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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: DTJX

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00381

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245628**

2. STATE VENDOR OR MEDICAID NO. (L2)

3. NAME AND ADDRESS OF FACILITY
(L3) **MN VETERANS HOME SILVER BAY**
(L4) **56 OUTER DRIVE**
(L5) **SILVER BAY, MN** (L6) **55614**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **6/28/2017** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35) **06/30**

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

12. Total Facility Beds **83** (L18)

13. Total Certified Beds **83** (L17)

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date :
Teresa Ament, Unit Supervisor — 07/21/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Anne Peterson, Enforcement Specialist — 08/22/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30) **00**

VOLUNTARY
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **06201** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **07/14/2017** (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245628 July 21, 2017

Ms. Carol Gilbertson, Administrator
Minnesota Veterans Home Silver Bay
56 Outer Drive
Silver Bay, MN 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 June 2, 2017 the above facility is recommended 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.

Please contact me if you have any questions.

Sincerely,

Anne Peterson

Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered July 21, 2017

Ms. Carol Gilbertson, Administrator
Minnesota Veterans Home Silver Bay
56 Outer Drive
Silver Bay, MN 55614

RE: Project Number S5628002

Dear Ms. Gilbertson:

On May 23, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 11, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On June 28, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on June 15, 2017 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 May 11, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 2, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 11, 2017, effective June 2, 2017 and therefore remedies outlined in our letter to you dated May 23, 2017, 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.

Feel free to contact me if you have questions.

Sincerely,

Anne Peterson

Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: DTJX

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00381

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

3. NAME AND ADDRESS OF FACILITY
(L3) **MN VETERANS HOME SILVER BAY**
(L4) **56 OUTER DRIVE**
(L5) **SILVER BAY, MN** (L6) **55614**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/11/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Kimberly Settergren, HFE II 06/05/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 07/14/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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3. Both of the Above :

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 23, 2017

Ms. Carol Gilbertson, Administrator
Minnesota Veterans Home Silver Bay
56 Outer Drive
Silver Bay, MN 55614

RE: Project Number S5628002

Dear Ms. Gilbertson:

On May 11, 2017, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

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

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

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**
>
> **Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and**

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

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

DEPARTMENT CONTACT

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

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Building
11 East Superior Street, Suite #290
Duluth, Minnesota 55802
Email: Teresa.Ament@state.mn.us
Phone: (218) 302-6151 Fax: (218) 723-2359

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 June 20, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by June 20, 2017 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within ten calendar days of your receipt of this letter. Your ePoC 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,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC 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 ePoC 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 ePoC 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 ePoC 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 ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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 August 11, 2017 (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 November 11, 2017 (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
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC 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 electronic 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

Please contact me if you have questions related to this eNotice.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245628	A. BUILDING _____ B. WING _____	05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME SILVER BAY	56 OUTER DRIVE SILVER BAY, MN 55614

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow the care plan to ensure foot support/rests were used for 1 of 1 resident (R3) reviewed for wheel chair positioning. Findings include: R3's Admission Record printed 5/11/17, indicated R3's diagnoses included dementia, restless leg syndrome, and chronic obstructive pulmonary disease (COPD).	F 282	Failure to follow care plan to ensure foot supports/rests were used for 1 of 1 resident (R3) reviewed for wheelchair positioning. Facility Citation Action: Resident R3's foot supports/rests were placed on his wheelchair immediately. Staff were re-educated on the need to provide foot supports/rests per the plan of care on 5/11/17 and on 6/2/17. Prevention Plan:	6/2/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/01/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245628	A. BUILDING _____ B. WING _____	05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME SILVER BAY	56 OUTER DRIVE SILVER BAY, MN 55614

