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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: K4H5

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 **06/14/2018** (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:
Kathie Siemsen, HFE NE II 07/17/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas Larson, Enforcement Specialist 07/30/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
June 26, 2018

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

RE: Project Number S5628003

Dear Ms. Gilbertson:

On June 14, 2018, 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 electronically attached 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 an "F" tag) and emergency preparedness deficiencies (those preceded by an “E” 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 Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
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 July 24, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

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

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 September 14, 2018 (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 December 14, 2018 (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 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

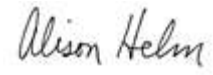
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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,



Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@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 _____	06/14/2018

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
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on June 11 through June 14, 2018, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On June 11 through June 14, 2018, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic 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 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with	F 585		7/6/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 07/05/2018

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F 585	Continued From page 1 respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman	F 585		

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F 585	Continued From page 2	F 585		

program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement

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F 585	Continued From page 3 Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure grievances were sufficiently acted upon for 1 of 2 residents (R33) reviewed for grievances. Findings include: On 6/11/18, at 2:39 p.m. R10 was observed sitting at a dining room window eating lunch. Strong body odors were noted coming from R10 that could be smelled into the connecting lounge area. On 6/12/18, at 11:15 a.m. during the resident council meeting, R33 stated he was unhappy with his roommate's (R10) personal body odor. R33 stated he did not like to be around R10 because of the pervasive body order, and none of the staff could get R10 to take a bath. R33 stated all of the staff were aware of R10's body odor, and nothing had been done about it. R33's Admission Record printed 6/14/18, indicated R33's diagnoses included major depressive disorder and paranoid schizophrenia. R33's quarterly Minimum Data Set (MDS) dated 4/18/18, indicated R33 was cognitively intact, had mild depressive symptoms, and displayed no behaviors.	F 585	Facility Citation Action: 1. R33 was offered new room on 6/15/18 and resident declined offer. 2. Resident R33 was provided a room deodorizer on 6/18/18 3. Social Services reached out to Ombudsman for ideas on 6/28/18. No new ideas received. Prevention Plan: 1. Re-education to be provided to interviewable residents at the Resident Council meeting on 7/11/18 and for the following 2 meetings, regarding the grievance procedure and location to obtain grievance information. A family letter will be mailed the week of July 9 to re-educate family. 2. Interviewable residents and/or significant others will be asked if they have any grievances during quarterly interview as appropriate. 3. When a resident has a verbal concern we will continue to offer them the grievance process as appropriate. 4. Facility grievance processes will continue to be followed. 5. The facility grievance process may include the following: Social worker and/or designee will follow up with resident within 3 business days with correction and/or	

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F 585	Continued From page 4 R33's undated care plan printed 6/14/18, indicated R33 had the potential for behavioral symptoms and had minimal symptoms of depression. R33's care plan directed staff to encourage R33 to express feelings, allow him time to talk when he initiated conversation, and offer to sit with him when he was feeling anxious and paranoid. R33's target behaviors included irritability, and use of negative language toward others. R10's admission record printed 6/14/18, indicated R10's diagnoses included paranoid schizophrenia, vascular dementia with behavioral disturbance, and a mental disorder due to known physiological condition. R10's annual MDS dated 3/16/18, indicated R10 was independent with cognitive skills for daily decision making, and had no signs or symptoms of depression, no psychosis, and no rejection of care. R10's MDS indicated he was independent with activities of daily living, preferred sponge baths and did not bathe during the assessment period. R10's care plan initiated 6/13/18, directed staff to record occurrences of paranoia. R10's care plan indicated R10 required one assist to supervise and set up for bathing or showering, but R10 often declined weekly bathing or showers, and preferred to wash himself at the skink with personal hygiene wipes. R33's progress notes dated 3/28/18, indicated R33 had reported to a nurse that he had concerns about the difficulty he had being around his roommate. R33 stated, "He [R10] really needs	F 585	plan of correction. If a resolution cannot be found with resident and/or resident representative, then Social Work will contact the Ombudsman (if party consents)for a meeting to discuss concern. Monitoring Plan: 1. Social Service or designee will monitor grieviences that are reported to ensure the grievance is addressed within 3 business days and was satisfactorily resolved or further action is needed as appropriate. Monitoring will be followed in QAPI as follows: 1. Weekly audits x 3 months until 100% compliant. 2. Then monthly x 3 months until 100% compliant. 3. Then quarterly x 6 months until 100% compliant	

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F 585	Continued From page 5	F 585		

a bath. It's getting so I can hardly barely stand to be in my room. It makes it hard to live here." The nurse documented that his concerns would be passed along.

R33's medical services progress notes dated 6/5/18, indicated R33 expressed concern regarding his roommate's poor hygiene.

R10's progress notes dated 6/5/18, indicated R10 was offered a bath weekly and as necessary, was provided cleansing cloths and encouraged to use them, continued to refuse to bathe, and would be continued to be encouraged to bathe.

R10's progress note dated 6/1/18, indicated R10 frequently refused bathing, was provided with wipes, and skin would be examined as he allowed.

R10's progress note dated 5/15/18, indicated R10 had not bathed in past 7 days, and refused bathing and was approached by 2 different staff.

R10's progress notes from 4/18/18, through 6/14/18, indicated R10 continuously refused a bath.

R10's Medical Services progress note by the nurse practitioner (NP) dated 4/25/18, indicated R10 was disheveled, had ripped clothing, had long dirty hair, and continued to refuse bathing, though staff were trying to provide different bathing options.

On 6/13/18, at 7:51 a.m. R33 walked out of his bedroom with a walker, and stated he was still not sleeping. An strong body odor came from the room into the hallway.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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On 6/13/18, at 7:52 a.m. human services technician (HST)-F stated she tried to get R10 to shower or wash up every day, and set out clean clothes for him. HST-F stated the facility has tried different interventions. HST-F stated the nurse told her R33 disliked his roommate. HST-F stated she has told R33 to report his concerns to social services. HST-F stated she feels R33 is also a vulnerable adult. HST-F stated she reported R33's concerns to the nurse, as she was directed.

On 6/13/18, at 2:10 p.m. social worker (SW)-A was interviewed and stated residents have not filed a grievance regarding R10's odor, and there was no official grievance form for R33's concerns. SW-A stated the facility has offered R33 a different room, but he did not want a different room. SW-A stated he has spoken with R10 about his odor and told R10 about visitor's concerns regarding his odors. SW-A stated the facility has tried providing different shower and clothing options for R10. SW-A stated it was very much a team effort.

On 6/13/18, at 2:26 p.m. SW-B stated she has explained to R33 that R10 has rights, and R33 had not wanted to file a grievance. SW-A stated R10's odors have been brought up by other residents, and she reviewed the resident's rights with these residents. SW-B stated they continue to try different options for R10. SW-A stated they are trying to provide some guidelines for R10, while allowing him to be independent as much as possible.

