DEPARTMENT	OF	HEALTH	AND	HUMAN	SERV	/ICES
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CENTERS FOR MEDICARE & MEDICAID SERVICES

	ICARE/MEDICAID CERTIFICATION			
PART 1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245628 2.STATE VENDOR OR MEDICAID NO. (L2)	Y I - TO BE COMPLETED BY THE STA 3. NAME AND ADDRESS OF FACILITY (L3) MN VETERANS HOME SILVER BA (L4) 56 OUTER DRIVE (L5) SILVER BAY, MN		Facility ID: 00381 4. TYPE OF ACTION: 2 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint	
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	 On-Site Visit Other Full Survey After Complaint 	
6. DATE OF SURVEY 06/14/2018 (L.34) 8. ACCREDITATION STATUS:	02 SNF/NF/Dual 06 PRTF 10 NF 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IIE 04 SNF 08 OPT/SP 12 RHC	14 CORF 15 ASC 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 	And/Or Approved Waivers Of The 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	
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SN 83		* Code: B * 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L12) (L15)	
(L37) (L38) (L39) 16. STATE SURVEY AGENCY REMARKS (IF APPLICA				
17. SURVEYOR SIGNATURE	Date:	18. STATE SURVEY AGENCY A	PPROVAL Date:	
Kathie Siemsen, HFE NE II	07/17/2018 (L19)	Douglas Larson, Enfo	rcement Specialist 07/30/2018 (L20)	
PART II - TO	BE COMPLETED BY HCFA REGIONA	L OFFICE OR SINGLE STA	ATE AGENCY	
19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participate 2. Facility is not Eligible (L21)	20. COMPLIANCE WITH CIVIL RIGHTS ACT:	 Statement of Finan Ownership/Control Both of the Above : 	Interest Disclosure Stmt (HCFA-1513)	
22. ORIGINAL DATE 23. LTC AGRE	EMENT 24. LTC AGREEMENT	26. TERMINATION ACTION:	(L30)	
OF PARTICIPATION BEGINNII 10/20/2015 (L24) (L41)		VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimbursement	INVOLUNTARY 05-Fail to Meet Health/Safety	
25. LTC EXTENSION DATE: 27. ALTERNA A. Suspen	TIVE SANCTIONS sion of Admissions: (L44) Suspension Date:	03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active	
	(L45)			
28. TERMINATION DATE:	29. INTERMEDIARY/CARRIER NO.	30. REMARKS		
(L28)	06201 (L31)			
31. RO RECEIPT OF CMS-1539	32. DETERMINATION OF APPROVAL DATE	DETERMINATION		
(L32)	(L33)	DETERMINATION APPRO	JVAL	



Protecting, Maintaining and Improving the Health of All Minnesotans

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:

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

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

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

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

Mn Veterans Home Silver Bay June 26, 2018 Page 2

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

Mn Veterans Home Silver Bay June 26, 2018 Page 4

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.

Mn Veterans Home Silver Bay June 26, 2018 Page 5

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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 Mn Veterans Home Silver Bay June 26, 2018 Page 6 Feel free to contact me if you have questions.

Sincerely,

alison Helm

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

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			1		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	-		0	MB NO	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY IPLETED
		245628	B. WING			06/	14/2018
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
	ERANS HOME SILVE	R BAY			OUTER DRIVE ILVER BAY, MN 55614		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 0	00			
F 000	Emergency Prepare conducted on June during a recertificat		F 0'	00			
	survey was comple Minnesota Departm your facility was in o of 42 CFR Part 483	h June 14, 2018, a standard ted at your facility by the nent of Health to determine if compliance with requirements 3, Subpart B, and ong Term Care Facilities.					
	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the	f correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will tion of compliance.					
F 585 SS=D	on-site revisit of you validate that substa regulations has bee your verification. Grievances	acceptable electronic POC, an ur facility may be conducted to intial compliance with the en attained in accordance with)-(4)	F 5	85			7/6/18
	§483.10(j) Grievand §483.10(j)(1) The re grievances to the fa that hears grievance reprisal and without reprisal. Such griev	ces. esident has the right to voice acility or other agency or entity es without discrimination or t fear of discrimination or ances include those with					
	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE 07/05/2018
	nouny orginou						01/00/2010

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.

PRINTED: 07/30/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURV COMPLETE NAME OF PROVIDER OR SUPPLIER 245628 B. WING 06/14/20 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 56 OUTER DRIVE 56 OUTER DRIVE MN VETERANS HOME SILVER BAY SILVER BAY, MN 55614 SILVER BAY, MN 55614 (COMPLETE)			I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	07/30/2018 APPROVED 0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE MN VETERANS HOME SILVER BAY STREET ADDRESS, CITY, STATE, ZIP CODE (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) COME 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. F 585 §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	STATEMENT	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` ´		LE CONSTRUCTION	(X3) DATE	E SURVEY
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) COME 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. F 585 §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			245628	B. WING	·		06/ [.]	14/2018
MN VETERANS HOME SILVER BAY SILVER BAY, MN 55614 Image: Construct of the second sec	NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
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 §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 grievance 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	respect to care and furnished as well as furnished, the beha residents, and othe facility stay. §483.10(j)(2) The re facility must make p resolve grievances accordance with thi §483.10(j)(3) The fa on how to file a grie to the resident. §483.10(j)(4) The fa grievance policy to of all grievances re contained in this pa provider must give to the resident. The include: (i) Notifying resident postings in promine facility of the right to (meaning spoken) of grievances anonym of the grievance off can be filed, that is, address (mailing ar number; a reasonal completing the revit to obtain a written of grievance; and the independent entities be filed, that is, the Quality Improvement	d treatment which has been s that which has not been avior of staff and of other er concerns regarding their LTC resident has the right to and the prompt efforts by the facility to the resident may have, in is paragraph. acility must make information evance or complaint available facility must establish a ensure the prompt resolution garding the residents' rights aragraph. Upon request, the a copy of the grievance policy e grievance policy must at individually or through ent locations throughout the o file grievances orally or in writing; the right to file nously; the contact information ficial with whom a grievance , his or her name, business and email) and business phone able expected time frame for ew of the grievance; the right decision regarding his or her contact information of s with whom grievances may pertinent State agency, ant Organization, State Survey	F	585			