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 1 R3's annual Minimum Data Set (MDS) dated 4/6/17, indicated R3 had severe cognitive impairment. R3 used a wheel chair for mobility, and required extensive assistance of staff in locomotion on and off unit. R3's care plan dated 4/29/17, indicated R3 had impaired mobility related to lower extremity weakness, was non-ambulatory and had dementia. R3's care plan directed staff to use bilateral foot rests when they were transporting him in the wheel chair. R3's Safety/Falls Care Area Assessment (CAA) dated 4/25/16, indicated R3 used bilateral foot rests for transportation in his wheelchair. R3's bedside kardex indicated R3 used bilateral foot rests for transportation in his wheel chair. On 5/8/17, at 5:22 p.m. R3 was observed being transported in the wheel chair out of his room, into the dining by human services technician (HST)-E. R3 did not have any foot rests on his wheel chair, and his feet dragged on the carpeted floor. R3 stated, "Ouch." R3 was reminded by HST-E to lift his feet, which R3 did. On 5/9/17, at 8:26 a.m. HST-D transported R3 in the wheelchair from his room to the dining room. R3's wheelchair lacked foot rests. R3's had shoes on, and his feet dragged on the carpet. On 5/9/17, at 10:04 a.m. R3 was observed being transported in the wheel chair from his room, off the unit to worship service. R3 was being transported by a volunteer (V)-A. R3 was seated in his wheel chair, was wearing shoes, and did not have foot rests on the wheel chair. R3's feet	F 282	Supervisors or designee will conduct audits to assure all positioning devices are in place. Just in time education will be provided as appropriate. This was initiated on 6/2/17. Monitoring Plan: Nursing Supervisors or designees will monitor all residents care plans that note positioning devices to assure compliance is met. Monitoring will be followed in QAPI for 1 year as follows: Random audits will occur weekly x 3 months until 100% compliance is achieved then; monthly x 3 months until 100% compliance is achieved then; quarterly x 6 months until 100% compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245628	A. BUILDING _____ B. WING _____	05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME SILVER BAY	56 OUTER DRIVE SILVER BAY, MN 55614

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 2 kept on lowering to the carpeted floor, causing the wheelchair stop. This occurred five times. Each time V-A asked R3 to pick up his feet. V-A verified she was taking R3 to the worship service off of the unit. On 5/10/17, at 12:46 p.m. HST-D stated R3 needed to be transported in the wheel chair when going from his room to the dining room. HST-D stated sometimes staff put foot rests on R3's wheel chair, and sometimes they did not. On 5/10/17, at 1:03 p.m. registered nurse (RN)-C stated she would expect R3's foot rests would be applied to the wheel chair as directed by the care plan. RN-C stated she would also expect staff to apply the foot rests to the wheel chair prior to being transported to the great room or dining room. On 5/10/17 at 2:00 p.m. the director of nursing (DON) stated she would expect staff to follow the care plan. The facility's Resident Assessment- Care Plan policy dated 11/5/15, indicated the purpose of the policy was to ensure residents maintained the highest practical level of functionality and wellness.	F 282		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest	F 309		6/2/17

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F 309	Continued From page 3 practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure foot support/foot rests were provided for 1 of 1 resident (R3) reviewed for wheel chair positioning. Findings include: R3's Admission Record printed 5/11/17, indicated	F 309	Failure to follow care plan to ensure foot supports/rests were used for 1 of 1 resident (R3) reviewed for wheelchair positioning. Facility Citation Action: Resident R3's foot supports/rests were placed on his wheelchair immediately. Staff were re-educated on the need to	

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F 309	Continued From page 4 R3's diagnoses included dementia, restless leg syndrome, and chronic obstructive pulmonary disease (COPD). R3's annual Minimum Data Set (MDS) dated 4/6/17, indicated R3 had severe cognitive impairment. R3 used a wheel chair for mobility, and required extensive assistance of staff in locomotion on and off unit. R3's care plan dated 4/29/17, indicated R3 had impaired mobility related to lower extremity weakness, was non-ambulatory and had dementia. R3's care plan directed staff to use bilateral foot rests when they were transporting him in the wheel chair. R3's Safety/Falls Care Area Assessment (CAA) dated 4/25/16, indicated R3 used bilateral foot rests for transportation in his wheelchair. R3's bedside kardex indicated R3 used bilateral foot rests for transportation in his wheel chair. On 5/8/17, at 5:22 p.m. R3 was observed being transported in the wheel chair out of his room, into the dining by human services technician (HST)-E. R3 did not have any foot rests on his wheel chair, and his feet dragged on the carpeted floor. R3 stated, "Ouch." R3 was reminded by HST-E to lift his feet, which R3 did. On 5/9/17, at 8:26 a.m. HST-D transported R3 in the wheelchair from his room to the dining room. R3's wheelchair lacked foot rests. R3's had shoes on, and his feet dragged on the carpet. On 5/9/17, at 10:04 a.m. R3 was observed being transported in the wheel chair from his room, off	F 309	provide foot supports/rests per the plan of care on 5/11/17 and on 6/2/17. Prevention Plan: Supervisors or designee will conduct audits to assure all positioning devices are in place. Just in time education will be provided as appropriate. This was initiated on 6/2/17. Monitoring Plan: Nursing Supervisors or designees will monitor all residents care plans that note positioning devices to assure compliance is met. Monitoring will be followed in QAPI for 1 year as follows: Random audits will occur weekly x 3 months until 100% compliance is achieved then; monthly x 3 months until 100% compliance is achieved then; quarterly x 6 months until 100% compliance is achieved.	