On 6/14/18, at 9:09 a.m. outside of R33 and R10's room, a strong body odor was noted into

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the hallway.

On 6/14/18, at 9:21 a.m. R33 stated his roommate needs to take a shower stating, "It is annoying." R33 stated he gets enough sleep. R33 stated he did not remember being offered a different room, but wanted to stay in the room he is in, and wanted a different roommate. R33 stated he was sure others complained about R10's odors also. R33 stated the staff give R10 clean clothes, but he won't change. R33 stated he had talked to one of the employees, and he was told R10 had rights. R33 stated he feels his rights are infringed upon when R10 doesn't take a shower. R33 stated everyone had been patient with R10, and the nurses leave clothes out for R10, but he won't take their suggestions.

On 6/14/18, at 9:35 a.m. registered nurse (RN)-C stated they have tried a lot of things to manage R10's body odors. RN-C stated R10 bathes yearly and R33, along with other residents in the area have complained. RN-C stated she wonders about R33's rights and other resident's rights. RN-C stated they had not tried things like air fresheners/neutralizers, and was not sure if a private room for R10 had been offered.

On 6/14/18, at 4:08 p.m. the director of nursing (DON) stated they listen to a resident express a grievance, think about how they would resolve it, and document on a grievance form. The DON stated if a resident just wants to talk, they just talk, and do not do a formal grievance. The DON stated they had tried supplying R10 with bath wipes, offering a private shower, and other interventions. The DON stated they have offered R33 a room change. The DON stated they advocate for both residents' rights. The DON

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F 585	Continued From page 8 verified she had not filled out a tracking log for informal grievances. On 6/14/18, at 1:52 p.m. SW-A stated he did not know if a room deodorizer/neutralizer had been tried. SW-A stated private rooms were used for medical needs. SW-A acknowledged other residents' rights are being infringed upon, and stated R33 was in the SW office every day talking about his concerns with R10. On 6/14/18, at 3:00 p.m. SW-A stated he had ordered a room deodorizer, after asking R33 about it. SW-A stated they have not tracked informal resident concerns, so was unable to look at what the facility had done to address resident's concerns regarding R10's odors. SW-A stated they do not have many formal grievances. Review of grievance logs from 1/18, through the current date, indicated there had been only one formal grievance, and it was not R33's grievance with R10. The facility policy Resident Grievances dated 2/17, directed residents are encouraged to make their concerns and recommendations known, may file a verbal or written concern or grievance with any staff member, and every effort should be made to address verbal complaints. The policy directed the designated staff to report the resolution to the resident who originated the concern within three working days of the concern, and within seven working days for a grievance.	F 585		
F 609 SS=E	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility	F 609		7/6/18

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F 609	Continued From page 9 must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure incidents of alleged resident to resident abuse had been reported to the administrator and the State Agency (SA) for 9 of 10 residents (R27, R281, R79, R16, R44, R6, R2, R26, and R55) who resided on the memory care units and had been involved in resident to resident altercations with R27. Findings include:	F 609	Facility Citation actions: 1. The facility will continue with the current process of compiling internal incidents along with current action plans for safe care. 2. On 6/22/18 the DON provided education to nurses regarding external reporting of resident to resident altercations to include reporting of all negative resident to resident physical contact and verbal arguments. Prevention Plan:	

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F 609	Continued From page 10 R27's quarterly Minimum Data Set (MDS) dated 4/4/18, indicated R27 had severe cognitive impairment, and had diagnosis including vascular dementia with behaviors, major depressive disorder and visual hallucinations. The MDS also indicated R27 had the ability to ambulate without assistance, and displayed verbal and physical aggressive behaviors on one to three days during the assessment period. R27's behavioral Care Area Assessment (CAA) dated 1/2/18, indicated R27 had a history of being verbally and physically aggressive towards others. The CAA indicated R27 displayed disorganized thinking that fluctuated. R27's Vulnerabiltiy Assessment dated 4/4/18, indicated R27 had a history of verbal and physical aggressive behaviors towards others. The assessment indicated R27 was at risk for abuse from others due to difficulty findings words, confusion, and disorientation that made him unable to report abuse. The plan directed the staff to prove a save environment for R27. R27's Care Plan provided on 6/14/18, indicated R27 displayed depressive statements, visual hallucinations due to Alzheimer's Disease, and vascular dementia. The plan directed staff to offer behavioral interventions such as gardening, snacks, listening to stories or books, movies, redirect to tasks or activities when agitated, or pet therapy. The plan directed the staff monitor and intervene when R27 displayed behaviors. Review of R27's incident reports from 1/1/18, through 6/14/18, on 6/14/18 at 8:20 a.m. with the director of nurses (DON) and registered nurse (RN)-A revealed the following information:	F 609	1. Additional education will be provided to all employees regarding reporting of resident to resident altercations on 6/27/18 and 7/5/18. Monitoring : 1. All resident to resident physical contact and verbal arguments will be montiored by Licensed Nurses to assure prompt filing to OHFC. 2. Nurses will continue to review Shift charting for behavioral documentation and report concerns as appropriate. Monitoring: 1. Supervisors or Designee will audit incidents for proper reporting. Monitoring will be followed in QAPI as follows: 1. Weekly audits x 3 months until 100% compliant. 2. Then monthly x 3 months until 100% compliant. 3. Then quarterly x 6 months until 100% compliant	

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1. On 1/19/18, at 5:25 p.m. R27 grabbed R281's right forearm and squeezed it. R27 would not let go of R281's arm, and staff members had to remove R27's hand off of R281. Neither resident sustained injury. RN-A stated the incident did not have to be reported to the administrator of the SA as the altercations did not result in injury. RN-A added R27 was not that strong so he was unable to "Cause harm" to others.

2. On 1/21/18, at 6:59 p.m. R27 was found in R79's room. R79 had R27 pushed up against a closet door and proceeded to "Punch (R27) in the stomach." Staff separated the residents, and no physical injury was noted. RN-A stated she had investigated the incident on 1/22/18, and determined the direct care staff had not witnessed a punch between the two residents therefore, the incident was not reportable. RN-A stated staff members were provided education regarding appropriate and accurate documentation.

3. On 1/30/18, at 5:48 p.m. R281 reached across the dining room table to remove an item from R27's plate. R27 became agitated, and the two residents began yelling at each other. They stood up and R27 grabbed and pinched R281's arm and grabbed onto R281's shirt, and would not let go. Staff members intervened to separate the residents and redirect them. RN-A stated the incident did not cause physical harm, so the incident was not reportable.

