFICIENCIES LAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LTIPLE CONSTRUCTION DING 01 - MN VETS HOME	(X3) DA	TE SURVEY MPLETED
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(X4) ID PREFIX TAG	I (EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO	N SHOULD RE	(X5) COMPLETION DATE
K 062	The state of the s	tion was verified by a	KO	62	_	
	~					
			*			

SURVEY CLASS Annual Survey

SURVEY YEAR

2016

NAME OF FACILITY
Silver Bay Veterans Home

STREET ADDRESS

CITY

ZIP CODE 55614

STATE MN Silver Bay 45 Banks Blvd

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.

218 729 9774 P.04/06 REPORT OF INSPECTION

APR-27-2016 12:01 A G OBRIG 'A. L. U'BREN • FIKE PRUIECIUM

4907 LIGHTNING DRIVE . HERMANTOWN, MN 55811 PHONE (218) 729-9662

Propert	y Name: MM	VETS	Home		. Date:	7/17/2015			
Addres	40		BLVD			8578			
Madies			The state of the s						_
		VEIL IN	AM, MN		. Inspector:_	HILDER			
A. Explain B. Describ	ECTION (To be an any occupancy has fire protection many fires since is	zard change odifications n	s since the prev rade since last i	lous inspectionNo	ONE		*****		
				, corrosion or foreign m	aterial?P07	KNOWN			
	as the dry piping s			er pitch? NA					
F. Are dry	valves adequately	protected fro	m freezing?	NA		* •			
INSPECTOR	'S SECTION (All re	isponses ref	erence current i	nspection.)					
1. GENERA	IL	•		•			Y	N	NV
									+-
								-	+-
c. Is the	e a minimum of 1	8" (457 m) de	earance between	n top of storage and spi	inkler deflector	7	1	-	╁
d. in area	as protected by a	wet system, c	loes the building	appear to be properly	No. Ast San	Charle	X		1
Da ad	an areas, inclu exterior openinos	sone or to be	orotoded equir	er areas, where accessing?	ine ' LI' ' I tere	O.F. IMAGENTOR	-	_	1×
A Does	he hand hose on	the entinities	proteoted again	o be satisfactory?			-		X
2. CONTRO	L VALVES (See It	em 14)	ayatom appear	o be addalactory					
			and all other v	alves in the appropriate	or closed positi	on?	X		
b. Are all	control valves in t	he open posi	tion, locked sea	led or equipped with a t	amper switch?.		X	Š.	
3. WATER S	UPPLIES (See Ite	m 15)							
a. Was a	water flow test of	the main drai	n made at the s	prinkler riser? 75.5	51ATK	65 Res	X		_
, TANKS, F	'UMPS, FIRE DEP	artment C	onnections:				1 1		l
a. Are fire	pumpa, gravity ta	inks, reservoi	re and pressure	tanks in good condition	and properly n	naintained?			X
D. Are nre	department conn	ections in sat	isfactory conditi	on, coupling free, cape i	n place and che	ok valves tight?	X	3	
E WET QVQ	TEMS (See Item 1:	VISIDIO 7					A-	-	
			In the engrand	ate open or closed posi			1	1	X
b. Have a	ntfreeze system s	clutions been) tested?	ere oben or crosed both	uqii?	***********	-		X
c. Were th	e antifreeze test r	esults satisfa	ctory?						V
8. DRY 8YS1	'EMS (See Itams 1	0 to 14)				DATE SHOWN OF THEM			-
a. Is the d	ry valve in service	?					X		
b. Are the	air pressure and v	vater level in	accordance with	the manufacturer's les	tructions?	UNITED A SAMPLE OF THE	XXX		
c. Has the	operation of the a	ir or nitrogen	supply been te	sted?	2 - 1/2/12/12/12/12/12/12/12/12/12/12/12/12/		X		
e ninei	Brvicey, , , , , , , , ,	((0.4000)00000000		ALL KNOWN			X	_1	
e Did quia	v points orgined c	uring this ins	pection?	יא האם האין ייץ או			4	-+	K
f. Did the	irv valve trip prop	operate sau: Adv during th	e trin preseure t	est?			V	\dashv	-
g. Did the i	reating equipment	in the dry bir	se valva room o	perate at the time of the	inconstine?			-+	X
7. SPECIAL S	YSTEMS — as def	ined in Section	on 1-3 (See Item	16)		1		十	7
a. Did the o	leluge or pre-actio	n valves ope	rate property du	ring testing?	Wa			_1	X
ין פוע פוע ביע ים	iaar LesbousiAe de	vices operati	B Droderiv during	a testina?					经
c. Did the s	upervisory device	s operate dui	ing testing?						Z
, ALAKMO									. 1
a. Did moto	r and gang test sa	itisfactorily?.		************		L			X
c. Did supe	nc alarm test saus	ractorily?	and a state of the second				<u> </u>	-	-
SPRINKLER	S and a contraction	reat safist	acroniy?	*************			4		\dashv
		corrosion, los	idina or obstance	tion to spray discharge?	•	I	ابر		
o. Are sprini	dels over on Assu	B old, thus re	quiring samble t	estina? <i>NOTO</i> Y	ER 60 4	FARS			K
c. is stock o	r spare spankiers	available?			A.T.		7	1	
g. Does me	exterior condition	or the sprinkl	er system appe	Br to be satisfactory?			8		
e. Are sprint	ders of proper ten	voerature ratio	ga for their loca	tions?	rowner would be to the		XI		