If continuation sheet Page 2 of 22

		AND HUMAN SERVICES				FORM	07/30/2018 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245628	B. WING			06/ [,]	14/2018
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MN VET	ERANS HOME SILVER	R BAY			6 OUTER DRIVE SILVER BAY, MN 55614		
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F 585	program or protecti (ii) Identifying a Grie responsible for over receiving and tracki conclusions; leading by the facility; main information associa example, the identifi grievances submitte written grievance de coordinating with st necessary in light o (iii) As necessary, to prevent further poter right while the alleg investigated; (iv) Consistent with reporting all alleged abuse, including inj and/or misappropria anyone furnishing s provider, to the adm as required by State (v) Ensuring that all include the date the summary of the per regarding the reside as to whether the g confirmed, any corr taken by the facility and the date the wr (vi) Taking appropri accordance with St of the residents' rig or if an outside entit	on and advocacy system; evance Official who is rseeing the grievance process, ing grievances through to their g any necessary investigations taining the confidentiality of all ated with grievances, for ty of the resident for those ed anonymously, issuing ecisions to the resident; and tate and federal agencies as of specific allegations; aking immediate action to ential violations of any resident red violation is being §483.12(c)(1), immediately d violations involving neglect, uries of unknown source, ation of resident property, by services on behalf of the ninistrator of the provider; and	F 5	85			

If continuation sheet Page 3 of 22

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO	. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTR		· · ·	E SURVEY IPLETED
		245628	B. WING			06/	14/2018
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADD	DRESS, CITY, STATE, ZIP C	ODE	
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F 585	Continued From pa	age 3	F 5	35			
	confirms a violation rights within its area (vii) Maintaining ev result of all grievan 3 years from the ist decision. This REQUIREME by: Based on observa review, the facility f were sufficiently ac (R33) reviewed for Findings include: On 6/11/18, at 2:39 sitting at a dining ro Strong body odors that could be smell area. On 6/12/18, at 11:1 council meeting, R his roommate's (R stated he did not lik of the pervasive bo could get R10 to ta staff were aware of had been done abo R33's Admission R indicated R33's dia depressive disorde R33's quarterly Mir	 p.m. R10 was observed bom window eating lunch. were noted coming from R10 ed into the connecting lounge 5 a.m. during the resident 33 stated he was unhappy with 10) personal body odor. R33 ke to be around R10 because dy order, and none of the staff ke a bath. R33 stated all of the R10's body odor, and nothing but it. ecord printed 6/14/18, gnoses included major r and paranoid schizophrenia. 		 R33 and res Resideodor Soci Ombuo Soci Ombuo Soci Ombuo Soci Preven Rese intervie Counci followin grievar obtain letter w re-edu Intervie Intervie Intervie Intervie Signific have a intervie Whet we will grievar Signific have a intervie Whet We will grievar Faci continu The 	y Citation Action: 3 was offered new roo sident declined offer. ident R33 was provid rizer on 6/18/18 ial Services reached dsman for ideas on 8. No new ideas recention Plan: education to be provided ewable residents at the il meeting on 7/11/18 ng 2 meetings, regarn nce procedure and low grievance information vill be mailed the weend cate family. rviewable residents a cant others will be ask iny grievances during was appropriate. en a resident has a very continue to offer them has a process as appro- lity grievance process ue to be followed. facility grievance process the followed. facility grievance process facility facility facility facility facility facility facility facility facili	led a room out to ived. ded to ne Resident and for the rding the cation to n. A family ek of July 9 to nd/or ked if they quarterly erbal concern m the opriate. ses will pcess may	
		R33 was cognitively intact, had mptoms, and displayed no		design	e the following: Social ee will follow up with ness days with correc	resident within	

Facility ID: 00381

If continuation sheet Page 4 of 22

STATEMENT	OF DEFICIENCIES	KEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	0938-039 E SURVEY PLETED
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		245628	B. WING _			06/	14/2018
	PROVIDER OR SUPPLIER			56	TREET ADDRESS, CITY, STATE, ZIP CODE 6 OUTER DRIVE		
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	[PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 585	Continued From pa	age 4	F 58	35			
	indicated R33 had symptoms and had depression. R33's encourage R33 to time to talk when h offer to sit with him and paranoid. R33 irritability, and use others. R10's admission re R10's diagnoses in schizophrenia, vas disturbance, and a physiological condi R10's annual MDS was independent v decision making, a of depression, no p care. R10's MDS i with activities of da baths and did not b period.	cular dementia with behavioral mental disorder due to known ition. 6 dated 3/16/18, indicated R10 with cognitive skills for daily and had no signs or symptoms osychosis, and no rejection of indicated he was independent ally living, preferred sponge bathe during the assessment			 plan of correction. If a resolution c be found with resident and/or resid representative, then Social Work w contact the Ombudsman (if party consents)for a meeting to discuss concern. Monitoring Plan: Social Service or designee will r grieviences that are reported to enthe grievance is addressed within business days and was satisfactor resolved or further action is neede appropriate. Monitoring will be followed in QAP follows: Weekly audits x 3 months until compliant. Then monthly x 3 months until 1 compliant. 	lent vill nonitor sure 3 ily d as l as 100% 00%	
	record occurrences indicated R10 requ and set up for bath often declined wee	tiated 6/13/18, directed staff to s of paranoia. R10's care plan uired one assist to supervise ning or showering, but R10 kly bathing or showers, and himself at the skink with vipes.					
	R33 had reported to concerns about the	tes dated 3/28/18, indicated to a nurse that he had e difficulty he had being around 3 stated, "He [R10] really needs					