4. On 2/2/18 at 5:10 p.m. R27 was observed ambulating towards R16. When the two resident's paths crossed, R16 "Lunged" his walker towards R27, "Took a few swings at [R27]"

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and made contact. No injury was noted. RN-A stated R27 was not injured as a result of the incident, therefore it was not reportable. On 2/5/18, the interdisciplinary team reviewed the incident, contacted R27's physican for possible pain medication changes, and the psychologist was updated.

5. On 2/9/18, at 7:00 p.m. R27 entered R44's room while he was in the bathroom brushing his teeth. R27 argued briefly with R44, then struck R44 several times in the back of his arm and chest. Neither resident sustained injury or distress as a result of the altercations. RN-A stated no injury was noted therefore, the incident was not reportable. A "STOP" sign was added to R44's door to deter wandering residents from entering R44's room.

6. On 2/17/18, at 10:00 p.m. R16 was walking through the neighborhood living room when he crossed paths with R27. R16 had a verbal altercation with a staff member and threw his walker at R27. The walker hit R27's arm. R16 and R27 then became verbally aggressive towards each other. R27 grabbed R16's walker, and a staff member had to pry R27's hands off of R16's walker. RN-A stated the altercation was not reportable as no injury was sustained as a result of the altercation.

7. On 4/21/18, at 8:01 p.m. R27 approached R16 who was seated in a recliner in the neighborhood living room. R27 attempted to get R16's attention by tapping him on the chest. R16 responded by swinging his arms and kicking at R27 . R27 was struck "More than once in his upper leg area." RN-A stated the altercation did not result in injury, therefore it was not reportable.

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8. On 4/28/18, at 8:49 p.m. R27 was packing in the neighborhood living room. R27 was holding a handled cup as he approached R6. R27's cup got entangled in R6's shirt and R27 was unable to get it out. R6 grabbed R27's wrist and would not let go. Staff members had to separate R27 and R6. No injury was sustained. RN-A stated the altercation did not result in injury, therefore it was not reportable. The DON stated R27 had been temporarily moved off of the Birch neighborhood during a construction project. After this occurred, R27 was transferred back to the Birch neighborhood.

9. On 5/12/18, at 7:18 p.m. R2 grabbed R27's wrist while he was sitting in the living room. Staff members had to redirect R2 away from R27. R27 was not injured. RN-A stated the altercation did not result in injury, therefore it was not reportable.

10. On 5/22/18, at 6:25 p.m. R27 approached R26 while R26 was seated in a wheelchair. R27 began yelling at R26 and "Put his hands in R26's face, and grabbed his lift wrist." Direct care staff redirected R27 away from R26. No injury was noted. RN-A stated the altercation did not result in injury, therefore it was not reportable.

On 6/14/18, at 9:28 a.m. RN-A stated the aforementioned incidents did not result in physical injury or mental anguish, therefore, none of the incidents were required to be reported to the facility administrator of the State Agency.

On 6/14/18, at 9:30 a.m. the DON stated R27 suffered from severe dementia, therefore, his actions could not be considered willful. The DON

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F 609	Continued From page 14 stated the altercations did not result in injury or mental anguish, therefore, they were not required to be reported to the State Agency. Upon further discussion, the DON confirmed residents who suffered from dementia did have the ability to make willful actions therefore, the identified incidents should have been reported to the administrator and the SA as directed by the facility policy. The facility Vulnerable Adult/Resident Protection Plan policy dated 2/23/17, directed staff to report allegations of abuse in accordance to the federal and state laws. The policy further directed abuse allegations are reported immediately. The policy defined willful abuse as the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. The policy further directed staff to report the allegations immediately to their supervisor, facility administrator, and other individuals in accordance to the State and Federal law.	F 609		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess suicidal/homicidal ideations, and failed to direct staff on how to handle these ideations for 1 of 1 residents (R75) who expressed thoughts of being better off dead, as well as thoughts of hurting himself and others.	F 745	Facility Citation Action: 1. Resident (R75) care plan was updated to include additional interventions for how to respond to any future suicidal statements. Prevention Plan: 1. Re-education for all staff will be	7/6/18

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F 745	Continued From page 15 Findings include: R75's Admission Sheet dated 5/19/17, indicated R75 had diagnoses that included dementia with behavioral disturbance, psychotic disorder with hallucinations, major depressive disorder, agoraphobia (a type of anxiety disorder in which a person fears and avoid places or situations that might cause them to panic and make them feel trapped, helpless or embarrassed) with panic disorder, anxiety disorder, post-traumatic stress disorder, a sleep behavior disorder, as well as visual hallucinations. R75's quarterly Minimum Data Set (MDS) dated 5/23/18, indicated R75 had moderate cognitive impairment, felt down, depressed, or hopeless nearly every day of the assessment period, had thoughts of being better off dead, or thoughts of hurting himself in some way several of the days of the assessment period. The MDS further identified R75 required extensive assistance with most activities of daily living (ADLs). R75's Care Area Assessment (CAA) note dated 12/4/17, indicated R75 had mild signs/symptoms of depression. The CAA also indicated R75 had thoughts that he would be better off dead, or harming himself 2-6 days during the review period. When reassessed 3/6/18, R75 triggered for moderate/severe signs and symptoms of depression. The plan was for R75 to have indicators of depression, anxiety, or sad mood less than daily. Social services was to follow as needed. R75 was being followed by psychiatry and physician. R75's Self Preservation Assessment dated	F 745	provided on 7/5/18 in regards to facility policy; Resident Danger to Self and/or Others. 2. If a resident has homicidal thoughts, suicidal thoughts, and/or attempts to harm self staff will determine and implement resident safety intervention needs. 3. All resident's care plan have been reviewed an enhanced as noted above as appropriate. Monitoring Plan: 1. Nurses will continue to review Shift charting for behavioral documentation and verify assessments and care planning needs have been addressed as appropriate. Monitoring will be followed in QAPI as follows: 1. Weekly audits x 3 months until 100% compliant. 2. Then monthly x 3 months until 100% compliant. 3. Then quarterly x 6 months until 100% compliant	

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5/23/18, included R75 was feeling down, depressed, or hopeless 12-14 days of 14 days, and thoughts that he would be better off dead, or of hurting self in some way 2-6 days of 14 days. The summary included R75 was at risk for abuse, but failed to address thoughts of being better off dead, or hurting himself.