14. Review Contro			•	VALVE				C.O.D.	(A)		
		MAKE		MODEL	SERIAL NO.	-, 4	MAKE		MODEL	SER	AL N
	CENTR	AL		AG	<u> </u>		<u> </u>		X		X
DRY PIPE		TO TRIP	TION	WATER PRESSURE			IP POINT PRESSURE	REAC TEST C	WATER CHED OUTLET	OPER PROP	ERL
OPERATING TEST	WITHOUT Q.O.D.	MIN.	SEC.	75	99 39		7 -	MIN.	SEC.	YES	N
	WITH Q.O.D.										
	IF NO, EXPL	AIN	19			- 14-21					
	OPERATION			PNEUMATIC	() ELECT	RIC E	J HYDRAULI	C			
	PIPING SUP	ERVISE) _ (JYES \	OND	DETEC	TING MEDIA	SUPERV	ISED	CWES	0
	DOES WALVE	E OPERA	TE FROM	THE MANUAL	RIP AND/OR RE	MOYE CONT	ROL STATIO	NE	/	O YES	'n
DELUGE &	IS THERE AN	ACCESS!	LE FACILIT	Y IN EACH CIRCL	IT POR TESTINO	IF NO, EXPLAI	N		1	2	
PREACTION		X€s		0 .							
	1 /	4 \	\ '	SUPERVISION	CUIT OF BRATE	OPERATE V	ACH CIRCUIY	2E /		M TIME T	
	MAKE	M	ODEL	YES	NO	YES	NO		MIN.	-	C.
						V				1	
NTROL VALVES Y CONNECTION CON	TROL VALVES	NO.			MAINTENANC PEN \$	E TABLE	CLOSED	sic	SNS	EXP ABNO COND	RMA
K CONTROL VALVES	****								X		_
P CONTROL VALVES										~	
TIONAL CONTROL V		T_{-}	3"	BEV	403	Yes			Yes		
TEM CONTROL VALV		2,	4"	BEV	YES	yes	٠٠.		yes		
ER CONTROL VALVE	3		212	BFV	yes	res	~		'4es		_
NATER FLOW T			RISER					3			
ER SUPPLY SOURCE	6	D	TAN	IK '	PUMP	LASTW	ATER FLOW	EST 7	5-6	5	
TEST P		SIZE TEST PIF	PE 21	STATIC PSI 75	RESIDUAL (FLOW) PRESSURE	65-THIS W	ATER FLOW T	EBT	5-6	5	
7/2015 LOCATI	OR CORRECT	TIONS	MADE DU	JRING THIS	NSPECTION:	4/0			· · · · · · · · · · · · · · · · · · ·		_
72017				- V		100	NE				-
1/2019											
72017										SIDADI (
ADJUSTMENTS (E COMMENT	TS ARE	NOT THE	E RESULT O	F AN ENGINE	ERING REV	NEW, THE	POLLOV	VING DE	SILMOLI	_
DJUSTMENTS (E COMMENT	TS ARE	NOT THE	E RESULT O	F AN ENGINE	ERING REV	/IEW, THE I	FOLLOV	VING DE	SILVADLI	
ADJUSTMENTS	E COMMENT	TS ARE	NOT THE	E RESULT O	- H- U - U - U - U - U - U - U - U - U -	ERING REV	/IEW, THE I	FOLLOV	VING DE	SILVADLI	

Quarterly Report of 4907 Lightning Drive Hermantown, MN 55811 Inspections & Tests (218) 720-0662 phone (218) 729-9774 fax Property Name: MA Address: Date: 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, Fire Department Connections Residual: 60 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 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: LARMS+TAMPERS OK

A.G. O'Brien Fire Protection

A.G. O'Brien Fire Protection

4907 Lightning Drive Hermantown, MN 55811 (218) 729-9662 phone (218) 729-9774 fex

Quarterly Report of Inspections & Tests

(210)125-911-10A			
Address: US AUCS BY MV Inspector: ALTICOSA)			
Main Drain Test			Ī
Record the static pressure on the control riser guage and residual pressure	Y	N.	ļ
once the Two Inch main drain valve is fully opened. Static: Residual:			l
Fire Department Connections	-		l
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			١
Test water-flow alarms by opening the inspector's test valve.			l
(Notify alarm company to avoid false alarms)	4	- 1	ł
Dry Pipe Valve Priming Level			l
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.			l
Dry Pipe System Low-Air-Pressure Alarm	*		ł
Close the water supply valve and slowly open the test valve to reduce air pressure.	1 1		ı
(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		13	
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		8	
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:	<u>(5)</u>		
ALLALAPMS ATAMORAS ON			
			
		12	
		(6)	

A.G. O'Brien Fire Protection **Quarterly Report of** 4907 Lightning Drive Hermantown, MN 55811 Inspections & Tests (218) 729-9662 phone (218) 729-9774 fex Property Name: MW VETS HOME Address: 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: 25 Residual: 6 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 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:

ALARMST TAMPERS OX

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A.G. O'Brien Fire Protection **Quarterly Report of Inspections & Tests** 4907 Lightning Drive Hermantown, MN 55811 (218) 729-9662 phone (218) 729-9774 fex Property Name: MA Date: 4 Address: 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 **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 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:

SET OFF HORN STROP

ALADMS-ITAMPERS.OK

A.G. O'Brien Fire Protection	Quarterly Report of	
4907 Lightning Drive Hermantown, MN 55911 (218) 729-9002 phone (218) 729-9774 fex	Inspections & Tests	
Address: MVETS HOME STLUER RAY	Inspector: AHTWEN	
Mala Bala Tark	· · · · ·	lai
Main Drain Test Record the static pressure on the control riser once the Two Inch main drain valve is fully ope	guage and residual pressure	N. N
Fire Department Connections		
Verify that the connection is visible, not damage sign is in piece, and ball drip is working satisfa	ed, caps are in place, identification	
Wet Pipe System Flow Alarm Test water-flow alarms by opening the inspect	or's test valve.	
(Notify alarm company to avoid false alarms)	·	
Dry Pipe Valve Priming Level Check dry priming water level by opening the teamount of water discharge. If no water flows on	est valve and checking for a small ut of the test line, add priming water.	
Dry Pipe System Low-Air-Pressure Alarm Close the water supply valve and slowly open to (Do not reduce air pressure enough to trip the of the low air pressure alarm, record air pressure close the test valve, allow air pressure to rise to supply control valve.	dry pipe valve) Confirm operation	
10 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	p.s.l. <u>A A</u>	<u></u>
Ory Pipe System Flow Alarm Open the alarm bypass valve. (Notify alarm co	mpany to avoid false alarms)	
Quick Opening Device Test in accordance with manufacturers instruction	lons.	1
Presction System Flow Alarm Open the slarm bypass valve. (Notify alarm cor	mpany to avoid false alarms)	1/
Deluge System Flow Alarm Open the alarm bypass valve. (Notify alarm cor	mpany to avoid false alarms)	V
Notes:		· volume
ALARMS ATA	MAGES OK	

A.G. O'Brien Fire Protection Quarterly Report of 4907 Lightning Drive Hermantown, MN 55811 Inspections & Tests (218) 729-9662 phone (218) 729-9774 fax Property Name: Address: 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 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: GLARMS+ TAMOERS OF

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:	MAINETS HOME	Date: 11-7-16			
	45 BANKS BLUD		*:	797	
	STLVER BAY MIT	Inspector: AHILDEN			
	20 B 2000	iii ear			
Main Drain Test		•	Y	N.	IN/
Record t	he static pressure on the control rise	r guage and residual pressure	-	- 1	/A
once the	Two Inch main drain valve is fully of	pened.	$\perp \!\!\! \perp \!\!\! \! \! \! \! \! \! \! \! \! \! \! \! \! \!$		
Fire Department	he static pressure on the control rise Two linch main drain valve is fully of Stati Connections	lo: Residual:	V		
	at the connection is visible, not damag		1 ,	/	
sign is in	place, and ball drip is working satisf	actority.	W		
			-		-
Wet Pipe System	Flow Alarm	27. GMA . P. 12	1 .		
(Notify a	er-flow alarms by opening the inspect farm company to avoid false alarms)	tors test valve.	-11		
(Nouly a	ann company to avoid idiza statilis) 		35.5	
Dry Pipe Valve Pr	riming Level				
Check dr	y priming water level by opening the	test valve and checking for a small			
amount o	f water discharge. If no water flows o	out of the test line, add priming water.			
Dry Pine System	Low-Air-Pressure Alarm	e 9	1		
Close the	water supply valve and slowly open	the test valve to reduce air pressure.	1 1	0 7	
(Do not re	educe air pressure enough to trip the	dry pipe valve) Confirm operation	1 1		
of the low	air pressure alarm, record air pressu	ure at which the alarm activated	1 1		
close the	test valve, allow air pressure to rise t	to normal, then open the water	1 1		
supply cor	iuoi vaivę.	11/A			\vee
Dry Pipe System F	low Alarm	p.s.i. N/A		1	
Open the	alamı bypass valve. (Notify alamı co	ompany to avoid false alarms \	\perp / \mid	- 1	
			V		
Quick Opening De	vice cordance with manufacturers instruct	w	1 1		7
· · · ·	ordance with manufacturers instruct	lions,			V
Preaction System I	flow Alarm				
Open the a	ilarm bypass valve. (Notify alarm co	ompany to avoid false alarms)	1 .1	- 1	ī/I
	- 38				"
Deluge System Flo	w Alarm Ilarm bypass valve. ('Notify alarm co		1 1	- di	7 1
Open the a	raini bypass valve. (Notily alaitti Co	impany to avoid false alams)			
Notes:		•	35		
	111000 1-11	Commission to the			
	MINTICHIS ATAM	ARS OK			
		7%			
		***************************************	-		