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		AND HUMAN SERVICES				FORM	07/30/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245628	B. WING			06/	14/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	ERANS HOME SILVER	RBAY			6 OUTER DRIVE ILVER BAY, MN 55614		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 585	be in my room. It m The nurse documen be passed along. R33's medical servi 6/5/18, indicated R3 regarding his room R10's progress note was offered a bath provided cleansing them, continued to continued to be end R10's progress note frequently refused to wipes, and skin woo allowed. R10's progress note had not bathed in p bathing and was ap R10's progress note 6/14/18, indicated F bath. R10's Medical Serv nurse practitioner (I R10 was disheveled long dirty hair, and of though staff were tr bathing options. On 6/13/18, at 7:51 bedroom with a wal	so I can hardly barely stand to nakes it hard to live here." Inted that his concerns would ices progress notes dated 33 expressed concern mate's poor hygiene. es dated 6/5/18, indicated R10 weekly and as necessary, was cloths and encouraged to use refuse to bathe, and would be couraged to bathe. e dated 6/1/18, indicated R10 bathing, was provided with uld be examined as he e dated 5/15/18, indicated R10 bast 7 days, and refused oproached by 2 different staff. es from 4/18/18, through R10 continuously refused a vices progress note by the NP) dated 4/25/18, indicated d, had ripped clothing, had continued to refuse bathing, rying to provide different a.m. R33 walked out of his lker, and stated he was still not	F	585			
		body odor came from the					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FOR	D: 07/30/2018 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		PLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		245628	B. WING	;		06	5/14/2018
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
	ERANS HOME SILVE	R BAY			56 OUTER DRIVE SILVER BAY, MN 55614		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 585	Continued From pa	ge 6	F (585	5		
	technician (HST)-F shower or wash up clothes for him. HS different interventio told her R33 dislike she has told R33 to services. HST-F sta vulnerable adult. HS R33's concerns to t directed. On 6/13/18, at 2:10 was interviewed an filed a grievance re was no official griev concerns. SW-A st R33 a different roor different room. SW R10 about his odor concerns regarding facility has tried pro- clothing options for much a team effort. On 6/13/18, at 2:26 explained to R33 th had not wanted to f R10's odors have b residents, and she with these residents to try different optio are trying to provide while allowing him t possible. On 6/14/18, at 9:09	a.m. human services stated she tried to get R10 to every day, and set out clean T-F stated the facility has tried ns. HST-F stated the nurse d his roommate. HST-F stated report his concerns to social ated she feels R33 is also a ST-F stated she reported he nurse, as she was p.m. social worker (SW)-A d stated residents have not garding R10's odor, and there vance form for R33's ated the facility has offered m, but he did not want a '-A stated he has spoken with and told R10 about visitor's his odors. SW-A stated the viding different shower and R10. SW-A stated it was very p.m. SW-B stated she has at R10 has rights, and R33 ile a grievance. SW-A stated een brought up by other reviewed the resident's rights s. SW-B stated they continue ns for R10. SW-A stated they e some guidelines for R10, o be independent as much as					

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		AND HUMAN SERVICES				FORM	2: 07/30/2018 1 APPROVED 2: 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		245628	B. WING	i		06	/14/2018
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	· ·	
	ERANS HOME SILVER	R BAY			6 OUTER DRIVE SILVER BAY, MN 55614		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 585	Continued From pa the hallway.	ge 7	F	585			
	roommate needs to annoying." R33 sta R33 stated he did r different room, but v is in, and wanted a stated he was sure R10's odors also. F clean clothes, but h had talked to one o told R10 had rights are infringed upon v shower. R33 stated with R10, and the n R10, but he won't ta On 6/14/18, at 9:35 stated they have tria R10's body odors. F and R33, along with have complained. F about R33's rights a RN-C stated they h fresheners/neutraliz private room for R1 On 6/14/18, at 4:08 (DON) stated they I grievance, think abo and document on a stated if a resident talk, and do not do stated they had trie wipes, offering a pr interventions. The I R33 a room change	a.m. R33 stated his b take a shower stating, "It is ated he gets enough sleep. not remember being offered a wanted to stay in the room he different roommate. R33 others complained about R33 stated the staff give R10 he won't change. R33 stated he f the employees, and he was . R33 stated he feels his rights when R10 doesn't take a l everyone had been patient hurses leave clothes out for ake their suggestions. a.m. registered nurse (RN)-C ed a lot of things to manage RN-C stated R10 bathes yearly n other residents in the area RN-C stated she wonders and other resident's rights. ad not tried things like air zers, and was not sure if a 0 had been offered. p.m. the director of nursing listen to a resident express a out how they would resolve it, grievance form. The DON just wants to talk, they just a formal grievance. The DON d supplying R10 with bath ivate shower, and other DON stated they have offered e. The DON stated they esidents' rights. The DON					