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F 309	Continued From page 5 the unit to worship service. R3 was being transported by a volunteer (V)-A. R3 was seated in his wheel chair, was wearing shoes, and did not have foot rests on the wheel chair. R3's feet kept on lowering to the carpeted floor, causing the wheelchair stop. This occurred five times. Each time V-A asked R3 to pick up his feet. V-A verified she was taking R3 to the worship service off of the unit. On 5/10/17, at 12:46 p.m. HST-D stated R3 needed to be transported in the wheel chair when going from his room to the dining room. HST-D stated sometimes staff put foot rests on R3's wheel chair, and sometimes they did not. On 5/10/17, at 1:03 p.m. registered nurse (RN)-C stated she would expect R3's foot rests would be applied to the wheel chair as directed by the care plan. RN-C stated she would also expect staff to apply the foot rests to the wheel chair prior to being transported to the great room or dining room. The facility's Resident Assessment- Care Plan policy dated 11/5/15, indicated the purpose of the policy was to ensure residents maintained the highest practical level of functionality and wellness.	F 309		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-	F 314		6/2/17

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F 314	Continued From page 6 (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess pressure ulcers and status of skin upon readmission for 1 of 2 residents (R47) reviewed for pressure ulcers. Findings include: Pressure Ulcer stages defined by the National Pressure Ulcer Advisory Panel (NPUAP): Stage 1: Nonblanchable Erythema: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Stage 2: Partial Thickness Skin Loss: Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising.	F 314	The facility failed to comprehensively assess pressure ulcers and status of skin upon re-admission. Facility Citation Action: Resident R47's plan of care and assessment/interventions accurately reflect and treat his current needs as noted 3 days post re-admission on 3/6/17. Prevention Plan: Nursing Supervisors or designees will audit newly admitted or re-admitted residents with a risk of pressure ulcers per facility standards to assure compliance. Just in time education will be provided as appropriate. Initiated on 6/2/17. Monitoring Plan: Supervisors will monitor all new admissions and re-admissions to assure the facility skin management policy is met. Monitoring will be followed in QAPI for 1 year as follows: All new admissions and re-admissions will be followed to assure	

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F 314	Continued From page 7 Stage 3 Pressure Ulcer: Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough (yellow devitalized tissue, that can be stringy or thick and adherent on the tissue bed) and/or eschar (dark, dead tissue) may be visible. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Ulcer. Stage 4 Pressure Ulcer: Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Ulcer. Unstageable Pressure Ulcer: Obscured full-thickness skin and tissue loss. Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure ulcer will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed. Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration. Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood	F 314	all assessments are completed per policy. Audits for completion of assessments per policy will occur as appropriate x 3 months until 100% compliance is achieved then; monthly x 3 months until 100% compliance is achieved then quarterly x 6 months until 100% compliance is achieved.	

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filled blister. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4).

R47's Admission Record printed 5/11/17, indicated R47's diagnoses included vascular dementia (thinking/memory problems caused by inadequate blood flow to the brain), hemiplegia and hemiparesis (weakness or decreased movement on one side of the body) following cerebral infarction (stroke) affecting right dominant side, and edema (swelling).

R47's quarterly Minimum Data Set (MDS) dated 4/21/17, indicated R47 was cognitively intact and required limited assistance with bed mobility, and was independent with transfers. The MDS further indicated R47 was at risk for the development of pressure ulcers, and had an unstageable pressure ulcer. R47's MDS also indicated R47 had a pressure reducing device for chair and bed, was on a turning and repositioning program, and had pressure ulcer care. R47's previous admission MDS dated 1/24/17, indicated R47 did not have a pressure ulcer and was not on a repositioning program.

R47's care plan dated 4/21/17, indicated R47 was at risk for alteration in skin related to history of pressure ulcers, impaired mobility, stroke with right sided weakness and bowel and bladder incontinence. R47's care plan interventions initiated 4/21/17, and revised on 5/7/17, included a Mepilex (foam) border dressing over coccyx for protection, wound treatments as ordered by the physician, electric alternating pressure mattress, and pressure relieving cushion in the wheelchair.

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Further interventions initiated on 4/21/17, included assisting R47 to reposition using a pillow, two staff assist to turn left side to back every 2 hours and as needed, provide high protein snacks and beverages between meals, and to get up for meals only. R47 was independent with bed mobility with the assistance of one staff as needed.

R47's Skin Risk Factors assessment completed on 1/19/17, following R47's initial admission to the facility, identified R47 as being at risk for pressure ulcers due to a personal history of pressure ulcers prior to admission, and a stroke with right sided hemiparesis. The skin risk assessment indicated R47's skin was intact at that time with non-blanchable areas over the bony prominences on the ischial tuberosities (sitting bones) and coccyx to which Mepilex border dressings were applied, and a pressure relief mattress rated to a Stage 2 pressure ulcer was used.