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 <u>only a suggestion</u> 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

MN Veterans Home Silver Bay May 6, 2016 Page 2

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, Program Specialist

Licensing and Certification Program

Kumalu Fiske Downing

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

PRINTED: 05/06/2016 FORM APPROVED

	<u>ota Department of He</u>	alth			·			
	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		00381	B. WING		04/20/2016			
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 45 BANKS BOULEVARD SILVER BAY, MN 55614								
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICY)	D BE COMPLETE			
2 000	Initial Comments		2 000					
	****ATTENTION*****							
	In accordance with 144A.10, this correct pursuant to a survey found that the defici herein are not corrected shall be with a schedule of fithe Minnesota Department of the Minnesota Departments of the number and MN Rul When a rule contain comply with any of the lack of compliance.	Minnesota Statute, section tion order has been issued to If, upon reinspection, it is ency or deficiencies cited cited, a fine for each violation he assessed in accordance nes promulgated by rule of riment of Health. ether a violation has been compliance with all rule provided at the tag e number indicated below. It is several items, failure to the items will be considered below to the items will be considered below.		See attachment for all state and Plansof correction	nts totan			
	result in the assessn that was violated dur corrected. You may request a h that may result from orders provided that the Department withinotice of assessmen INITIAL COMMENTS On 4/18/2016, throug this Department's stand the following cor When corrections are date, make a copy of original to the Minnes	y item of multi-part rule will nent of a fine even if the item ing the initial inspection was earing on any assessments non-compliance with these a written request is made to n 15 days of receipt of a t for non-compliance. S: gh 4/20/2016, surveyors of lift, visited the above provider rection orders are issued. The completed, please sign and these orders and return the sota Department of Health, ce Monitoring, Licensing and		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal softwa Tag numbers have been assigned to Minnesota state statutes/rules for Nurs Homes.				

Minnesota Department of Health
LABORATURY DIRECTOR'S OR RROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

6899

H7F11

continuation sheet 1 of 29

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00381	B. WING		04/00/0016
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE	04/20/2016
	ERANS HOME SILVER	AS BANKS	S BOULEVAI AY, MN 556	RD	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETE
2 000	Initial Comments		2 000		
	****ATTE	NTION*****			
	NH LICENSING	CORRECTION ORDER			
	144A.10, this correspursuant to a surve found that the deficion herein are not correspond to corrected shall with a schedule of the Minnesota Department of which is a schedule of the Minnesota Department of which is a schedule of the Minnesota Department of which is a schedule of the Minnesota Department of which is a schedule of the Minnesota Department of the Mi	nether a violation has been compliance with all			
	number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	rule provided at the tag ale number indicated below. In several items, failure to the items will be considered Lack of compliance upon my item of multi-part rule will ment of a fine even if the item uring the initial inspection was			
	that may result from orders provided tha the Department wit	hearing on any assessments non-compliance with these tawritten request is made to hin 15 days of receipt of a ent for non-compliance.			
	this Department's s and the following co When corrections a date, make a copy original to the Minn	TS: ugh 4/20/2016, surveyors of taff, visited the above provider prrection orders are issued. ure completed, please sign and of these orders and return the esota Department of Health, nce Monitoring, Licensing and		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal soft Tag numbers have been assigned to Minnesota state statutes/rules for No Homes.	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING.			
		00381	B. WING		04/20/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MN VET	ERANS HOME SILVE	⊰ HΔY	S BOULEVAI AY, MN 556			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLE	
2 000	Certification Progra Suite 290, Duluth, N	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		" ce is e "To		
2 565	Plan of Care; Use Subp. 3. Use. A comust be used by al care of the resident This MN Requirements: Based on observation review, the facility for the subplements of the residents.	ent is not met as evidenced ion, interview and document ailed to follow the care plan entions for 2 of 3 residents	2 565	Comply" portion of the correction ord This column also includes the finding which are in violation of the state stat after the statement, "This Rule is not as evidence by." Following the surver findings are the Suggested Method of Correction and Time period for Correction and Ti	sute met vors ction. G OF	
	diagnoses that incluanemia, type I diab osteoarthritis, a his repeated falls. R50 Set (MDS) dated 3/cognitively impaired behaviors. The MD required assistance extensive assistance chair and wheelchar R50 required extentoileting and ambula history of orthostapressure when risin sitting or standing.)	cord, dated 3/3/16, identified uded Alzheimer's disease, etes mellitus, dementia, tory of hip fracture and s admission Minimum Data (10/16, indicated R50 was d and exhibited wandering S further indicated that R50 e with moving about in bed and ce with transfers from bed, air. The MDS further indicated sive assistance with dressing, ation. The MDS also indicated atic hypotension (drop in blooding from a lying position to The MDS further indicated by and was only able to				

6899

	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00381	B. WING	·····	04/	20/2016
NAME O	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
MN VE	TERANS HOME SILVER	RBAY	S BOULEVAR BAY, MN 5561			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EACH) (EA	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
2 56	stabilize with staff a a seated to standing around and facing ton and off the toilet transfer from bed a R50's care area as dated 3/16/16, indic prior to admission, betady with transfer further indicated R5 after admission. The safety interventions safety skid socks we clothing in bed and bed. R50's care plan dawas to have the call when in bed, to ensure (non-slip, cushioned bed, to provide asswalker or use a wheor unsteady, and R5 garment with impact to prevent hip fracture. R50's Fall Risk assindicated multiple fadequate vision, or daily agitated behaves of assistive devorbalance while staff worksheets for Fall had six falls in the form of 4/20/16, at 7:36	essistance when moving from g position, walking, turning he opposite direction, moving and surface-to-surface and chair or wheelchair. Essessment (CAA) for falls ested R50 had a history of falls balance problems and was not so r walking. The CAA for falls to had three falls the first week e CAA for falls also indicated including hipsters at all times, then in bed, clip call light to black anti-skid mat at side of light clipped to his clothing ture a black anti-mat amat) is at the right side of his sistance with ambulation with eelchair if R50 appeared weak to is to wear hipsters (a tabsorbing pads over the hipsters that can occur with a fall). Essment dated 4/15/16, alls within the last six months, casional bladder incontinence, viors, no orthostatic BP drop, vices with walking and a loss				