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					FORM	07/30/2018 APPROVED 0938-0391
OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
	245628	B. WING			06/ [,]	14/2018
PROVIDER OR SUPPLIER					-	
ERANS HOME SILVER	RBAY					
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFI TAG	x	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
Continued From parverified she had not informal grievances On 6/14/18, at 1:52 know if a room deo tried. SW-A stated medical needs. SW residents' rights are stated R33 was in t about his concerns On 6/14/18, at 3:00 ordered a room deo about it. SW-A state informal resident co about it. SW-A state informal resident co at what the facility f concerns regarding they do not have m of grievance logs fr date, indicated ther grievance, and it wa R10. The facility policy R 2/17, directed resid their concerns and may file a verbal or with any staff memily made to address ver directed the design resolution to the resident their and within seven we	age 8 t filled out a tracking log for s. P.m. SW-A stated he did not dorizer/neutralizer had been private rooms were used for V-A acknowledged other e being infringed upon, and the SW office every day talking with R10. P.m. SW-A stated he had odorizer, after asking R33 ted they have not tracked oncerns, so was unable to look had done to address resident's pR10's odors. SW-A stated any formal grievances. Review om 1/18, through the current e had been only one formal as not R33's grievance with Resident Grievances dated ents are encouraged to make recommendations known, written concern or grievance ber, and every effort should be erbal complaints. The policy ated staff to report the sident who originated the e working days of the concern, orking days for a grievance.	F 5				
CFR(s): 483.12(c)(§483.12(c) In respo	1)(4) onse to allegations of abuse,	F 6	509			7/6/18
	RS FOR MEDICARE OF DEFICIENCIES OF DEFICIENCIES F CORRECTION PROVIDER OR SUPPLIER ERANS HOME SILVEF SUMMARY STA (EACH DEFICIENCY REGULATORY OR LANK) (EACH ANK ANK) (EACH ANK ANK) (EACH ANK ANK ANK) (EACH ANK ANK ANK) (EA	IDENTIFICATION NUMBER: 245628 PROVIDER OR SUPPLIER ERANS HOME SILVER BAY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. Reporting of Alleged Violations	RS FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MUL A. BUILD PROVIDER OR SUPPLIER 245628 B. WING SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFI TAG Continued From page 8 verified she had not filled out a tracking log for informal grievances. F 5 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 firee working days of the concern, and within seven working days for a grievance. Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4	RS FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES F CORRECTION (X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER: (X2) MULTIPL A BUILDING 245628 B. WING PROVIDER OR SUPPLIER 245628 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 8 verified she had not filled out a tracking log for informal grievances. ID PREFIX TAG 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 a grievance. Reporting of Alleged Viola	MENT OF HEALTH AND HUMAN SERVICES O SF OR MEDICARE & MEDICAID SERVICES O OP DEFICIENCIES (X1) PROVIDERSUPPLERVICES (X2) MULTIPLE CONSTRUCTION A BUILDING A BUILDING A BUILDING ROVIDER OR SUPPLIER 245628 B. WING ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 56 OUTER DRIVE SUMMARY STATEMENT OF DEFICIENCIES B. WING BUILDING IEACH DERIVERY ON LSC DENTFYING INFORMATION, JD PROVIDERS PLAN OF CORRECTION Continued From page 8 F 585 PRECIDE OF THE APPROPH Continued From page 8 F 585 F 585 Verified she had not filled out a tracking log for informal grievances. F 585 On 6/14/18, at 1:52 p.m. SW-A stated he did not throw in 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 grievances. Review of grievance logs from 1/18, through the current date, indicated there had been only one formal grievance stated 2/17, directed there had been only one formal grievance with ray staff member, and every effort should be made to address verbal or written concern or grievance with ray staff member,	MENT OF HEALTH AND HUMAN SERVICES FORM SF COR MEDICARE & MEDICAID SERVICES OMB NO. OF DEFICIENCIES OMB NO. OF DEFICIENCIES (X1) PROVIDERUBPLERCIA IDENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATA A. BUILDING PROVIDER OR SUPPLER 245628 B. WING 06/ SRANS HOME SILVER BAY STREET ADDRESS, CITY, STATE, ZIP CODE 56 OUTER DRIVE 06/ SUMMARY STATEMENT OF DEFICIENCIES (PCA) DEPICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC DENTFYING INFORMATION) IP PROVIDERS YAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLD BE (CACH CORRECTIVE ACTION SHOLD BE

Facility ID: 00381

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTII	PLE CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	COMF	PLETED
		245628	B. WING		06/1	4/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 56 OUTER DRIVE		
	RANS HOME SILVER	R BAY		SILVER BAY, MN 55614		
(X4) ID PREFIX		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		DATE
			1			
F 609	Continued From pa	ge 9	F 60	9		
	must:					
	§483.12(c)(1) Ensu	re that all alleged violations				
		glect, exploitation or ding injuries of unknown				
	source and misapp	ropriation of resident property,				
		liately, but not later than 2 gation is made, if the events				
	that cause the alleg	ation involve abuse or result in				
		<i>i</i> , or not later than 24 hours if se the allegation do not involve				
	abuse and do not re	esult in serious bodily injury, to				
		the facility and to other the State Survey Agency and				
	adult protective service	vices where state law provides				
		ng-term care facilities) in ate law through established				
	procedures.	ale lan anough completioned				
	§483.12(c)(4) Repo					
		e administrator or his or her ntative and to other officials in				
	accordance with Sta	ate law, including to the State				
		nin 5 working days of the alleged violation is verified				
	appropriate correcti	ve action must be taken.				
	This REQUIREMEN	NT is not met as evidenced				
	Based on interview	and document review, the		Facility Citation actions:		
		ure incidents of alleged abuse had been reported to		1. The facility will continue with the process of compiling internal incide		
	the administrator ar	nd the State Agency (SA) for 9		along with current action plans for s	safe	
		7, R281, R79, R16, R44, R6, who resided on the memory		care. 2. On 6/22/18 the DON pr education to nurses regarding extern		
	care units and had	been involved in resident to		reporting of resident to resident		
	resident altercations	s with R27.		altercations to include reporting of a negative resident to resident physic		
	Findings include:			contact and verbal arguments. Prevention Plan:		

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PRINTED: 07/30/2018

	OF DEFICIENCIES	<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPLE CONSTRUCTION	OMB NO.	E SURVEY		
	F CORRECTION	IDENTIFICATION NUMBER:	· ·	ING		PLETED		
		245628	B. WING		06/*	14/2018		
NAME OF F	PROVIDER OR SUPPLIER	·	•	STREET ADDRESS, CITY, STATE, ZIP	CODE			
	ERANS HOME SILVE	R BAY		56 OUTER DRIVE SILVER BAY, MN 55614				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE		
F 609	Continued From pa	age 10	F6	609				
	4/4/18, indicated R impairment, and ha dementia with beha disorder and visual indicated R27 had assistance, and dis aggressive behavio the assessment per R27's behavioral C dated 1/2/18, indica verbally and physic others. The CAA in disorganized thinki R27's Vulnerability indicated R27 had aggressive behavio assessment indica from others due to confusion, and diso unable to report ab staff to prove a sav R27's Care Plan pr R27 displayed dep hallucinations due vascular dementia.	are Area Assessment (CAA) ated R27 had a history of being cally aggressive towards idicated R27 displayed		 Additional education will all employees regarding to resident to resident alterca 6/27/18 and 7/5/18. Monitoring : All resident to resident p and verbal arguments will Licensed Nurses to assure OHFC. Nurses will continue to r charting for behavioral door report concerns as approp Monitoring: Supervisors or Designer incidents for proper reportion Monitoring will be followed follows: Weekly audits x 3 month compliant. Then monthly x 3 month compliant. Then quarterly x 6 month compliant 	eporting of ations on ohysical contact be montiored by prompt filing to review Shift cumentation and riate. e will audit ing. in QAPI as ths until 100%			
	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:							