R75's care plan dated 5/31/18, included the problem, "I am having difficulty adjusting to my environment." Staff were instructed to encourage R75 to participate in conversation with staff and other residents daily. R75's care plan also included antidepressant medication, and antipsychotic medication as ordered by the physician. Interventions included alerting the doctor if antidepressant was ineffective, and to monitor for side effects. Non-medication interventions included assuring R75 he was safe, visiting, assisting to make a phone call, validating feelings, listening to music or books on tape, reporting depressive symptoms to medical providers, offering tea, essential oils, and snacks, as well as ways to interact with resident. The care plan for hallucinations included a goal of not harming himself or others, and directed staff to offer time to reflect and share about experiences, and ways to interact with R75. The care plan for depression included interventions of taking prescribed medications, monitoring for side effects, notifying provider with concerns, and referral to behavioral services as needed. The care plan failed to direct staff on what to do if R75 has suicidal or homicidal ideations.

On 6/12/18, at 8:52 a.m. R75 was interviewed and stated he had a lot of bad dreams and some hallucinations that bothered him, and he was here to die, and frequently thought about dying. When

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observed on 6/2/18, at 9:30 a.m. R75 had gotten up out of bed on his own, and had tipped his wheel chair over. R75 ambulated on his own out to the day room, and asked for direction back to his room.

On 6/14/18, at 12:22 p.m. nursing assistant (NA)-E was interviewed, and stated she had heard R75 make hopeless statements such as, "I won't be here long," and "I don't want to be here." NA-E stated she would be to try to determine if R75 was mentally present or not; if he was hallucinating. If he was hallucinating, NA-E stated you,"Can't get him to come back, he's gone. There is no redirection." If R75 was hallucinating, NA-E stated she would keep him safe. If R75 was not hallucinating and mentally present, NA-E stated she would ask him why he made statements like that, and tell him they love him, and don't want him to hurt anyone. NA-E stated she would let the nurse know about the suicidal or homicidal thoughts. NA-E or the nurse would alert the facility charge person if the threats were serious enough, and then it would be determined whether R75 needed to be put on a watch, with observations every 10 minutes, every 5 minutes, or whatever the facility charge person determined. NA-E stated she would alert other NA's by pulling them aside, and telling them to keep an eye on R75 because he was having bad thoughts.

On 6/14/18, at 2:08 p.m. licensed practical nurse (LPN)-B stated she had written a progress note regarding R75 dated 6/12/18, which included, "HST Alert: depressive statements: Res stated that I (sik) he wished that he wouldn't have got rid of his gun because he would use it on a few people and that (sik) him self. Res was easily

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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redirected away from that conversation." LPN-B stated this documentation was flagged in the chart so that all nurses on duty would receive the information and be aware of the suicidal/homicidal ideation. LPN-B stated she was not concerned that R75 was seriously considering suicide or that he had the means to carry through with suicide or homicide. LPN-B stated R75 occasionally made suicidal statements, but was easily redirected. LPN-B had not followed the facility policy which indicated staff would perform an assessment to determine risk of suicide or homicide, because he was so easily redirected and had dementia. LPN-B stated if she had felt R75 was unsafe, she would have stayed with him and contacted his psychiatrist. LPN-B stated she did not know if R75's care plan directed exactly what to do if he made suicidal/homicidal statements, or when to redirect him versus assess him for suicide plan or potential.

On 6/14/18, at 12:47 p.m. registered nurse (RN)-C stated when a resident voices suicidal ideation (SI) or homicidal ideation (HI), the staff was to ensure resident safety immediately. Then staff are to notify the nurse for further discussion. RN-C stated a staff member would, "Talk it out" with the resident to see if the resident had a plan, and update the psychiatrist and medical staff in case the situation escalated. If the resident could not be left alone, a staff member could press their alarm to call other staff to the site of the emergency. Once safety had been established, staff would update supervisors, social services, and psychiatry. If the emergency continued, staff would call 911. RN-C further stated if SI/HI became a target behavior for a resident, the resident's care plan would be updated to monitor

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	245628	A. BUILDING _____ B. WING _____	06/14/2018

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the behavior all of the time, and non-medication interventions, such as checks, would be part of the care plan. RN-C stated staff would make sure recreation staff and life enrichment coaches were aware of the interventions so they could also provide support. RN-C continued to state there would be a team meeting, the interdisciplinary team (IDT) would assess the incident. RN-C reviewed an incident in R75's progress notes from 6/12/18, which indicated R75 stated he wished he had a gun to take out others and them himself. RN-C stated she had no idea this had occurred. RN-C stated it appeared a staff member heard the comments, and an LPN wrote the incident into the chart, but the person in charge was not notified and should have been. RN-C stated R75 had been thriving on the special care unit, he was sometimes impulsive, but now was much better, more quickly. RN-C verified R75's care plan lacked any direction to staff on how to approach R75 if he made suicidal or homicidal statements.

On 6/14/18, at 1:21 p.m. the assistant director of nursing (ADON) was interviewed and was asked if there was anything about SI/HI on R75's care plan. The ADON stated there was a significant change MDS document completed for R75, and plans were written onto the sheet of care instructions that were left in his closet. The ADON stated staff can ask R75 if he is playing games, or if what he is talking about really exists. Staff could also reassure him. Regarding the 6/12/18, incident when R75 was talking about using a gun to shoot peers and himself, the ADON stated the incident did not get to R75's care plan because staff were able to redirect him. When asked if it would be appropriate for staff to ask if there was a plan for coping with R75's SI/HI verbalizations,

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the ADON stated the NAs would redirect R75 or hand the situation off to a supervisor. With the 6/12/18, incident, the NA did hand off the information to the LPN. Since there were no further behaviors, staff may have just not reported it further. If the behaviors continued, the ADON continued, staff would know to report further, as they always reported behaviors. Then staff have the ability to put custom alerts on the resident. When asked if she was comfortable with the care plan not having specific interventions identified for when R75 has SI/HI, the ADON answered if one would see staff redirecting or reorienting R75, one would see that staff were doing a good job with him. The ADON asserted the life enrichment coaches spend a lot of time with R75, and he is doing well with the extra attention he receives on his unit. The ADON stated residents with behaviors get extra attention. The ADON also noted staff report behaviors to the psychiatrist.

R75's psychiatry notes from January to May 2018, failed to identify any suicidal or homicidal ideation.

On 6/14/18, at 1:56 p.m. RN-B (a staff member responsible for updating the MDS, was asked why R75 had nothing on his care plan regarding SI/HI when the CAA of 11/25/17, and the significant change MDS of 2/22/18, indicated regular thoughts of suicide, but the care plan generated did not include any specific interventions or response to try when R75 spoke of SI or HI. RN-B checked the care plan and stated social services completes the mood section of the care plan and was responsible for that part of the care plan.

On 6/14/18, at 2:07 p.m. social worker (SW)-A

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stated redirection was appropriate for R75 when he made suicidal or homicidal statements, but that was not addressed specifically on the care plan to direct staff. SW-A stated he was unsure why the facility policy was not being followed for R75. SW-A stated he would check with the other social worker regarding this. No further response was received from SW-A.