Minnesota Department of Health

STATE FORM 6899 DHZE11 If continuation sheet 3 of 29

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
		00381	B. WING		04/2	0/2016
NAME OF I	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	1 04/2	0/2010
		45 BANKS	BOULEVAI	•		
MN VEII	ERANS HOME SILVER	SILVER B.	AY, MN 556	14		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	with no walker and was observed not a black mat was obse and R50 was not w was unsteady in the handle. Surveyor rourse (LPN)-A to as observed to have a the bathroom floor puddle of urine. LPI changed R50's pan a.m., LPN-A placed of R50's bed and as hipster garment. On 4/20/16, at 7:51 and stated she kne LPN-A confirmed the R50's bedside when R50 was not wearicall light was not clistated changes in the highlighted and place board. On 4/20/16, the at 9 nursing (ADON) was not wearicall light was not clistated changes in the highlighted and place board. On 4/20/16, the at 9 nursing (ADON) was not wearicall light was not clistated changes in the highlighted and place board. On 4/20/16, the at 9 nursing (ADON) was not wearicall light was not clistated changes in the highlighted and place board. On 4/20/16, the at 9 nursing (ADON) was not wearicall light was not clistated changes in the highlighted and place board. On 4/20/16, the at 9 nursing (ADON) was not wearicall light was not clistated changes in the highlighted and place of ambulation and standard recently had service wed R50's carbon was reviewed R50's carbon wa	ge 3 no staff present. The call light attached to R50's clothing, no erved at the side of his bed, earing a hipster garment. R50 to bathroom, holding on to toilet equested licensed practical sist R50. R50's pants were large wet spot in front, and was observed to have a large N-A assisted R50 to bed and to clean clothing. At 7:56 to a black mat by the right side esisted R50 in donning a a.m. LPN-A was interviewed we R50 had at least two falls. The black anti-mat was not at the R50 was up in the bathroom, and a hipster garment and the pped to R50's clothing. LPN-A the residents' care plan were deed on the communication a:33 a.m. assistant director of the interviewed and stated R50 everal falls. The ADON to staff and a walker for the communication board, the etings and highlighted in the resident's closet the staff and the resident's closet the staff and the resident's closet the resident's closet the staff and the resident's closet the resident resident resident resident	2 565			

6899

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00381	B. WING		04/	20/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
MN VET	ERANS HOME SILVER	R BAY	S BOULEVAR			
(VA) ID	SLIMMADV STA	TEMENT OF DEFICIENCIES	SAY, MN 556	PROVIDER'S PLAN OF COI	DDECTION .	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 4	2 565			
	(DON) was intervier plan included direct next to R50's bed, or clothing when he is wears a hipster at a changes in care pla communication boar meetings and highlic placed in the reside. The facility's Reside Policy dated 11/5/18 develop a plan of control individualized focus a resident centered directed the reside implemented on the also directed the reside in the reside implemented on the also directed the reside in the reside implemented on the also directed the reside in the reside implemented on the also directed the reside in the reside	9 p.m. the director of nursing wed and confirmed R50's care tives to place a black anti-mat clip the call light to R50's in bed, and to ensure R50 all times. The DON confirmed ans are placed on the ard, discussed in daily ighted in care plan copies ent's closet space. The plan care plan copies ent's closet space. The policy further not plan of care will be aday of admission. The policy sident's care plan was ed by the resident's change of				
	diagnoses included behavioral disturba anemia secondary delirium, Alzheimer (increased pressure	ed 4/20/16, indicated R4's vascular dementia with nce, chronic iron deficiency to blood loss, hypothyroidism, 's disease, glaucoma e in the eyes, affecting vision), ischemic attack (TIA), heart mia's.				
	assessment for a s 4/11/16, indicated F short and long term moderately impaire decision-making, a MDS further indicat	a Set (MDS) comprehensive ignificant change dated R4 had highly impaired vision, memory impairment, d cognitive skills for daily and symptoms of delirium. The red R4's behaviors had aded physical and verbal				

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00381	B. WING		04/	20/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		45 BANK	S BOULEVAR	RD		
MN VET	ERANS HOME SILVER	R BAY SILVER B	AY, MN 556	14		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 565	behaviors, and rejet assessment period. indicated R4 require staff for transfers, be extensive assistance and required the assimpaired balance. walker and a wheelinjury and one fall wajor since the pretain the Care Area Assimplicated R4 was a falls without major in period. Safety intervidentified in the CAR	ction of care 1 to 3 days of the In addition, the MDS ed extensive assistance of 2 led mobility, and toilet use, see of one staff for ambulation, sist of staff to stabilize due to The MDS indicated R4 used a chair, and had 2 falls with no with an injury that was not vious MDS assessment. Lessment (CAA) dated 4/11/16, thrisk for falls and had several injury during the past review wentions in place were A, including clipping the calling in bed and gripper socks	2 565			
	at risk for falls, had unaware of safety ristaff to provide: stand-by assist with needed gait belt at all times anti-rollback brakes transportation wear gripper socks keep bed at transferemind to use front-wear hipsters as Raclip call light to shirt from bed set up an activity if anticipate and meet Approach slowly froproblems provide a bedtime standard safety of the safety of	or shoes at all times rable height wheeled walker dallows to alert staff if he is getting up wandering t needs om the front due to visual				

Minnesota Department of Health

STATE FORM 6899 DHZE11 If continuation sheet 6 of 29

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			
		00381	B. WING		04/2	0/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MN VETI	ERANS HOME SILVE	R RAV	S BOULEVAI AY, MN 556			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 6	2 565			
	distance as tolerate	ed				
	closet, identified all for safety, including goes to bed incase	ex Report, located in R4's of the care plan interventions clip call light to shirt when R4 R4 forgets to push the call stance and gripper socks on				
	Falls indicated R4 hand 4/11/16. Each interventions were be appropriate. On 4/20/16, at 7:54 sleeping. The call	Investigation Worksheets for nad 8 falls between 1/21/16 fall was reviewed and new initiated as were determined to a.m. R4 was lying in bed, light cord was draped over h the call button on the back ard.				
	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.					
	at 10:20 a.m. licens read the closet care LPN-A verified the c R4's shirt and R4 d but should have. L	an observation and interview sed practical nurse (LPN)-A e guide. R4 was lying in bed. call light was not clipped to id not have gripper socks on, PN-A clipped the call light cord it some gripper socks on him.				
	but was dressed. This shirt, but was ly	0 p.m. R4 was lying in bed, The call light was not clipped to ing on the bed next to his right erified it was not clipped to clipped earlier.				