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		AND HUMAN SERVICES				FORM	APPROVED
	OF DEFICIENCIES	<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA		דוחו			0938-0391 E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	` '				PLETED
		245628	B. WING			06/	14/2018
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
	RANS HOME SILVER	R BAY			56 OUTER DRIVE		
				5	SILVER BAY, MN 55614		
(X4) ID PREFIX		TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL	ID PREFIX	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION
TAG		SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROP		DATE
			r.		DEFICIENCY)		
F 609	Continued From no	ao 11	БО	~~~			
F 009	Continued From pa	gen	F 6	09	1		
	1. On 1/19/18. at 5	:25 p.m. R27 grabbed R281's					
	right forearm and se	queezed it. R27 would not let					
		and staff members had to					
		l off of R281. Neither resident					
		N-A stated the incident did not I to the administrator of the SA					
		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					
		ad R27 pushed up against a					
	closet door and pro	ceeded to "Punch (R27) in the					
	•	parated the residents, and no					
		noted. RN-A stated she had ident on 1/22/18, and					
	5	ect care staff had not					
		between the two residents					
		ent was not reportable. RN-A					
		rs were provided education					
	regarding appropria documentation.	ate and accurate					
	3. On 1/30/18, at 5	:48 p.m. R281 reached across					
		le to remove an item from					
	•	ecame agitated, and the two					
		lling at each other. They stood d and pinched R281's arm					
		R281's shirt, and would not let					
	5	intervened to separate the					
	residents and redire	ect them. RN-A stated the					
		se physical harm, so the					
	incident was not rep						
	4. On 2/2/18 at 5:1	0 p.m. R27 was observed					
	ambulating towards	R16. When the two					
		ssed, R16 "Lunged" his					
	walker towards R27	7, "Took a few swings at [R27]"					

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		AND HUMAN SERVICES				FORM	07/30/2018 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		LE CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		245628	B. WING			06/	14/2018
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
MN VET	ERANS HOME SILVE	R BAY			6 OUTER DRIVE SILVER BAY, MN 55614		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 609	 and made contact. stated R27 was not incident, therefore i 2/5/18, the interdisc incident, contacted pain medication chaws updated. 5. On 2/9/18, at 7:0 room while he was teeth. R27 argued R44 several times i chest. Neither resid distress as a result stated no injury was not reportable. R44's door to deter entering R44's roor 6. On 2/17/18, at 1 through the neighbor crossed paths with altercation with a st walker at R27. The R27 then became we each other. R27 gr staff member had to walker. RN-A stated reportable as no inj of the altercation. 7. On 4/21/18, at 8 who was seated in living room. R27 at by tapping him on the st walker at R27. 	No injury was noted. RN-A injured as a result of the t was not reportable. On ciplinary team reviewed the R27's physican for possible anges, and the psychologist 00 p.m. R27 entered R44's in the bathroom brushing his briefly with R44, then struck n the back of his arm and dent sustained injury or of the altercations. RN-A s noted therefore, the incident A "STOP" sign was added to wandering residents from n. 0:00 p.m. R16 was walking orhood living room when he R27. R16 had a verbal caff member and threw his walker hit R27's arm. R16 and verbally aggressive towards tabbed R16's walker, and a o pry R27's hands off of R16's d the altercation was not ury was sustained as a result c:01 p.m. R27 approached R16 a recliner in the neighborhood ttempted to get R16's attention he chest. R16 responded by and kicking at R27 . R27 was once in his upper leg area." ercation did not result in injury,	F	609			

Facility ID: 00381

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		AND HUMAN SERVICES					FORM	APPROVED	
	OF DEFICIENCIES	<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(Y2) MI II -		LE CONSTRUCTION	0	OMB NO. 0938-0391 (X3) DATE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER:	` '					PLETED	
		245628	B. WING				06/ [,]	14/2018	
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP COD	Е	-		
	ERANS HOME SILVER	R BAY			56 OUTER DRIVE				
				5	SILVER BAY, MN 55614				
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH			(X5) COMPLETION	
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFI> TAG	^	CROSS-REFERENCED TO THE AP			DATE	
					DEFICIENCY)				
			1						
F 609	Continued From pa	ge 13	F 6	09					
	$0 Op \ 1/20/10 et \ 0$	10 p m D27 was packing in							
		:49 p.m. R27 was packing in ving room. R27 was holding a							
		approached R6. R27's cup							
	got entangled in R6	s's shirt and R27 was unable to							
		bed R27's wrist and would not							
		ers had to separate R27 and sustained. RN-A stated the							
		esult in injury, therefore it was							
		DON stated R27 had been							
		off of the Birch neighborhood							
		on project. After this occurred,							
	R27 was transferred neighborhood.	d back to the Birch							
	neighbornood.								
		:18 p.m. R2 grabbed R27's							
		sitting in the living room. Staff							
		direct R2 away from R27. d. RN-A stated the altercation							
		ry, therefore it was not							
	reportable.	,							
		6:25 p.m. R27 approached							
		seated in a wheelchair. R27 6 and "Put his hands in R26's							
		his lift wrist." Direct care staff							
		y from R26. No injury was							
		the altercation did not result in							
	injury, therefore it w	as not reportable.							
	On 6/14/18, at 9.28	a.m. RN-A stated the							
		idents did not result in							
		ental anguish, therefore, none							
		re required to be reported to							
	the facility administr	rator of the State Agency.							
	On 6/14/18. at 9:30	a.m. the DON stated R27							
		re dementia, therefore, his							
		e considered willful. The DON							