The facility policy Resident Danger to Self and/or Others dated 2018, included a purpose to "Provide guidelines for the implementation of timely, effective and safe assessment, and interventions while providing safety for all individuals within the facility at all times." The policy included guidelines for assessment and intervention of suicidal behavior/harm to self which directed staff to assess the risk by, "a. Provide for privacy; either take the resident to a private place or remove all other residents from the area. b. Interview the resident to determine his or her intentions: i. Is the resident thinking about hurting him/herself? ii. Does he/she have a plan (i.e. time, place and opportunity, method selected and is the method readily available)? iii. What are, if any, the precipitating factors (i.e. recent losses/increased stresses/depression/difficulty with adaptation to life changes)? iv. Has the resident made any preparations for his/her death (i.e. suicide note, giving away possessions, making final arrangements)? v. Any presence of hallucinations (auditory or visual) encouraging suicidal or harm to self? The policy further directed the care plan and medical record was to be reviewed and the DON was to be notified. This would be followed by a debriefing session.

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K 000	INITIAL COMMENTS FIRE SAFETY 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 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. Minnesota Veterans Home-Silver Bay is a one story building, partial basement original year of construction 1960's, and it was converted into a nursing home in the early 1990's. The original building and additions are all Type II(111) construction. The building is fully sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 83 beds and had a census of 80 the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is MET.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed

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.

Electronically delivered
June 26, 2018

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

Re: State Nursing Home Licensing Orders - Project Number S5628003

Dear Ms. Gilbertson:

The above facility was surveyed on June 11, 2018 through June 14, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order 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 Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement 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 immediately contact Teresa Ament, Unit Supervisor at (218) 302-6151 or teresa.ament@state.mn.us.

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.

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@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
	00381	A. BUILDING: _____ B. WING _____	06/14/2018

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: 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	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. 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. On 6/11/18, through 6/14/18, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
21495	MN Rule 4658.1005 Subp. 5 Social Services; Providing Social Services Subp. 5. Providing social services. Social services must be provided on the basis of identified social service needs of each resident, according to the comprehensive resident assessment and comprehensive plan of care described in parts 4658.0400 and 4658.0405. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess suicidal/homicidal ideations, and failed to direct staff on how to handle these ideations for 1 of 1 residents (R75) who expressed thoughts of being better off dead, as well as thoughts of hurting himself and others. Findings include: R75's Admission Sheet dated 5/19/17, indicated R75 had diagnoses that included dementia with behavioral disturbance, psychotic disorder with hallucinations, major depressive disorder, agoraphobia (a type of anxiety disorder in which a person fears and avoid places or situations that might cause them to panic and make them feel trapped, helpless or embarrassed) with panic disorder, anxiety disorder, post-traumatic stress disorder, a sleep behavior disorder, as well as visual hallucinations.	21495	Corrected	7/6/18

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R75's quarterly Minimum Data Set (MDS) dated 5/23/18, indicated R75 had moderate cognitive impairment, felt down, depressed, or hopeless nearly every day of the assessment period, had thoughts of being better off dead, or thoughts of hurting himself in some way several of the days of the assessment period. The MDS further identified R75 required extensive assistance with most activities of daily living (ADLs).

R75's Care Area Assessment (CAA) note dated 12/4/17, indicated R75 had mild signs/symptoms of depression. The CAA also indicated R75 had thoughts that he would be better off dead, or harming himself 2-6 days during the review period. When reassessed 3/6/18, R75 triggered for moderate/severe signs and symptoms of depression. The plan was for R75 to have indicators of depression, anxiety, or sad mood less than daily. Social services was to follow as needed. R75 was being followed by psychiatry and physician.

R75's Self Preservation Assessment dated 5/23/18, included R75 was feeling down, depressed, or hopeless 12-14 days of 14 days, and thoughts that he would be better off dead, or of hurting self in some way 2-6 days of 14 days. The summary included R75 was at risk for abuse, but failed to address thoughts of being better off dead, or hurting himself.

R75's care plan dated 5/31/18, included the problem, "I am having difficulty adjusting to my environment." Staff were instructed to encourage R75 to participate in conversation with staff and other residents daily. R75's care plan also included antidepressant medication, and antipsychotic medication as ordered by the

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physician. Interventions included alerting the doctor if antidepressant was ineffective, and to monitor for side effects. Non-medication interventions included assuring R75 he was safe, visiting, assisting to make a phone call, validating feelings, listening to music or books on tape, reporting depressive symptoms to medical providers, offering tea, essential oils, and snacks, as well as ways to interact with resident. The care plan for hallucinations included a goal of not harming himself or others, and directed staff to offer time to reflect and share about experiences, and ways to interact with R75. The care plan for depression included interventions of taking prescribed medications, monitoring for side effects, notifying provider with concerns, and referral to behavioral services as needed. The care plan failed to direct staff on what to do if R75 has suicidal or homicidal ideations.

On 6/12/18, at 8:52 a.m. R75 was interviewed and stated he had a lot of bad dreams and some hallucinations that bothered him, and he was here to die, and frequently thought about dying. When observed on 6/2/18, at 9:30 a.m. R75 had gotten up out of bed on his own, and had tipped his wheel chair over. R75 ambulated on his own out to the day room, and asked for direction back to his room.

On 6/14/18, at 12:22 p.m. nursing assistant (NA)-E was interviewed, and stated she had heard R75 make hopeless statements such as, "I won't be here long," and "I don't want to be here." NA-E stated she would be to try to determine if R75 was mentally present or not; if he was hallucinating. If he was hallucinating, NA-E stated you,"Can't get him to come back, he's gone. There is no redirection." If R75 was hallucinating, NA-E stated she would keep him

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safe. If R75 was not hallucinating and mentally present, NA-E stated she would ask him why he made statements like that, and tell him they love him, and don't want him to hurt anyone. NA-E stated she would let the nurse know about the suicidal or homicidal thoughts. NA-E or the nurse would alert the facility charge person if the threats were serious enough, and then it would be determined whether R75 needed to be put on a watch, with observations every 10 minutes, every 5 minutes, or whatever the facility charge person determined. NA-E stated she would alert other NA's by pulling them aside, and telling them to keep an eye on R75 because he was having bad thoughts.