6899

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURV COMPLETE	
		00381	B. WING		04/2	0/2016
	PROVIDER OR SUPPLIER	R BAY 45 BANKS	DRESS, CITY, S BOULEVAI AY, MN 556			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	On 4/20/16, at 2:09 (DON) stated staff stardex to implement DON stated change interventions are condaily report and through the Director of Nurdevelop, review, an procedures to ensurall residents. The Director of Nurdeducate all appropriocedures. The Director of Nurdevelop monitoring compliance. TIME PERIOD FOR (21) days.	p.m. the director of nursing should refer to the bedside nt safety interventions. The es in resident cares or immunicated to staff through ough the bedside Kardex. THOD OF CORRECTION: sing or designee could d/or revise policies and re care plans are followed for sing or designee could iate staff on the policies and systems to ensure ongoing	2 565			
2 830	Proper Nursing Car Subpart 1. Care in receive nursing car- custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ng home resident must be out possible unless there is a he attending physician that the in in bed or the resident	2 830			

6899

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	` ´COMPI	
		00381	B. WING		04/2	20/2016
	PROVIDER OR SUPPLIER	R BAY 45 BANK	DDRESS, CITY, ST S BOULEVAR BAY, MN 5561	D		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 830	This MN Requirements: Based on observation review, the facility fainterventions to mind 3 residents (R50, R) Findings include: R50's Admission rediagnoses that includanemia, type I diabousteoarthritis, and a repeated falls. R50' Set (MDS) dated 3/ cognitively impaired behaviors. The MD required assistance extensive assistance extensive assistance extensive assistance extensive assistance in the company of orthosts pressure when rising sitting or standing.) R50 was not stead stabilize with staff a a seated to standing around and facing the contents of the company of the	ent is not met as evidenced on, interview and document ailed to implement appropriate imize the risk for falls for 2 of .4). cord, dated 3/3/16, identified uded Alzheimer's disease, etes mellitus, dementia, a history of hip fracture with a sadmission Minimum Data 10/16, indicated R50 was a and exhibited wandering S further indicated that R50 with moving about in bed and the with transfers from bed, ir. The MDS further indicated sive assistance with dressing, ation. The MDS also indicated atic hypotension (drop in blooding from a lying position to The MDS further indicated y and was only able to issistance when moving from g position, walking, turning he opposite direction, moving		DEFICIENCY)		
	R50's care area ass loss/dementia dated confusion, disorient decreased ability to understand others. hearing and/or visu	and surface-to-surface nd chair or wheelchair. sessment (CAA) for cognitive d 3/15/16, indicated R50 had ration, forgetfulness and make self understood or to The CAA further indicated al loss may have an impact or tess information. The CAA for				

6899

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00381	B. WING		04/2	0/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI		STATE, ZIP CODE		
MN VET	ERANS HOME SILVER	R BAY	BOULEVAL			
(VA) ID	SHIMMA DV STA	TEMENT OF DEFICIENCIES	AY, MN 556	PROVIDER'S PLAN OF CORRECTION	ON	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 9	2 830			
	falls prior to admiss was not steady with CAA for falls further the first week after also identified safet hipsters at all times	indicated R50 had a history of sion, balance problems and a transfers or walking. The rindicated R50 had three falls admission. The CAA for falls by interventions including safety skid socks when in a clothing in bed and black e of bed.				
	was to have the cal when in bed, to ens (non-slip,cushioned bed, to provide ass walker or use a who or unsteady, and Rigarment with impact	tted 4/15/16, directed staff R50 I light clipped to his clothing sure a black anti-mat I mat) is at the right side of his sistance with ambulation with eelchair if R50 appeared weak 50 was to wear a hipster (a ct absorbing pads over the hipsures that can occur with a fall).				
	indicated multiple fa adequate vision, or daily agitated behav	essment dated 4/15/16, alls within the last six months, casional bladder incontinence, viors, no orthostatic BP drop, vices with walking and a loss anding.				
		by Post Incident Investigation Is since 3/3/16, indicated the				
	to exit the facility lo door, hit his nose ar bridge of his nose. interventions in place wear, automatic loc escort for outside a socks when in bed.	c.m. R50 fell when attempting cked unit door, slid down the do sustained a cut to the Current care plan ce were proper fitting foot king bakes on wheelchair, ppointments and non-skid New care intervention: om entranced/exit doors if				

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-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00381	B. WING		04/2	20/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MN VETI	ERANS HOME SILVER	R BAY	BOULEVAR			
		SILVER B	AY, MN 556			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 10	2 830			
	on 3/4/16, and direct Check orthostatic bedays, one person a as oriented to his sineeds, hipsters at a	terdisciplinary team (IDT) met cted the following actions: lood blood pressure (BP) x 7 ssist with ambulation until he urroundings, anticipate his all times, redirect resident and tivities if noted to be exit				
	bathroom floor with investigation works. Current care plan ir assist with ambulat surroundings, hipst wear, magnetic lock that will alert staff if secure unit), autom wheelchair, escort finon-skid socks whe standing BP measuintervention: Clip cawas in bed to alert for help. The IDT mesident is currently order for orthostatic calorie count and e readings. The IDT finas to be seen 3/8/	all light to pajamas when R50 staff if resident forgets to call et on 3/7/16, and directed the being monitored per MD BP changes, elevated BP, levated glucose (blood sugar) urther directed the resident 16 on MD rounds.				
	floor of his room will door with a blanket slipped on a rug wh bathroom, pointing documented no inju worksheet indicated systolic blood press position (orthostation	th his head by the bathroom under his head. R50 said he ille trying to go to the to the blanket The worksheet ary. The falls investigation d R50 had a 43 point drop in sure from a lying to standing a BP). The falls investigation cated R50 had a blood				

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			(3) DATE SURVEY COMPLETED			
		00381	B. WING		04/2	20/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MN VETI	ERANS HOME SILVER	R BAY	S BOULEVAI AY, MN 556			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	glucose reading of 70-99). Current care were one person as oriented to surround anticipate R50's nemagnetic lock to rig brakes on wheelcha appointments, nonlying/sitting/ standin met on 3/7/16, and calorie count with b meals and at bedtin and orthostatic BP. to be seen on MD recommoders on MD recomm	48 (normal blood glucose is e plan interventions in place sist with ambulation until R50 dings, hipsters at all times, eds, proper foot wear, ht wrist, automatic locking air, escort for outside skid socks when in bed, and g BP measurements. The IDT directed R50 was on a strict lood glucose checks before ne, monitoring elevated BP The IDT further directed R50 ounds on 3/8/16. 5 p.m. R50 fell on mat near was trying to get something to imeter reddened area was ip. The falls investigation d orthostatic BP was not ed documentation of blood are ton 4/13/16, and directed cans x three days, a bedside and to try to move his bed to allow staff monitoring when a note in the falls investigation d all bladder scans were within	2 830			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION .		(X3) DATE SURVEY COMPLETED	
			A. BUILDING	:		
		00381	B. WING		04/2	20/2016
NAME OF	PROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY,	STATE, ZIP CODE		
MN VET	MN VETERANS HOME SILVER BAY 45 BANK SILVER					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 830	behaviors or was n was notified, and la On 4/15/16, at 3:4 bathroom leaning a and wall. The falls indicated no orthos lacked documentat investigation works interventions in play was called with a fin C-reactive protein (infection) and order the emergency roor indicated R50 was and bladder spasm and oxybutynin ord On 4/20/16, at 7:36 get up from his bedwith no walker and was observed not a black mat was observed to have a the bathroom floor puddle of urine. LPN-A assisted R5 pants to clean cloth placed a black mat and assisted R50 in On 4/20/16, at 7:51 and stated she kne LPN-A confirmed th R50's bedside whe	ot redirectable. The physici	e k alls an ces			