If continuation sheet Page 14 of 22

PRINTED: 07/30/2018

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/30/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í	PLE CONSTRUCTION G		(X3) DATI	E SURVEY PLETED
		245628	B. WING_			06/	14/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CIT	Y, STATE, ZIP CODE	-	
MN VETI	ERANS HOME SILVER	R BAY		56 OUTER DRIVE SILVER BAY, MN 5	55614		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORR	S PLAN OF CORRECTION ECTIVE ACTION SHOULD ENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
	stated the altercation mental anguish, the to be reported to the discussion, the DOI suffered from demen make willful actions incidents should ha administrator and the facility policy. The facility Vulneral Plan policy dated 2/ allegations of abuse and state laws. The allegations are report defined willful abuse acted deliberately, r have intended to inf further directed staf immediately to their administrator, and of to the State and Fee Provision of Medica CFR(s): 483.40(d) \$483.40(d) The faci medically-related so maintain the highes and psychosocial w This REQUIREMEN by: Based on observat review, the facility fa assess suicidal/hon direct staff on how t of 1 residents (R75)	Ins did not result in injury or refore, they were not required e State Agency. Upon further N confirmed residents who intia did have the ability to therefore, the identified we been reported to the ne SA as directed by the oble Adult/Resident Protection 23/17, directed staff to report e in accordance to the federal policy further directed abuse orted immediately. The policy e as the individual must have not that the individual must dict injury or harm. The policy f to report the allegations supervisor, facility other individuals in accordance deral law. Ily Related Social Service lity must provide ocial services to attain or t practicable physical, mental ell-being of each resident. NT is not met as evidenced ion, interview, and document ailed to comprehensively nicidal ideations, and failed to o handle these ideations for 1 o who expressed thoughts of d, as well as thoughts of	F 60	5 Facility Citation 1. Resident (R7 to include additi to respond to an statements. Prevention Plar	75) care plan was up ional interventions fo ny future suicidal		7/6/18

Facility ID: 00381

ATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED	
		245628	B. WING		06/1	4/2018	
IAME OF F	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE			
IN VETE	RANS HOME SILVER	R BAY		6 OUTER DRIVE SILVER BAY, MN 55614			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIC DATE	
F 745	Continued From pa	ge 15	F 745				
	Findings include:			provided on 7/5/18 in regards to fa policy; Resident Danger to Self an Others.			
	 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). 			 If a resident has homicidal thousuicidal thoughts, and/or attempts self staff will determine and impler resident safety intervention needs All resident's care plan have bereviewed an enhanced as noted a appropriate. Monitoring Plan: Nurses will continue to review S charting for behavioral documenta verify assessments and care plann needs have been addressed as appropriate. Monitoring will be followed in QAP follows: Weekly audits x 3 months until compliant. Then monthly x 3 months until 1 compliant. Then quarterly x 6 months until compliant 	to harm nent en bove as Shift tion and hing I as 100%		
	12/4/17, indicated F of depression. The thoughts that he wo harming himself 2-6 period. When reas for moderate/sever depression. The pla indicators of depress less than daily. Soc	essessment (CAA) note dated R75 had mild signs/symptoms CAA also indicated R75 had buld be better off dead, or 6 days during the review sessed 3/6/18, R75 triggered e signs and symptoms of an was for R75 to have ession, anxiety, or sad mood cial services was to follow as being followed by psychiatry					

		AND HUMAN SERVICES				FORM): 07/30/2018 APPROVED). 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	· /	TE SURVEY MPLETED	
		245628	B. WING			06/14/2018		
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
MN VET	ERANS HOME SILVER	R BAY			6 OUTER DRIVE SILVER BAY, MN 55614			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 745	5/23/18, included R depressed, or hope and thoughts that h of hurting self in so The summary inclu but failed to address dead, or hurting him R75's care plan dat problem, "I am have environment." Staf R75 to participate in other residents dail included antidepress antipsychotic medic physician. Interven doctor if antidepress monitor for side effe interventions includ visiting, assisting to feelings, listening to reporting depressiv providers, offering t as well as ways to i care plan for halluc harming himself or offer time to reflect and ways to interact depression included prescribed medicat effects, notifying pro- care plan failed to o has suicidal or hom On 6/12/18, at 8:52 and stated he had a hallucinations that b	75 was feeling down, dess 12-14 days of 14 days, e would be better off dead, or me way 2-6 days of 14 days. ded R75 was at risk for abuse, s thoughts of being better off nself. and 5/31/18, included the ing difficulty adjusting to my f were instructed to encourage n conversation with staff and y. R75's care plan also asant medication, and cation as ordered by the tions included alerting the sant was ineffective, and to ects. Non-medication ed assuring R75 he was safe, make a phone call, validating o music or books on tape, e symptoms to medical ea, essential oils, and snacks, nteract with resident. The inations included a goal of not others, and directed staff to and share about experiences, it with R75. The care plan for d interventions of taking ions, monitoring for side ovider with concerns, and al services as needed. The direct staff on what to do if R75	F	745				

If continuation sheet Page 17 of 22

	OF DEFICIENCIES	<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA		IPLE CONSTRUCTION		<u>). 0938-039</u> TE SURVEY		
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		NG		MPLETED		
		245628	B. WING _		06	6/14/2018		
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
MN VETI	ERANS HOME SILVE	R BAY		56 OUTER DRIVE SILVER BAY, MN 55614				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE		
F 745	• · · · · · · · · · · · · · · · · · · ·	-	F 74	15				
	up out of bed on hi wheel chair over. R	8, at 9:30 a.m. R75 had gotten s own, and had tipped his R75 ambulated on his own out nd 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.							
	(LPN)-B stated she regarding R75 date "HST Alert: depress that I (sik) he wishe	8 p.m. licensed practical nurse had written a progress note d 6/12/18, which included, sive statements: Res stated ed that he wouldn't have got rid he would use it on a few						