R47's was discharged from the facility to the hospital on 2/27/17, returning to the facility on 3/3/17. R47's Discharge Home Instructions from the hospital dated 3/3/17, indicated R47 had been admitted to the hospital with Influenza A and gastroenteritis, and was discharged with no active wound/skin impairments, though he had redness on the coccyx. R47's discharge orders did not include orders for wound care.

R47's progress notes dated 3/3/17, indicated R47 was re-admitted to the facility with admitting diagnoses of Influenza A and gastroenteritis, and had generalized weakness. R47's progress note further indicated R47 had trace edema (swelling), but lacked documentation of other skin integrity concerns.

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F 314	Continued From page 10 R47's progress notes and assessments lacked documentation of observation of R47's skin condition until 3/6/17, 3 days following his re-admission to the facility. R47's progress notes dated 3/6/17, at 7:43 a.m. indicated a tissue tolerance (a tool used to assist in determining the resident's tolerance of skin exposed to pressure without adverse effects) was done due to a brown circular area on the right buttock, found when a Mepilex dressing was rolled up and was not covering the brown area. Documentation at that time indicated R47 had a brown, nickel-sized area that was blanchable on the edges, Mepilex dressing was reapplied over the area, and a nurse was to assess it further. A tissue tolerance was started at that time. R47's progress notes dated 3/6/17, at 1:16 p.m. indicated he had a deep tissue pressure injury on the right iliac (hip) bone that measured 2.0 centimeters (cm) x 2.5 cm x 0.1 cm. The progress notes indicated R47 was re-admitted with the deep tissue pressure injury that was a partial thickness with defined edges and was 75% purple with some non-intact skin, and 25% intact non-blanchable maroon skin. The progress notes further indicated R47 was independent with bed mobility. R47's progress note indicated treatment with Medihoney (used to promote healing) and Mepilex sacrum border dressing. The progress note further indicated R47 was to be in bed and up for meals only, and turning from left side to back every two hours, using a wedge. R47's Tissue Tolerance Assessment dated 3/6/17, indicated R47 had blanchable redness after lying in bed for two hours.	F 314		

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R47's Wound Assessment Details Report (WADR) dated 3/6/17, indicated R47 had a pressure ulcer identified as a suspected deep tissue injury (SDTI) present on admission, but not identified until 3/6/17, and described as 25% maroon and 75% purple ecchymosis (bruising) with redness around the wound, measuring 2.0 cm x 2.5 cm x 0.1 cm. R47's WADR dated 3/8/17, indicated there was no change.

R47's Tissue Tolerance Assessment dated 3/7/17, indicated R47 had blanchable redness after lying in bed for three hours. R47 was encouraged and educated to keep weight off the right buttock and reposition self accordingly while in bed.

R47's progress notes dated 3/7/17, indicated R47 was compliant with repositioning side to side in bed, and the pressure ulcer on the right buttock was 75% open and 25% intact, with blanchable borders and non-blanchable wound bed.

R47's WADR dated 3/20/17, indicated R47 had a suspected deep tissue injury (SDTI) measuring 1.5 cm x 1.2 cm x 0.1 cm, and was 25% deep maroon and 75% purple ecchymosis. There were no WADR's dated between 3/8/17, and 3/20/17.

R47's progress note dated 3/20/17, indicated R47's physician had visited and had identified redness on R47's right iliac crest. R47's physician identified it as a SDTI that was treated with a Mepilex sacrum border dressing.

R47's WADR dated 3/25/17, indicated R47 had a SDTI that remained open and measured 1.5 cm x 1.5 cm x 0.1 cm.

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R47's progress note dated 3/31/17, indicated physical therapy (PT) assessed R47 for bed positioning using pressure mapping, which identified moderate pressure to the sacrum and posterior iliac crest region, with more pressure on the right than the left when supine (back-lying). PT recommended trial of different pressure relieving mattress, and indicated R47 was in agreement to try the electric alternating pressure relieving mattress, and reassess with pressure mapping.

R47's signed physician's orders dated 3/31/17, directed to clean the pressure ulcer with DAB Solution (a double antibiotic solution) twice daily and cover with gauze.

R47's progress note dated 4/3/17, indicated a follow-up pressure mapping was completed, and noted R47 had improved pressure distribution and decreased in all areas with the electric alternating pressure relieving mattress.

R47's WADR dated 4/4/17, indicated R47 had a SDTI, but the pressure ulcer was open with 100% bright pink or red bed, and had a scant amount of bloody drainage. R47's pressure ulcer measured 1.4 cm x 1.2 cm x 0.1 cm. The WADR indicated the pressure ulcer was cleansed with DAB solution, and covered with gauze and secured twice daily.