6899

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00381	B. WING	B. WING		20/2016
_	PROVIDER OR SUPPLIER ERANS HOME SILVER	R BAY 45 BANK	DDRESS, CITY, S S BOULEVAI BAY, MN 556			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 830	call light was not clistated changes in the highlighted and place board. On 4/20/16, at 9:33 nursing (ADON) was had several falls read assistance of staff and staff was to an ADON further confilight clipped to his coblack anti-mat was observation as diread ADON stated change on the communicat meetings and highliplaced in the reside On 4/20/16, at 12:4 (DON) was intervied plan included direct next to R50's bed, colothing when he is wore hipsters at all changes in care placed communication boas meetings and highliplaced in the reside The facility's Fall Predirected floor mats bedside for those rehigh risk for a fall fredirected additional a including protective R4's face sheet dat	pped to R50's clothing. LPN-A he residents' care plan are ced on the communication a.m. the assistant director of as interviewed and stated R50 cently. The ADON reviewed distated R50 was to have and a walker for ambulation ticipate R50's needs. The rmed R50 was to have the call clothing when in bed and the not at R50's bedside at time of cted by his care plan. The ges in care plans were placed ion board, discussed in daily ighted in care plan copies ent's closet space. 9 p.m. the director of nursing wed and confirmed R50's care tives to place a black anti-maticip the call light to R50's in bed, and to ensure R50 times. The DON confirmed and were placed on the ard, discussed in daily ighted in care plan copies				

Minnesota Department of Health

STATE FORM DHZE11 If continuation sheet 14 of 29

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00381	B. WING		— 04/20/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
MN VETI	ERANS HOME SILVEI	R RAV	S BOULEVAI BAY, MN 556			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	anemia secondary delirium, Alzheimer (increased pressurchistory of transient blocks and arrhythromatics and arrhythromatics and arrhythromatics and arrhythromatics and arrhythromatics and long term moderately impaired decision-making, a MDS further indicated worsened and inclubehaviors, and rejeassessment period assistance of 2 states and toilet use, exterior ambulation, and stabilize due to impindicated R4 used a had 2 falls with notinjury that was not assessment. The Care Area Assindicated R4 was a falls without major in period. The CAA idmedications that we safety interventions including clipping thin bed and gripper all times. R4's care plan revisat risk for falls, had	ince, chronic iron deficiency to blood loss, hypothyroidism, i's disease, glaucoma e in the eyes, affecting vision), ischemic attack (TIA), heart mia. a Set (MDS) comprehensive significant change dated R4 had highly impaired vision, in memory impairment, and cognitive skills for daily and symptoms of delirium. The ted R4's behaviors had added physical and verbal action of care 1 to 3 days of the later of the required extensive for transfers, bed mobility, insive assistance of one staff of required the assist of staff to baired balance. The MDS a walker and a wheelchair, and injury and one fall with an imajor since the previous MDS dessment (CAA) dated 4/11/16, it risk for falls and had several injury during the past review dentified diagnoses and ere potential fall risk factors. In place were identified the call light to R4's shirt when socks or shoes to be worn at seed 4/12/16, indicated R4 was a history of falls and was				
	unaware of safety r staff to provide:	needs. The care plan directed				

6899

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		B. WING				
	00381	B. WING		04/2	20/2016	
NAME OF PROVIDER OR SUPPLIER			STATE, ZIP CODE			
MN VETERANS HOME SILVER B	ΧΔ Υ	S BOULEVAI AY, MN 556				
PREFIX (EACH DEFICIENCY MI	MENT OF DEFICIENCIES IUST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
needed gait belt at all times, s anti-rollback brakes for transportation wear gripper socks or keep bed at transferal remind to use front-wh wear hipsters as R4 a clip call light to shirt to from bed set up an activity if wa anticipate and meet n Approach slowly from problems provide a bedtime sna Walk with human serv distance as tolerated R4's Bedside Kardex closet, identified all of for safety, including cl goes to bed in case R light to ask for assista while in bed. R4's signed physician included medications affect R4's falls, includ blood pressure), timol hydrochlorothiazide (c) (antipsychotic), and c) (gastro-esophageal re A physician's progress indicated R4 had frequence	all ambulation, assist as standard wheelchair with or long distance r shoes at all times ble height heeled walker allows o alert staff if he is getting up andering needs the front due to visual ack vices technician twice daily, Report, located in R4's fine care plan interventions lip call light to shirt when R4 forgets to push the call ance and gripper socks on a orders dated 3/28/16, that had the potential to ding verapamil (increased lol eye drops for glaucoma, diuretic), seroquel omeprazole eflux).	2 830				

Minnesota Department of Health

STATE FORM 6899 DHZE11 If continuation sheet 16 of 29

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:	A. BUILDING:		
		00381	B. WING		04/	20/2016
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
MN VET	MN VETERANS HOME SILVER BAY 45 BANK SILVER I					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 830	moving as well. The contributing factors cognitive impairme R4's admission Fall darted 12/30/16, iderisk for falls. R4's Post-Incident Falls indicated R4 Is and 4/11/16: On 1/21/16, at 8:30 and tipped backwainjury. The interdisc 1/22/16, and the new "Do not sit" sign on sit on top of the wa On 2/12/16, at 2:30 fall in the dining rook he had been sitting the back of the hea and orthostatic blook taken when lying, so checked for 3 days dizzy or light-headed On 2/24/16, at 7:10 floor beside the been on the floor next to had to have a bowe injury. It was noted from 133/72 while so standing. The IDT intervention of offer the shift. Orthostat following the incide orthostasis. On 3/4/16, at 4:50 pwalking without a well. R4 had no injurt the new intervention walker close to him walker close to him	ne physician identified to R4's falls, including nt and TIA's. I Risk Assessment (FRA) entified R4 as being at high Investigation Worksheets for nad 8 falls between 1/21/16 I p.m. R4 sat on the walker rds to the floor. R4 had no ciplinary team (IDT) met on ew intervention was to put a the walker to remind R4 not to lker. I p.m. R4 had an unwitnessed om, about 4 steps from where a R4 had a small abrasion on a R5 had a small abrasion on a R6. The IDT met on 2/16/16, and pressures (blood pressures itting and then standing) were R4 did not complain of being	r			