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		AND HUMAN SERVICES				FORM	07/30/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245628	B. WING			06/	14/2018
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
MN VETE	ERANS HOME SILVER	₹ BAY			56 OUTER DRIVE SILVER BAY, MN 55614		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 745	stated this document chart so that all numiniformation and be suicidal/homicidal id was not concerned considering suicide carry through with sist stated R75 occasion statements, but was had not followed the staff would perform risk of suicide or hot easily redirected and stated if she had fe have stayed with hit psychiatrist. LPN-B R75's care plan dire made suicidal/homining redirect him versus potential. On 6/14/18, at 12:4 (RN)-C stated when ideation (SI) or hom was to ensure reside staff are to notify th RN-C stated a staff with the resident to and update the psy case the situation en not be left alone, a alarm to call other sis emergency. Once sis staff would update sis and psychiatry. If th would call 911. RN-	m that conversation." LPN-B ntation was flagged in the ses on duty would receive the aware of the deation. LPN-B stated she that R75 was seriously or that he had the means to suicide or homicide. LPN-B nally made suicidal s easily redirected. LPN-B e facility policy which indicated an assessment to determine omicide, because he was so do had dementia. LPN-B It R75 was unsafe, she would m and contacted his stated she did not know if ected exactly what to do if he icidal statements, or when to assess him for suicide plan or 7 p.m. registered nurse n a resident voices suicidal hicidal ideation (HI), the staff lent safety immediately. Then e nurse for further discussion. member would, "Talk it out" see if the resident had a plan, chiatrist and medical staff in escalated. If the resident could staff member could press their staff to the site of the safety had been established, supervisors, social services, he emergency continued, staff of C further stated if SI/HI	F	745			
	became a target be	havior for a resident, the would be updated to monitor					

Facility ID: 00381

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	07/30/2018 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245628	B. WING		06/	14/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<u>, </u>	
	ERANS HOME SILVE	R BAY		56 OUTER DRIVE SILVER BAY, MN 55614		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 745	the behavior all of t interventions, such the care plan. RN-C recreation staff and aware of the interve provide support. RN would be a team m team (IDT) would a reviewed an incider from 6/12/18, which wished he had a gu himself. RN-C state occurred. RN-C state	the time, and non-medication as checks, would be part of C stated staff would make sure d life enrichment coaches were entions so they could also N-C continued to state there eeting, the interdisciplinary assess the incident. RN-C nt in R75's progress notes in indicated R75 stated he un to take out others and them ed she had no idea this had ated it appeared a staff comments, and an LPN wrote e chart, but the person in tified and should have been. ad been thriving on the special ometimes impulsive, but now nore quickly. RN-C verified tked any direction to staff on 75 if he made suicidal or	F 745			

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	07/30/2018 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245628	B. WING		06/ [.]	14/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
	ERANS HOME SILVER	R BAY		56 OUTER DRIVE SILVER BAY, MN 55614		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 745	the ADON stated th hand the situation of 6/12/18, incident, the information to the L further behaviors, s it further. If the beh continued, staff wort they always reported the ability to put cus When asked if she plan not having spe when R75 has SI/H would see staff redit one would see that with him. The ADON coaches spend a lo doing well with the of his unit. The ADON behaviors get extra noted staff report be R75's psychiatry no 2018, failed to ident ideation. On 6/14/18, at 1:56 responsible for upd why R75 had nothin SI/HI when the CAA significant change I regular thoughts of generated did not in interventions or res of SI or HI. RN-B c stated social service section of the care that part of the care	The NAs would redirect R75 or off to a supervisor. With the he NA did hand off the LPN. Since there were no staff may have just not reported haviors continued, the ADON uld know to report further, as ed behaviors. Then staff have stom alerts on the resident. was comfortable with the care ecific interventions identified for fl, the ADON answered if one lirecting or reorienting R75, staff were doing a good job N asserted the life enrichment of time with R75, and he is extra attention he receives on N stated residents with a attention. The ADON also behaviors to the psychiatrist. otes from January to May tify any suicidal or homicidal 6 p.m. RN-B (a staff member dating the MDS, was asked ing on his care plan regarding A of 11/25/17, and the MDS of 2/22/18, indicated 5 suicide, but the care plan include any specific sponse to try when R75 spoke checked the care plan and ces completes the mood plan and was responsible for	F 745			

		AND HUMAN SERVICES				FORM	07/30/2018 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245628	B. WING			06/ [,]	14/2018
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-	
MN VET	ERANS HOME SILVER	R BAY			6 OUTER DRIVE SILVER BAY, MN 55614		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 745	stated redirection w he made suicidal or that was not addres plan to direct staff. why the facility polic R75. SW-A stated social worker regar was received from 3 The facility policy R Others dated 2018, "Provide guidelines timely, effective and interventions while individuals within th policy included guid intervention of suici which directed staff Provide for privacy; private place or rem the area. b. Intervit his or her intentions about hurting him/h a plan (i.e. time, plas selected and is the What are, if any, the recent losses/increas stresses/depression life changes)? iv. I preparations for his giving away posses arrangements)? v. hallucinations (audi suicidal or harm to directed the care pl be reviewed and the	vas appropriate for R75 when r homicidal statements, but ssed specifically on the care SW-A stated he was unsure cy was not being followed for he would check with the other rding this. No further response SW-A. Resident Danger to Self and/or , included a purpose to for the implementation of d safe assessment, and providing safety for all he facility at all times." The delines for assessment and idal behavior/harm to self f to assess the risk by, "a. c either take the resident to a nove all other residents from iew the resident to determine s: i. Is the resident thinking herself? ii. Does he/she have ace and opportunity, method method readily available)? iii. e precipitating factors (i.e. ased n/difficulty with adaptation to Has the resident made any s/her death (i.e. suicide note, asions, making final	F 7	745			

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		AND HUMAN SERVICES			PRINTED: 06/28/2018 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDINC	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
NAME OF F	PROVIDER OR SUPPLIER	245628	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	06/14/20 <u>18</u>
	ERANS HOME SILVE	R BAY		56 OUTER DRIVE SILVER BAY, MN 55614	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
K 000	INITIAL COMMEN	TS	K 000		
	FIRE SAFETY				
	Minnesota Departn Fire Marshal Division MN Veterans Homo compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National (NFPA) Standard 1 Chapter 19 Existing	Survey was conducted by the nent of Public Safety, State on. At the time of this survey, e - Silver Bay was found in e requirements for participation aid at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC), g Health Care. s Home-Silver Bay is a one			
	story building, parti construction 1960's nursing home in the	al basement original year of s, and it was converted into a e early 1990's. The original ons are all Type II(111)			
	facility has a compl smoke detection in	e sprinkler protected. The lete fire alarm system with the corridors and spaces r, that is monitored for artment notification.			
		censed capacity of 83 beds of 80 the time of the survey.			
	The requirement at MET.	t 42 CFR Subpart 483.70(a) is			
	Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIGN	ATURE	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.