On 6/14/18, at 2:08 p.m. licensed practical nurse (LPN)-B stated she had written a progress note regarding R75 dated 6/12/18, which included, "HST Alert: depressive statements: Res stated that I (sik) he wished that he wouldn't have got rid of his gun because he would use it on a few people and that (sik) him self. Res was easily redirected away from that conversation." LPN-B stated this documentation was flagged in the chart so that all nurses on duty would receive the information and be aware of the suicidal/homicidal ideation. LPN-B stated she was not concerned that R75 was seriously considering suicide or that he had the means to carry through with suicide or homicide. LPN-B stated R75 occasionally made suicidal statements, but was easily redirected. LPN-B had not followed the facility policy which indicated staff would perform an assessment to determine risk of suicide or homicide, because he was so easily redirected and had dementia. LPN-B stated if she had felt R75 was unsafe, she would have stayed with him and contacted his psychiatrist. LPN-B stated she did not know if

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21495	Continued From page 6 R75's care plan directed exactly what to do if he made suicidal/homicidal statements, or when to redirect him versus assess him for suicide plan or potential. On 6/14/18, at 12:47 p.m. registered nurse (RN)-C stated when a resident voices suicidal ideation (SI) or homicidal ideation (HI), the staff was to ensure resident safety immediately. Then staff are to notify the nurse for further discussion. RN-C stated a staff member would, "Talk it out" with the resident to see if the resident had a plan, and update the psychiatrist and medical staff in case the situation escalated. If the resident could not be left alone, a staff member could press their alarm to call other staff to the site of the emergency. Once safety had been established, staff would update supervisors, social services, and psychiatry. If the emergency continued, staff would call 911. RN-C further stated if SI/HI became a target behavior for a resident, the resident's care plan would be updated to monitor the behavior all of the time, and non-medication interventions, such as checks, would be part of the care plan. RN-C stated staff would make sure recreation staff and life enrichment coaches were aware of the interventions so they could also provide support. RN-C continued to state there would be a team meeting, the interdisciplinary team (IDT) would assess the incident. RN-C reviewed an incident in R75's progress notes from 6/12/18, which indicated R75 stated he wished he had a gun to take out others and them himself. RN-C stated she had no idea this had occurred. RN-C stated it appeared a staff member heard the comments, and an LPN wrote the incident into the chart, but the person in charge was not notified and should have been. RN-C stated R75 had been thriving on the special care unit, he was sometimes impulsive, but now	21495		

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21495	Continued From page 7	21495		

was much better, more quickly. RN-C verified R75's care plan lacked any direction to staff on how to approach R75 if he made suicidal or homicidal statements.

On 6/14/18, at 1:21 p.m. the assistant director of nursing (ADON) was interviewed and was asked if there was anything about SI/HI on R75's care plan. The ADON stated there was a significant change MDS document completed for R75, and plans were written onto the sheet of care instructions that were left in his closet. The ADON stated staff can ask R75 if he is playing games, or if what he is talking about really exists. Staff could also reassure him. Regarding the 6/12/18, incident when R75 was talking about using a gun to shoot peers and himself, the ADON stated the incident did not get to R75's care plan because staff were able to redirect him. When asked if it would be appropriate for staff to ask if there was a plan for coping with R75's SI/HI verbalizations, the ADON stated the NAs would redirect R75 or hand the situation off to a supervisor. With the 6/12/18, incident, the NA did hand off the information to the LPN. Since there were no further behaviors, staff may have just not reported it further. If the behaviors continued, the ADON continued, staff would know to report further, as they always reported behaviors. Then staff have the ability to put custom alerts on the resident. When asked if she was comfortable with the care plan not having specific interventions identified for when R75 has SI/HI, the ADON answered if one would see staff redirecting or reorienting R75, one would see that staff were doing a good job with him. The ADON asserted the life enrichment coaches spend a lot of time with R75, and he is doing well with the extra attention he receives on his unit. The ADON stated residents with behaviors get extra attention. The ADON also

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21495	Continued From page 8 noted staff report behaviors to the psychiatrist. R75's psychiatry notes from January to May 2018, failed to identify any suicidal or homicidal ideation. On 6/14/18, at 1:56 p.m. RN-B (a staff member responsible for updating the MDS, was asked why R75 had nothing on his care plan regarding SI/HI when the CAA of 11/25/17, and the significant change MDS of 2/22/18, indicated regular thoughts of suicide, but the care plan generated did not include any specific interventions or response to try when R75 spoke of SI or HI. RN-B checked the care plan and stated social services completes the mood section of the care plan and was responsible for that part of the care plan. On 6/14/18, at 2:07 p.m. social worker (SW)-A stated redirection was appropriate for R75 when he made suicidal or homicidal statements, but that was not addressed specifically on the care plan to direct staff. SW-A stated he was unsure why the facility policy was not being followed for R75. SW-A stated he would check with the other social worker regarding this. No further response was received from SW-A. The facility policy Resident Danger to Self and/or Others dated 2018, included a purpose to "Provide guidelines for the implementation of timely, effective and safe assessment, and interventions while providing safety for all individuals within the facility at all times." The policy included guidelines for assessment and intervention of suicidal behavior/harm to self which directed staff to assess the risk by, "a. Provide for privacy; either take the resident to a private place or remove all other residents from	21495		

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21495	Continued From page 9 the area. b. Interview the resident to determine his or her intentions: i. Is the resident thinking about hurting him/herself? ii. Does he/she have a plan (i.e. time, place and opportunity, method selected and is the method readily available)? iii. What are, if any, the precipitating factors (i.e. recent losses/increased stresses/depression/difficulty with adaptation to life changes)? iv. Has the resident made any preparations for his/her death (i.e. suicide note, giving away possessions, making final arrangements)? v. Any presence of hallucinations (auditory or visual) encouraging suicidal or harm to self? The policy further directed the care plan and medical record was to be reviewed and the DON was to be notified. This would be followed by a debriefing session. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could review and/or revise policies and procedures to ensure residents are properly cared for if they have suicidal or homicidal ideations. The DON or designee could educate the appropriate staff on the policies/procedures. The DON or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21495		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout	21880		7/6/18

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21880	Continued From page 10 their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure.	21880		

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21880	Continued From page 11 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure grievances were sufficiently acted upon for 1 of 2 residents (R33) reviewed for grievances. Findings include: On 6/11/18, at 2:39 p.m. R10 was observed sitting at a dining room window eating lunch. Strong body odors were noted coming from R10 that could be smelled into the connecting lounge area. On 6/12/18, at 11:15 a.m. during the resident council meeting, R33 stated he was unhappy with his roommate's (R10) personal body odor. R33 stated he did not like to be around R10 because of the pervasive body order, and none of the staff could get R10 to take a bath. R33 stated all of the staff were aware of R10's body odor, and nothing had been done about it. R33's Admission Record printed 6/14/18, indicated R33's diagnoses included major depressive disorder and paranoid schizophrenia. R33's quarterly Minimum Data Set (MDS) dated 4/18/18, indicated R33 was cognitively intact, had mild depressive symptoms, and displayed no behaviors. R33's undated care plan printed 6/14/18, indicated R33 had the potential for behavioral symptoms and had minimal symptoms of depression. R33's care plan directed staff to encourage R33 to express feelings, allow him	21880	Corrected	

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time to talk when he initiated conversation, and offer to sit with him when he was feeling anxious and paranoid. R33's target behaviors included irritability, and use of negative language toward others.