Minnesota Department of Health

STATE FORM DHZE11 If continuation sheet 17 of 29

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
				A. BUILDING:			
		00381		B. WING		04/20/2016	
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MN VET	MN VETERANS HOME SILVER BAY			S BOULEVAI			
SILVER E			SILVER B	AY, MN 556	14		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 17		2 830			
	Kardex. On 3/18/16, at 3:15 bathroom, lost his bathroom, lost his band R4 fell. R4 had elbow. During a poidentified he needed times. The IDT menneeded to sleep-in bedtime snack, and ambulation. On 3/23/16, at 10:1 floor next to his roomovement. R4 had 3/23/16, and approwere initiated by sta following the fall. TR4 was to wear hip and the call light wanight when put to bOn 4/5/16, at 7:40 living room and was the walker. R4 apprometric he fall. R4's physicordered lab work. ambulate with stanat a distance as tolereminders to use the Contributing factors the fall. R4's physicordered lab work. ambulate with stanat a distance as tolereminders to use the Con 4/11/16, at 8:30 his walker and tripp foot. R4 was wearing had no injury. The laction was to locate with using the wheethe walker properly were checked and have orthostasis.	p.m. R4 was walking palance, the walker to a skin tear on the rest-fall meeting, the state on 3/21/16 and indiction in the morning, offer a required stand-by-and on p.m. R4 was found mates bed and had no injury. The IDT wed new intervention aff during a post-fall these interventions in sters to help preventas to be clipped to R	tipped over right staff at all cated R4 red a assist with d on the ad a bowel met on as that review ancluded to injury 4's shirt at a linto the wall with and fall to meeting d different ause for eations and was to wice daily needed ance. If without ident's shoes. R4 and the sist him and to use oressures 4 did not				

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00381	B. WING	B. WING		04/20/2016	
	PROVIDER OR SUPPLIER	R BAY 45 BANK	DDRESS, CITY, S'S BOULEVAR BAY, MN 5561	D			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
2 830	included a review of vision, continence of behaviors, mobility, balance. R4 was dor high risk for falls On 4/20/16 at 7:54 sleeping. The call I R4's headboard wit side of the headboard height, using his waneeds. HST-C states he needs, because On 4/20/16, during at 10:20 a.m. with list (LPN)-A the closet was lying in bed. Long to clipped to R4's gripper socks on, but LPN-A clipped the county some gripper socks on this shirt, but was ly shoulder. HST-C whim and said it was gripper socks on. On 4/20/16, at 2:09 (DON) stated follow meeting was held to immediate interven follow-up meeting to decide if a new interventage.	f risk factors, medications, of bowel and bladder, blood pressures, gait and etermined to be at moderate with each FRA. a.m. R4 was lying in bed, ight cord was draped over h the call button on the back ard. a.m. human services stated R4's safety ed having his bed at transfer alker, and wheelchair as he ed R4 required a gait belt as he is unsteady at times. an observation and interview censed practical nurse care guide was reviewed. R4 PN-A verified the call light was shirt and R4 did not have ut should have had both. call light cord to R4's shirt and					

6899

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00381	B. WING		04/2	20/2016	
	PROVIDER OR SUPPLIER	R BAY 45 BANK	DRESS, CITY, S S BOULEVA SAY, MN 556				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
2 830	Kardex to implement DON stated change interventions are condaily report and through the Director of Nurdevelop, review, an procedures to fall in assessed and revisal The Director of Nureducate all approprint procedures. The Director of Nurdevelop monitoring compliance.	ge 19 Int safety interventions. The es in resident cares or ommunicated to staff through ough the bedside Kardex. HOD OF CORRECTION: sing or designee could d/or revise policies and interventions are implemented ed as needed for all residents. sing or designee could iate staff on the policies and sing or designee could systems to ensure ongoing	2 830				
21610	and Preparation Are Subpart 1. Storage must store all drugs under proper tempe only authorized nur access to the keys. This MN Requireme by: Based on observati review the facility fa proper temperature refrigerators review Findings include:	e of drugs. A nursing home in locked compartments erature controls, and permit sing personnel to have ent is not met as evidenced on, interview and document alled to store medications at in 2 of 4 medication	21610				

6899

STATEMENT OF DEFICIENC AND PLAN OF CORRECTION			/SUPPLIER/CLIA TION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
				A. BUILDING:			
		00381		B. WING		04/2	20/2016
NAME OF PROVIDER OR SU	JPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MN VETERANS HOME SILVER BAY				S BOULEVAI AY, MN 556			
PREFIX (EACH DE	FICIENC'	ATEMENT OF DEFI Y MUST BE PRECE SC IDENTIFYING	EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
(Fahrenheit) (TMA)-A ver On 4/20/16, refrigerator of Registered refrigerator of Registered refrigerators can be a seen and seen and stated, all." The ADO maintenance supposed to temperature hour later. To temperature and stated, all." The ADO maintenance supposed to temperature and stated, all. The ADO maintenance supposed to temperature and stated, all. The ADO maintenance supposed to temperature and read on 4/5/The ADON and read low reading of 20 on 2/17-18/11 frequently freque	on Map. Traindified the at 12:20 on Maphurse (I readiliphore the tated so should in the at the solution of the the to fix adjust on the ADO solution of the ADO of th	elle unit was 34 eld medication is reading on the properties of p.m. the medication is reading on the control of p.m. the medication representation of the control of p.m. the did not know the did not know the did not know the control of p.m. the did not know the control of p.m. the did not know the did when the control of the did not know the control of the refrigeration of the refrigeration. The medication of the refrigeration.	assistant the thermometer. dication degrees F. the ed the night emperature. where the range the ausually saw the be 34 degrees for of nursing frigerator 3-44 degrees he outside ead 54 degrees so not accurate at get stated staff was the refrigerator d then re-temp a erefrigerator deen running low ture was not ture was not ture was not through 4/7/16. tures on the log 16/16, with a 3, 28 degrees 16/16, with a 3, 28 degrees 17/16, with a 46/16, with a 5, 28 degrees 18/16/16, with a 5, 28 degrees 18/16/16, with a 6, 28 degre	21610			

6899

_	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00381	B. WING		04/2	04/20/2016	
	NAME OF PROVIDER OR SUPPLIER MN VETERANS HOME SILVER BAY SILVER BAY						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
21610	degrees F. RN-F verthermometer and sidial a little and wou her shift. RN-F stair refrigerator were us and staff. The refrigerator were us and staff. The refrigerator correction a box of interferon a medication a box of Risperdal of The inserts in the box estated the beautiful properties. The influenza vaccing 15 FluZone Quad vor 3 unopened vials of 12 acetaminophen suppositories. On 4/20/16, at 1:21 the director of nursing working on a correction stated the Minneap medication refrigeral maintained within 3 the DON stated, "I vapproximately 1:52 to pharmacy, they some dications might stated the refrigerator on the Edegrees F. The refrigerator on the Edegrees F. The refrigerator to 4/4/16. Prior to 4/4/16.	erified the reading on the tated she would turn up the ld recheck the temperature on ted the vaccines in the sed to administer to residents on tained: Deta-1a IM (intramuscular) Consta IM medication oxes indicated the be stored 36-46 degrees. The sindicated the be stored the medications red but not be frozen. es accines f Lantus insulin 650 mg (milligrams) I p.m. the ADON sitting with ng (DON) stated, "We were stion" for this. The ADON olis pharmacy said the ator temperatures should be 6-46 degrees F. At 1:27 p.m. will call the pharmacy." At p.m. the DON stated, "I talked said it is borderline, the					