R47's WADR dated 4/12/17, indicated R47's pressure ulcer was a SDTI that was open with 100% white fibrinous slough, but measured 1.4 cm x 1.0 cm x 0.1 cm. R47's WADR indicated R47's pressure ulcer was present on admission, though was not identified until 3/6/17.

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R47's Skin Risk Factors assessment dated 4/13/17, indicated R47 was at risk for pressure ulcers, and currently had a pressure ulcer. The assessment further indicated R47 had a SDTI which was treated with DAB solution, and an electric alternating pressure relief mattress on the bed. The assessment also identified R47 had a heel manager to float heels off the bed, and a pillow for positioning left side to back every 2 hours and as necessary. R47 was able to reposition independently in bed and wheelchair.

R47's WADR dated 4/19/17, indicated R47's pressure ulcer had become larger, measuring 2.0 cm x 2.3 cm x 0.1 cm and was 100% white fibrinous slough.

R47's signed physician orders directed to offer a high protein snack twice daily.

R47's physician progress note dated 4/19/17, indicated R47's hip and coccyx ulcer were stable to improved.

R47's WADR dated 4/21/17, indicated the director of nursing (DON) assessed R47's pressure ulcer, indicated it was unstageable due to 50% white fibrinous slough. Documentation indicated the remainder of the wound bed was 50% pale pink and non-granulating (non-healing), and measured the pressure ulcer at 1.2 cm x 1.0 cm with unknown depth. The documentation indicated the wound base had adherent slough that was moist, the wound edges were slightly puckered, but no longer were red. Prior to this date, the WADR's were completed by various licensed nurses.

R47's WADR dated 5/3/17, indicated the DON

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assessed the pressure ulcer and indicated it was unstageable. The pressure ulcer was described as 50% pale pink non-granulating tissue and 50% white fibrinous slough, and measured 1.4 cm x 1.0 cm x unknown depth. The DON documented the wound had mild shelving starting and the wound bed was dry, so would discontinue the DAB solution and change to hydrogel with a Mepilex foam covering to reduce wound pressure and add moisture.

R47's signed physician orders dated 5/3/17, directed discontinuation of DAB solution to wound, and to use hydrogel covered with Mepilex daily.

R47's WADR dated 5/10/17, indicated the DON assessed the pressure ulcer. The DON indicated the pressure ulcer was unstageable with 90% loosely adhered slough and 10% pale pink non-granulating tissue, had light serous (transparent, pale yellow) drainage, and measured 1.4 cm x 0.8 cm, and had less depth appearance with the edges filling in.

On 5/10/17, continuous observations were performed from 7:26 a.m. until 8:37 a.m. when staff entered R47's room and assisted him to get out of bed and complete morning cares. At 9:26 a.m. R47 was in the dining room eating breakfast, while seated in his wheelchair.

On 5/10/17, at 10:32 a.m. during an observation, registered nurse (RN)-A and the DON completed a dressing change on R47's right iliac crest using hydrogel, covered with a Mepilex dressing. The DON measured the pressure ulcer at 1.2 cm x 1.8 cm and stated the depth was unable to be determined due to the presence of 100% yellow

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	245628	A. BUILDING _____ B. WING _____	05/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME SILVER BAY	56 OUTER DRIVE SILVER BAY, MN 55614

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 15	F 314		

slough over the wound bed, though it looked more shallow than previously. The DON stated there was a small amount of serous drainage, the edges were filling in, and the pressure ulcer was unstageable. R47 had stood up from his wheelchair independently and used his walker to support himself in a standing position during the dressing change. R47 sat on his bed independently following the dressing change. R47's bed had an electric alternate pressure relief mattress and his wheelchair had a cushion on it.

On 5/11/17, at 1:47 p.m. the DON verified skin assessments should be done within the first 24 hours of admission or re-admission to the facility. The DON verified R47's skin had not been assessed until three days after re-admission to the facility, and was unable to determine whether R47 was admitted with the pressure ulcer or acquired it in the facility. The DON stated R47 had a dressing in place upon re-admission from the hospital 3/3/17, the facility was unaware of this dressing until 3/6/17, when the dressing was removed after nursing noted a SDTI with some non-intact skin. The DON stated she prefers to evaluate the pressure ulcers herself, so she looked at R47's pressure ulcer the first time on 4/21/17, and has followed it since that time. The DON stated R47 was repositioned every two hours since admission, and all residents have a pressure reduction mattress rated up to a Stage 2 pressure ulcer. The DON stated when R47's pressure ulcer was identified 3/6/17, a positioning wedge was initiated as R47 was not always compliant with positioning off his back. The DON stated occupational therapy (OT) assessed R47's wheelchair cushion on 3/17/17, but he declined a new cushion. The DON stated R47 had a history of pressure ulcers when he was residing at home.