R10's admission record printed 6/14/18, indicated R10's diagnoses included paranoid schizophrenia, vascular dementia with behavioral disturbance, and a mental disorder due to known physiological condition.

R10's annual MDS dated 3/16/18, indicated R10 was independent with cognitive skills for daily decision making, and had no signs or symptoms of depression, no psychosis, and no rejection of care. R10's MDS indicated he was independent with activities of daily living, preferred sponge baths and did not bathe during the assessment period.

R10's care plan initiated 6/13/18, directed staff to record occurrences of paranoia. R10's care plan indicated R10 required one assist to supervise and set up for bathing or showering, but R10 often declined weekly bathing or showers, and preferred to wash himself at the skink with personal hygiene wipes.

R33's progress notes dated 3/28/18, indicated R33 had reported to a nurse that he had concerns about the difficulty he had being around his roommate. R33 stated, "He [R10] really needs a bath. It's getting so I can hardly barely stand to be in my room. It makes it hard to live here." The nurse documented that his concerns would be passed along.

R33's medical services progress notes dated 6/5/18, indicated R33 expressed concern

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21880	Continued From page 13 regarding his roommate's poor hygiene. R10's progress notes dated 6/5/18, indicated R10 was offered a bath weekly and as necessary, was provided cleansing cloths and encouraged to use them, continued to refuse to bathe, and would be continued to be encouraged to bathe. R10's progress note dated 6/1/18, indicated R10 frequently refused bathing, was provided with wipes, and skin would be examined as he allowed. R10's progress note dated 5/15/18, indicated R10 had not bathed in past 7 days, and refused bathing and was approached by 2 different staff. R10's progress notes from 4/18/18, through 6/14/18, indicated R10 continuously refused a bath. R10's Medical Services progress note by the nurse practitioner (NP) dated 4/25/18, indicated R10 was disheveled, had ripped clothing, had long dirty hair, and continued to refuse bathing, though staff were trying to provide different bathing options. On 6/13/18, at 7:51 a.m. R33 walked out of his bedroom with a walker, and stated he was still not sleeping. An strong body odor came from the room into the hallway. On 6/13/18, at 7:52 a.m. human services technician (HST)-F stated she tried to get R10 to shower or wash up every day, and set out clean clothes for him. HST-F stated the facility has tried different interventions. HST-F stated the nurse told her R33 disliked his roommate. HST-F stated she has told R33 to report his concerns to social	21880		

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services. HST-F stated she feels R33 is also a vulnerable adult. HST-F stated she reported R33's concerns to the nurse, as she was directed.

On 6/13/18, at 2:10 p.m. social worker (SW)-A was interviewed and stated residents have not filed a grievance regarding R10's odor, and there was no official grievance form for R33's concerns. SW-A stated the facility has offered R33 a different room, but he did not want a different room. SW-A stated he has spoken with R10 about his odor and told R10 about visitor's concerns regarding his odors. SW-A stated the facility has tried providing different shower and clothing options for R10. SW-A stated it was very much a team effort.

On 6/13/18, at 2:26 p.m. SW-B stated she has explained to R33 that R10 has rights, and R33 had not wanted to file a grievance. SW-A stated R10's odors have been brought up by other residents, and she reviewed the resident's rights with these residents. SW-B stated they continue to try different options for R10. SW-A stated they are trying to provide some guidelines for R10, while allowing him to be independent as much as possible.

On 6/14/18, at 9:09 a.m. outside of R33 and R10's room, a strong body odor was noted into the hallway.

On 6/14/18, at 9:21 a.m. R33 stated his roommate needs to take a shower stating, "It is annoying." R33 stated he gets enough sleep. R33 stated he did not remember being offered a different room, but wanted to stay in the room he is in, and wanted a different roommate. R33 stated he was sure others complained about

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21880	Continued From page 15 R10's odors also. R33 stated the staff give R10 clean clothes, but he won't change. R33 stated he had talked to one of the employees, and he was told R10 had rights. R33 stated he feels his rights are infringed upon when R10 doesn't take a shower. R33 stated everyone had been patient with R10, and the nurses leave clothes out for R10, but he won't take their suggestions. On 6/14/18, at 9:35 a.m. registered nurse (RN)-C stated they have tried a lot of things to manage R10's body odors. RN-C stated R10 bathes yearly and R33, along with other residents in the area have complained. RN-C stated she wonders about R33's rights and other resident's rights. RN-C stated they had not tried things like air fresheners/neutralizers, and was not sure if a private room for R10 had been offered. On 6/14/18, at 4:08 p.m. the director of nursing (DON) stated they listen to a resident express a grievance, think about how they would resolve it, and document on a grievance form. The DON stated if a resident just wants to talk, they just talk, and do not do a formal grievance. The DON stated they had tried supplying R10 with bath wipes, offering a private shower, and other interventions. The DON stated they have offered R33 a room change. The DON stated they advocate for both residents' rights. The DON verified she had not filled out a tracking log for informal grievances. On 6/14/18, at 1:52 p.m. SW-A stated he did not know if a room deodorizer/neutralizer had been tried. SW-A stated private rooms were used for medical needs. SW-A acknowledged other residents' rights are being infringed upon, and stated R33 was in the SW office every day talking about his concerns with R10.	21880		

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21880	Continued From page 16 On 6/14/18, at 3:00 p.m. SW-A stated he had ordered a room deodorizer, after asking R33 about it. SW-A stated they have not tracked informal resident concerns, so was unable to look at what the facility had done to address resident's concerns regarding R10's odors. SW-A stated they do not have many formal grievances. Review of grievance logs from 1/18, through the current date, indicated there had been only one formal grievance, and it was not R33's grievance with R10. The facility policy Resident Grievances dated 2/17, directed residents are encouraged to make their concerns and recommendations known, may file a verbal or written concern or grievance with any staff member, and every effort should be made to address verbal complaints. The policy directed the designated staff to report the resolution to the resident who originated the concern within three working days of the concern, and within seven working days for a grievance. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could review and/or revise policies and procedures to ensure resident grievances, both voiced and in writing, are addressed in a timely and satisfactory manner. The DON or designee could educate the appropriate staff on the policies/procedures. The DON or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21880		

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21995	MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure incidents of alleged resident to resident abuse had been reported to the administrator and the State Agency (SA) for 9 of 10 residents (R27, R281, R79, R16, R44, R6, R2, R26, and R55) who resided on the memory care units and had been involved in resident to resident altercations with R27. Findings include: R27's quarterly Minimum Data Set (MDS) dated 4/4/18, indicated R27 had severe cognitive impairment, and had diagnosis including vascular dementia with behaviors, major depressive disorder and visual hallucinations. The MDS also indicated R27 had the ability to ambulate without assistance, and displayed verbal and physical aggressive behaviors on one to three days during the assessment period. R27's behavioral Care Area Assessment (CAA) dated 1/2/18, indicated R27 had a history of being	21995	Corrected	7/6/18

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verbally and physically aggressive towards others. The CAA indicated R27 displayed disorganized thinking that fluctuated.