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
00381	B. WING	B. WING		04/20/2016	
MN VETERANS HOME SILVER BAY	EET ADDRESS, CITY, ST. BANKS BOULEVARI /ER BAY, MN 55614)			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES 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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
30-32 degrees F, 14 of 98 readings since 1/1 with intermittent readings of 36 degrees F or above. Licensed practical nurse (LPN)-D ver the refrigerator temperature was below 36 degrees F and the temperature log readings been below 36 degrees F. The refrigerator contained: one opened one milliliter (ml) vial of Tubercul 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 refrigerat between 36 and 46 degrees F, and should not frozen. The package insert for the Tuberculin solution indicated it should be stored between and 46 degrees F. On 4/20/16, at 1:59 p.m. the DON verified the medication refrigerator temperature range she be between 36 and 46 degrees. The DON state the facility would contact the pharmacy for direction regarding medications in the refrigerators. The policy provided by the facility dated 8/13/ Medication Storage and Security indicated "A prescription, nonprescription medications and biologicals are to be kept safe, orderly, secur and accessible to authorized nursing persont only. Whenever there are biologicals stored it refrigerator the temperature must be monitor least twice daily as close to 12 hour intervals possible. Biologicals drugs include antibodies interleukins, and vaccines. Refrigerator	rified had lin tor ot be n 35 e nould ated (15, III d re nel n the ed at as				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00381		B. WING		04/2	0/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MN VET	ERANS HOME SILVER	R BAY	S BOULEVAI AY, MN 556			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21610	Fahrenheit." SUGGESTED MET The Director of Nur develop, review, an procedures to ensu proper temperature The Director of Nur educate all appropr procedures. The Director of Nur develop monitoring compliance.	THOD OF CORRECTION: sing or designee could d/or revise policies and re medication is stored at the	21610			
21670	The following items resident: A. A bed of proconvenience of the mattress, and clear weather and reside condition. Each bebedspread. A mois mattress cover musconfined to bed and Rollaway type beds not be used. B. A chair or plathan the bed. C. A place adjapersonal possessio with a drawer. D. Clean bath I often as needed.	must be provided for each per size and height for the resident, a clean, comfortable bedding, appropriate for the nt's comfort, that are in good dimust have a clean ture-proof mattress or to be provided for all residents for other beds as necessary, cots, or folding beds must acce for the resident to sit other accent or near the bed to store ns, such as a bedside table inens provided and of an	21670			

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04/20/2	2016
TION JLD BE OPRIATE	(X5) COMPLETE DATE

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			71. BOILBING.			
		00381	B. WING		04/2	20/2016
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MN VETE	ERANS HOME SILVE	RRAY	S BOULEVAI BAY, MN 556			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21670	Continued From pa	age 25	21670			
	function.					
	director of nursing did not have a chai the bed in their room R21 and R80 room should have a chair on other than just the handbook it stated the resident's request to have a chair DON further stated request a chair one. The facility's Residedated) indicated a cresident's request a choose not to have On 4/19/16, at 10:1 sitting on his bed. To other than the bed. previously that he experienced in the state of the state	roximately 9:00 a.m. the (DON) verified R21 and R80 r or a place to sit other than ms and a chair was placed in its. The DON stated residents r in their room or a place to sit he bed. The DON stated in the a chair would be provided at est and some residents choose due to limited space. The if a resident was unable to e would be provided. The and Family Handbook (not chair would be provided at the and some residents may a chair due to limited space. The room lacked any seating R18 stated he had a recliner enjoyed sitting in, but the red from his room by the				
	SUGGESTED MET The Director of Nur develop, review, an procedures to ensu- chair or a place to so The Director of Nur educate all appropri procedures. The Director of Nur develop monitoring compliance.	THOD OF CORRECTION: rsing or designee could nd/or revise policies and ure resident's rooms had a sit other than a bed. rsing or designee could riate staff on the policies and rsing or designee could g systems to ensure ongoing R CORRECTION: Twenty-one				

6899

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3)		(X3) DATE SURVEY COMPLETED	
		00381	B. WING		04/2	0/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	-	
MN VETE	ERANS HOME SILVER	R BAY	S BOULEVAI AY, MN 556			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPLETED IN C		
21670	Continued From pa	ge 26	21670			
	(21) days.					
21685	1 0, 1	eration, & Maintenance	21685			
	including walls, floo systems, and equip continuous state of with regard to the h well-being of the re	plant. The physical plant, ors, ceilings, all furnishings, oment must be kept in a good repair and operation ealth, comfort, safety, and esidents according to a written e and repair program.				
	by: Based on observatireview, the facility fahomelike environment	ent is not met as evidenced on, interview and document ailed to ensure a clean and ent was maintained in 4 of 31 3, 211, 225, 226) and the Blue dining room.				
	Findings include:					
	environmental tour, (MD) and a mainter	ing at 3:30 p.m. during an the maintenance director nance staff member (MS) g environmental findings:				
	an area approximate chipped and missing the wall creating a rather other side of the with an unpainted, unpain	wall next to the bathroom was tely 6 inches by 4 inches of g sheet rock on the bottom of rough, uncleanable surface. He wall corner was covered uncleanable board that was et long and 6 inches wide.				
		t register had several areas of The corner molding between				

6899

-	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00381	B. WING		04/	20/2016
	PROVIDER OR SUPPLIER ERANS HOME SILVER	R BAY 45 BANK	DDRESS, CITY, S S BOULEVAR BAY, MN 5561			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
21685	the sink and the babroken off approxin creating a rough, un Room 225: had a dile in the bathroom uncleanable area. Room 226: had an chipped area in the wall causing a rough. The Blue Spruce did the wall between the areas with missing areas measured apinches and 1 inchebuncleanable surfactunder the window leexposed the sheethous and t	throom at the bottom was nately 3 inches by 4 inches ncleanable surface. ime sized hole in the ceramic wall by toilet creating an approximately 4 inch by 1 inch ceramic tile on the bathroom h and uncleanable surface. ning room the corner edge of e two rooms had two chipped and exposed sheet rock. The proximately 4 inches by 2 by 1 inch causing a rough and e. In addition the molding edge was missing and rock. p.m. the MD stated a painter rorked one weekend a month resident rooms and another ry third weekend to repair and other areas. The MS stated and the dule or log of what had been ed to be done. The MD further and a computer system in which aintenance of areas needing				

6899

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COMP	SURVEY
		00381	B. WING		04/2	20/2016
NAME OF PROVIDER OR SUPPLIER MN VETERANS HOME SILVER BAY STREET ADDRESS, CITY, STATE, ZIP CODE 45 BANKS BOULEVARD SILVER BAY, MN 55614						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21685	indicated painting a be done in a three to suggested MET The Director of Mai develop, review, an procedures to ensu common areas wer homelike environmenthe Director of Mai educate all approprizedures. The Director of Mai develop monitoring compliance.	nd room maintenance would o four week cycle. CHOD OF CORRECTION: ntenance or designee could d/or revise policies and re resident rooms and e maintained in a clean and	21685			