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F 314	Continued From page 16 The DON again verified R47's skin had not been looked at or assessed within 24 hours of re-admission to the facility, though it was the expectation to look at the resident's skin within 24 hours of admission/re-admission to the facility. The facility policy and procedure for Skin Integrity Management, reviewed 4/17, directed upon admission/readmission or change of condition a licensed nurse would complete a Skin Risk Assessment, a Tissue Tolerance Assessment, and a weekly Braden assessment (tool to help determine a resident's risk for skin breakdown). The facility policy and procedure directed if a pressure ulcer was present upon admission/readmission, or developed during time of residence, a through assessment would be completed to address risks, treatment, and prevention.	F 314		
F 441 SS=E	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);	F 441		6/2/17

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F 441	Continued From page 17 (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 441		

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F 441	Continued From page 18 (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide staff protective gowns for sorting potentially contaminated laundry in the laundry room. This had the potential to affect 76 of 77 residents who had their personal laundry washed in the facility. In addition, the facility failed to ensure infection control practices were maintained for 1 of 7 residents (R74) who required assistance with eating in the Evergreen unit. Findings include: On 5/9/17, at 10:40 a.m. a tour of the laundry was conducted with laundry worker (LW)-A. No protective gowns were observed in the laundry for staff to wear when sorting dirty and potentially contaminated laundry. LW-A verified there were not any protective gowns available in the laundry room for the staff to wear when sorting dirty and potentially contaminated laundry. LW-A further stated potentially infectious clothing was brought to the laundry in red bags, and staff never wore protective gowns to protect their clothing from potentially being contaminated. On 5/10/17, at 12:11 p.m. general maintenance worker (MW)-A stated she worked in the laundry part time, and protective gowns were not	F 441	CITATION F441: INFECTION CONTROL PREVENTION SPREAD, LINENS PART A: Failed to provide protective gowns for sorting potential contaminated laundry. PART B: Blowing on resident food to cool prior to feeding. Facility Citation Action: PART A: Protective gowns and education was provided to Laundry staff on 5/11/17. PART B: All staff have been re-educated on proper dining processes starting on 5/11/17 and completed on 6/2/17. Prevention Plan: PART A: The Housekeeping Supervisor will audit the use of protective gowns. Just in time education will be provided. This process was initiated on 6/2/17. PART B: Nursing Supervisors will lead auditing of the dining process to assure infection control standards are met. Just in time education will be provided. This process was initiated on 6/2/17. Monitoring Plan: PART A: Monitoring will be reported/followed in QAPI for 1 year as	

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F 441	Continued From page 19 available for staff to wear while sorting laundry. MW-A stated no one in the laundry ever wore protective gowns to protect their clothing when sorting dirty laundry. On 5/10/17, at 2:37 p.m. the building services supervisor (BSS) stated staff should be wearing protective gowns when coming in contact with potentially contaminated laundry. The BSS verified protective gowns were not available in the laundry room. On 5/11/17, at 9:48 a.m. the assistant director of nursing (ADON) stated she didn't know why the laundry staff were not using protective gowns when sorting laundry. The ADON further stated she expected laundry staff to wear protective gowns when sorting potential contaminated clothing, or when an illness was going around. The facility policy Employee Exposure Plan dated 8/20/09, directed protective clothing will be worn whenever there is the possibility of soiling clothing with blood or other potentially infections material. Employees who handle contaminated laundry will use personal protective equipment to prevent contact with blood or other potentially infectious material. The facility policy Linen Handling dated 4/17, directed soiled linen from residents in isolation precautions should be handled as appropriate for designated isolation precautions.	F 441	follows: The Housekeeping Supervisor will be monitor weekly x 3 months until 100% compliance is achieved then; monthly x 3 months until 100% compliance is achieved then; quarterly x 6 months until 100% compliance is achieved. PART B: Monitoring will be reported/followed in QAPI for 1 year as follows: The Dietary and Nursing Supervisors or designees will be monitor weekly x 3 months until 100% compliance is achieved then; monthly x 3 months until 100% compliance is achieved then; quarterly x 6 months until 100% compliance is achieved. Date of Correction: PART A: Corrected on 5/11/17 PART B: Corrected on 6/2/17	

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R74's Admission Record printed 5/11/17, indicated R74's diagnoses included Alzheimer's disease and Parkinson's disease.

R74's significant change Minimum Data Set (MDS), dated 3/20/17, indicated R74 was rarely or never understood, had short and long term memory problems, and severely impaired decision making skills. R74's required total assistance of one staff with eating.

R74's care plan dated 3/15/17, indicated R74 needed significant assistance for meal and fluid intake, and was not to be given anything to eat or drink independently.