R27's Vulnerabiltiy Assessment dated 4/4/18, indicated R27 had a history of verbal and physical aggressive behaviors towards others. The assessment indicated R27 was at risk for abuse from others due to difficulty findings words, confusion, and disorientation that made him unable to report abuse. The plan directed the staff to prove a save environment for R27.

R27's Care Plan provided on 6/14/18, indicated R27 displayed depressive statements, visual hallucinations due to Alzheimer's Disease, and vascular dementia. The plan directed staff to offer behavioral interventions such as gardening, snacks, listening to stories or books, movies, redirect to tasks or activities when agitated, or pet therapy. The plan directed the staff monitor and intervene when R27 displayed behaviors.

Review of R27's incident reports from 1/1/18, through 6/14/18, on 6/14/18 at 8:20 a.m. with the director of nurses (DON) and registered nurse (RN)-A revealed the following information:

1. On 1/19/18, at 5:25 p.m. R27 grabbed R281's right forearm and squeezed it. R27 would not let go of R281's arm, and staff members had to remove R27's hand off of R281. Neither resident sustained injury. RN-A stated the incident did not have to be reported to the administrator of the SA as the altercations did not result in injury. RN-A added R27 was not that strong so he was unable to "Cause harm" to others.

2. On 1/21/18, at 6:59 p.m. R27 was found in R79's room. R79 had R27 pushed up against a

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21995	Continued From page 19	21995		

closet door and proceeded to "Punch (R27) in the stomach." Staff separated the residents, and no physical injury was noted. RN-A stated she had investigated the incident on 1/22/18, and determined the direct care staff had not witnessed a punch between the two residents therefore, the incident was not reportable. RN-A stated staff members were provided education regarding appropriate and accurate documentation.

3. On 1/30/18, at 5:48 p.m. R281 reached across the dining room table to remove an item from R27's plate. R27 became agitated, and the two residents began yelling at each other. They stood up and R27 grabbed and pinched R281's arm and grabbed onto R281's shirt, and would not let go. Staff members intervened to separate the residents and redirect them. RN-A stated the incident did not cause physical harm, so the incident was not reportable.

4. On 2/2/18 at 5:10 p.m. R27 was observed ambulating towards R16. When the two resident's paths crossed, R16 "Lunged" his walker towards R27, "Took a few swings at [R27]" and made contact. No injury was noted. RN-A stated R27 was not injured as a result of the incident, therefore it was not reportable. On 2/5/18, the interdisciplinary team reviewed the incident, contacted R27's physican for possible pain medication changes, and the psychologist was updated.

5. On 2/9/18, at 7:00 p.m. R27 entered R44's room while he was in the bathroom brushing his teeth. R27 argued briefly with R44, then struck R44 several times in the back of his arm and chest. Neither resident sustained injury or distress as a result of the altercations. RN-A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00381	A. BUILDING: _____ B. WING _____	06/14/2018

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MN VETERANS HOME SILVER BAY	56 OUTER DRIVE SILVER BAY, MN 55614

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stated no injury was noted therefore, the incident was not reportable. A "STOP" sign was added to R44's door to deter wandering residents from entering R44's room.

6. On 2/17/18, at 10:00 p.m. R16 was walking through the neighborhood living room when he crossed paths with R27. R16 had a verbal altercation with a staff member and threw his walker at R27. The walker hit R27's arm. R16 and R27 then became verbally aggressive towards each other. R27 grabbed R16's walker, and a staff member had to pry R27's hands off of R16's walker. RN-A stated the altercation was not reportable as no injury was sustained as a result of the altercation.

7. On 4/21/18, at 8:01 p.m. R27 approached R16 who was seated in a recliner in the neighborhood living room. R27 attempted to get R16's attention by tapping him on the chest. R16 responded by swinging his arms and kicking at R27 . R27 was struck "More than once in his upper leg area." RN-A stated the altercation did not result in injury, therefore it was not reportable.

8. On 4/28/18, at 8:49 p.m. R27 was packing in the neighborhood living room. R27 was holding a handled cup as he approached R6. R27's cup got entangled in R6's shirt and R27 was unable to get it out. R6 grabbed R27's wrist and would not let go. Staff members had to separate R27 and R6. No injury was sustained. RN-A stated the altercation did not result in injury, therefore it was not reportable. The DON stated R27 had been temporarily moved off of the Birch neighborhood during a construction project. After this occurred, R27 was transferred back to the Birch neighborhood.

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21995	Continued From page 21	21995		

9. On 5/12/18, at 7:18 p.m. R2 grabbed R27's wrist while he was sitting in the living room. Staff members had to redirect R2 away from R27. R27 was not injured. RN-A stated the altercation did not result in injury, therefore it was not reportable.

10. On 5/22/18, at 6:25 p.m. R27 approached R26 while R26 was seated in a wheelchair. R27 began yelling at R26 and "Put his hands in R26's face, and grabbed his lift wrist." Direct care staff redirected R27 away from R26. No injury was noted. RN-A stated the altercation did not result in injury, therefore it was not reportable.

On 6/14/18, at 9:28 a.m. RN-A stated the aforementioned incidents did not result in physical injury or mental anguish, therefore, none of the incidents were required to be reported to the facility administrator of the State Agency.

On 6/14/18, at 9:30 a.m. the DON stated R27 suffered from severe dementia, therefore, his actions could not be considered willful. The DON stated the altercations did not result in injury or mental anguish, therefore, they were not required to be reported to the State Agency. Upon further discussion, the DON confirmed residents who suffered from dementia did have the ability to make willful actions therefore, the identified incidents should have been reported to the administrator and the SA as directed by the facility policy.

The facility Vulnerable Adult/Resident Protection Plan policy dated 2/23/17, directed staff to report allegations of abuse in accordance to the federal and state laws. The policy further directed abuse allegations are reported immediately. The policy defined willful abuse as the individual must have

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21995	Continued From page 22 acted deliberately, not that the individual must have intended to inflict injury or harm. The policy further directed staff to report the allegations immediately to their supervisor, facility administrator, and other individuals in accordance to the State and Federal law. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could review and/or revise policies and procedures to ensure allegations of abuse are reported to the administrator and the State Agency. The DON or designee could educate the appropriate staff on the policies/procedures. The DON or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21995		