On 5/9/17, at 8:46 a.m. R74 was observed being fed in the Evergreen dining area by human services technician (HST)-C. HST-C was observed blowing on R74's spoonfuls of hot food prior to putting the food into R74's mouth. HST-3 blew on the spoonfuls of hot food throughout the course of the breakfast meal.

On 5/9/17, at 4:19 p.m. HST-C verified he did he blow on R74's hot food to cool it down during breakfast that morning. HST-C verified he did this several times throughout breakfast for R74. HST-C stated he didn't remember being told not to do this.

On 5/10/20, at 1:00 p.m. registered nurse (RN)-C was interviewed. RN-C verified blowing on food to cool it down would be unusual. RN-C's expectation was that it should not happen, and verified it was not an acceptable practice.

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F 441	Continued From page 21 On 5/10/17, at 1:24 p.m. the assistant director of nursing (ADON) verified blowing on food to cool it down just prior to feeding it to a resident was not acceptable. A policy on infection control practices on assisting with meals was requested, but was not provided.	F 441		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/01/2017

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

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K 000	Continued From page 1 ST. PAUL, MN 55101-5145, or By e-mail to both: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Minnesota Veterans Home-Silver Bay is a one story building, partial basement original year of construction 1960's, and it was converted into a nursing home in the early 1990's. The original building and additions are all Type II(111) construction. The building is fully sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 83 beds and had a census of 76 the time of the survey.	K 000		

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K 000	Continued From page 2 The requirement at 42 CFR Subpart 483.70(a) is NOT MET.	K 000		
K 291 SS=D	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This STANDARD is not met as evidenced by: Based on observations and an interview with staff, the facility has failed to ensure that emergency lighting has been tested and maintained in accordance with the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 7.9.3. This deficient practice could affect 76 of 76 residents, as well as an undetermined number of staff, and visitors in the event of an emergency evacuation during a power outage. Findings include: On facility tour between 11:30 a.m. to 3:30 p.m. on 05/11/2017, observation during a review of all available testing and maintenance documentation and an interview with the program manager revealed that the facility has not been conducting a monthly 30 second test or the 90 minute annual test of the battery operated emergency lighting. The emergency generator is tied into lights that are located throughout the facility and the battery backup emergency light were left in place. Since the battery back up lights are still in place they are required to be tested per code requirements. This deficient condition was verified by the Maintenance Supervisor.	K 291	Facility Citation Action: All battery powered emergency lighting has been removed from the facility. The emergency generator powers the entire facility so there is no need for battery powered emergency lighting. Prevention Plan: Battery powered lighting removed from the facility Monitoring Plan: No battery back-up lights will be installed	5/26/17
K 321	NFPA 101 Hazardous Areas - Enclosure	K 321		5/26/17

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K 321 SS=D	Continued From page 3 Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility has failed to provide proper protection for 1 of several hazardous areas located throughout the facility in accordance with NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 19.3.2.1. This deficient conditions could in the event of a fire,	K 321	Facility Citation Action: Room 129 had a 5/8 inch sheetrock panel installed in the hole that was in the ceiling. It was fire taped and caulked. Prevention Plan: Physical Plant staff immediately repaired holes cut in the	

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K 321	Continued From page 4 allow smoke and flames to spread throughout the effected corridors and areas making them untenable, which could negatively affect the exiting capabilities for 20 of 76 residents as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 11:30 a.m. to 3:30 p.m. on 05/11/2017, observations revealed that the soiled linen room 129 had an opening in the gypsum ceiling lid that measured 4 feet by 2 feet. The sprinkler head is located in the remaining ceiling and the opening continues on to the roof deck creating a opening in the fire rated construction and preventing the heat from the fire from activating the sprinkler head. This deficient condition was verified by the Maintenance Supervisor.	K 321	sheetrock ceiling. The Physical Plant Director will conduct random monthly audits in areas where construction/maintenance has occurred to assure compliance. A quarterly preventive maintenance schedule has been made to check for new penetrations. Monitoring Plan: The Physical Plant Director will audit and report to QAPI monthly x 3 until 100% compliance is achieved; the audits will be followed quarterly x 3 until 100% compliance is achieved.	
K 346 SS=C	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This STANDARD is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the Fire Alarm	K 346	Facility Citation Action: Fire Alarm out of service policy updated to reflect the current Deputy State Fire Marshals Name and Phone number.	5/11/17

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K 346	Continued From page 5 system has to be placed out-of-service for four or more hours in a 24 hour period. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of 76 of 76 residents as well as an undetermined number of staff, and visitors to the facility . Findings include: On facility tour between 11:30 a.m. to 3:30 p.m. on 05/11/2017, during a records review and an interview with the Maintenance Supervisor, the facility did not have an acceptable fire alarm system out of service policy that included the current Deputy State Fire Marshal's contact information in the event of the fire alarm being out of service and the need for a fire watch to be initiated. At the time of the exit interview the facility provided a copy of the fire alarm system out of service policy that they had corrected during the inspection. This deficient condition was verified by the Maintenance Supervisor.	K 346	Prevention Plan: The Physical Plant Director will review Life Safety policies on an annual basis to assure current information. Monitoring Plan: The Physical Plant Director will review Life Safety policies every 6 months x 2; then annually 100% compliance is achieved. The Physical Plant Director will report finding in QAPI.	
K 354 SS=C	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the	K 354		5/11/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245628	A. BUILDING **01 - MN VETS HOME** B. WING _____	**05/11/2017**

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K 354	Continued From page 6 sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This STANDARD is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the automatic fire sprinkler system has to be placed out-of-service for four or more hours in a 24 hour period. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of 76 of 76 residents as well as an undetermined number of staff, and visitors to the facility . Findings include: On facility tour between 11:30 a.m. to 3:30 p.m. on 05/11/2017, during a records review and an interview with the Maintenance Supervisor, the facility did not have an acceptable fire sprinkler system out of service policy that included the current Deputy State Fire Marshal's contact information in the event of the fire sprinkler being out of service and the need for a fire watch to be initiated. At the time of the exit interview the facility provided a copy of the fire alarm system out of service policy that they had corrected during the inspection. This deficient condition was verified by the Maintenance Supervisor.	K 354	Facility Citation Action: Sprinkler system out of service policy updated to reflect the current Deputy State Fire Marshals Name and Phone number. Prevention Plan: The Physical Plant Director shall review Life Safety policies on an annual basis to assure current information Monitoring Plan: The Physical Plant Director will review Life Safety policies every 6 months x 2; then annually until 100% compliance is achieved. The Physical Plant Director will report finding in QAPI.	

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K 372	Continued From page 7	K 372		
K 372 SS=F	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain 1 of several smoke barrier walls in accordance with the requirements of NFPA 101 "The Life Safety Code" 2012 edition sections 19-3.7.3 and 8.3. This deficient practice could affect 20 of 76 residents as well as an undetermined number of staff, and visitors by allowing smoke to propagate from one smoke compartment to another. Findings include: On facility tour between 11:30 a.m. to 3:30 p.m. on 05/11/2017, observations revealed the following deficient condition affecting the facility's smoke barrier walls: 1) There was a penetration found around communication wires that are passing through the smoke barrier wall above the ceiling tiles located above the clock that is in the staff	K 372	Facility Citation Action: #1. Fire caulking was installed in the penetration above staff development office. #2 A door closure was reinstalled in the nurse□s office so to complete the smoke barrier. The facility drawing was corrected to reflect the proper smoke barrier wall. Prevention Plan: Physical Plant Director updated drawings to reflect proper smoke barriers. Monitoring Plan: The Physical Plant Director shall review facility blue prints for accuracy every 6 months x 2; then annually until 100% compliance is achieved. The Physical Plant Director will report findings in QAPI.	5/26/17

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K 372	Continued From page 8 development office. 2) There is a 6 foot by 8 inch opening in the smoke barrier wall above the ceiling tiles located between the kitchen and a hand washing sink. This deficient condition was verified by the Maintenance Supervisor.	K 372		
K 712 SS=F	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 This STANDARD is not met as evidenced by: Based on review of reports, records and staff interview, it was determined that the facility failed to conduct 1 of 12 fire drills in accordance with the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 19.7.1.6, during the last 12-month period. This deficient practice could affect 76 of 76 residents, as well as an undetermined number of staff, and visitors. Findings include:	K 712	Facility Citation Action: The names of the fire alarm participants at the time and date of the actual fire alarm were confirmed by the electronic employee attendance system. We located the employees and obtained their signatures. Prevention Plan: The Physical Plant Director shall randomly audit fire alarm reports to ensure that all staff participating in the fire alarm procedure have signed	5/26/17

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K 712	Continued From page 9 On facility tour between 11:30 a.m. to 3:30 p.m. on 05/11/2017, during the review of all available fire drill documentation and interview with the Maintenance Supervisor it was found that the facility did not transmit a fire alarm signal to the alarm monitoring company for 1 of 12 fire drills This deficient condition was verified by the Maintenance Supervisor.	K 712	the sheet. Review facility fire drills reports on a monthly basis for the correct information. Monitoring Plan: The Physical Plant Director shall review facility fire drill reports for accuracy every month x 3 until 100% compliance is achieved; then quarterly x 3 until 100% compliance is achieve; then annually x 1 until 100% compliance is achieved. The Physical Plant Director will report findings in QAPI.	