Protecting, Maintaining and Improving the Health of All Minnesotans

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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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 <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. 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

Mn Veterans Home Silver Bay June 26, 2018 Page 2 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

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

Minnesc	ota Department of He	alth				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00381	B. WING		06/1	4/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MN VET	ERANS HOME SILVER	R BAY 56 OUTER SILVER B	R DRIVE AY, MN 556	14		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at ate.mn.us/divs/fpc/profinfo/inf e licensing orders are				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVID ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 07/05/18

Electronically Signed

If continuation sheet 1 of 23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00381	B. WING		06/	14/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	ERANS HOME SILVE	R RAY	R DRIVE BAY, MN 5561	4		
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF C	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 000	Continued From pa	age 1	2 000			
	you electronically. is necessary for Sta enter the word "cor text. You must then State licensure pro- completion date, th corrected prior to e Minnesota Departm On 6/11/18, through Department's staff the following correc Please indicate in y correction that you and identify the dat Minnesota Departm the State Licensing federal software. Ta	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health. h 6/14/18, surveyors of this visited the above provider and ction orders are issued. your electronic plan of have reviewed these orders, e when they will be completed nent of Health is documenting correction Orders using ag numbers have been sota state statutes/rules for				
	column entitled "ID statute/rule out of of "Summary Stateme and replaces the "T correction order. Th findings which are in after the statement evidence by." Follo are the Suggested Time period for Con PLEASE DISREGA FOURTH COLUMN "PROVIDER'S PLA	number appears in the far left D Prefix Tag." The state compliance is listed in the ent of Deficiencies" column To Comply" portion of the his column also includes the in violation of the state statute , "This Rule is not met as wing the surveyors findings Method of Correction and rrection. ARD THE HEADING OF THE N WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY.				

K4H511

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	(X3) DATE SURVEY COMPLETED			
		00381	B. WING		06/14/2018	
AME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
	ERANS HOME SILVE	R BAY 56 OUTE	R DRIVE BAY, MN 556	4.4		
(X4) ID	SUMMARY ST			PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLE	
2 000	Continued From pa	age 2	2 000			
	PLAN OF CORRE	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
21495	MN Rule 4658.100 Providing Social Se	5 Subp. 5 Social Services; ervices	21495		7/6/18	
	services must be p identified social ser according to the co assessment and co	g social services. Social rovided on the basis of rvice needs of each resident, omprehensive resident omprehensive plan of care 4658.0400 and 4658.0405.				
	by: Based on observat review, the facility f assess suicidal/hor direct staff on how of 1 residents (R75	ent is not met as evidenced ion, interview, and document failed to comprehensively micidal ideations, and failed to to handle these ideations for 1 b) who expressed thoughts of ad, as well as thoughts of I others.		Corrected		
	R75 had diagnoses behavioral disturba hallucinations, maj agoraphobia (a typ person fears and a might cause them trapped, helpless of disorder, anxiety di	heet dated 5/19/17, indicated s that included dementia with once, psychotic disorder with or depressive disorder, e of anxiety disorder in which a void places or situations that to panic and make them feel or embarrassed) with panic sorder, post-traumatic stress ehavior disorder, as well as s.				

K4H511

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00381	B. WING		06/	14/2018
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	ERANS HOME SILVE	R BAY 56 OUTE SILVER E	R DRIVE BAY, MN 55614	4		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21495	Continued From pa	age 3	21495			
	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).					
	12/4/17, indicated I of depression. The thoughts that he we harming himself 2 period. When reas for moderate/sever depression. The pla indicators of depres- less than daily. Soc	AR75 had mild signs/symptoms CAA also indicated R75 had buld be better off dead, or 6 days during the review assessed 3/6/18, R75 triggered re signs and symptoms of an was for R75 to have ssion, anxiety, or sad mood cial services was to follow as being followed by psychiatry				
	5/23/18, included F depressed, or hope and thoughts that h of hurting self in so The summary inclu	ation Assessment dated R75 was feeling down, eless 12-14 days of 14 days, ne would be better off dead, or me way 2-6 days of 14 days. Ided R75 was at risk for abuse, as thoughts of being better off mself.				
	problem, "I am hav environment." Stat R75 to participate i other residents dail included antidepres	ted 5/31/18, included the ing difficulty adjusting to my ff were instructed to encourage n conversation with staff and ly. R75's care plan also ssant medication, and cation as ordered by the				

K4H511
IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY
		A. BUILDING:		COMPLETED	
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ERANS HOME SILVER	R BAY 56 OUTE SILVER E	R DRIVE BAY, MN 5561	4		
SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COF	RECTION	(X5)
		PREFIX TAG			COMPLETE
Continued From pa	ge 4	21495			
doctor if antidepress monitor for side effe interventions includ visiting, assisting to feelings, listening to reporting depressiv providers, offering t as well as ways to i care plan for halluc harming himself or offer time to reflect and ways to interact depression included prescribed medicat effects, notifying pro- referral to behaviora care plan failed to o has suicidal or hom On 6/12/18, at 8:52 and stated he had a hallucinations that k to die, and frequent observed on 6/2/18 up out of bed on his wheel chair over. R to the day room, an his room. On 6/14/18, at 12:2 (NA)-E was intervie heard R75 make hom	sant was ineffective, and to ects. Non-medication ed assuring R75 he was safe, make a phone call, validating o music or books on tape, e symptoms to medical ea, essential oils, and snacks, nteract with resident. The inations included a goal of not others, and directed staff to and share about experiences, t with R75. The care plan for d interventions of taking ions, monitoring for side ovider with concerns, and al services as needed. The lirect staff on what to do if R75 icidal ideations. a.m. R75 was interviewed a lot of bad dreams and some oothered him, and he was here dy thought about dying. When , at 9:30 a.m. R75 had gotten s own, and had tipped his 75 ambulated on his own out d asked for direction back to 2 p.m. nursing assistant wed, and stated she had opeless statements such as, "I				
NA-E stated she w R75 was mentally p hallucinating. If he stated you,"Can't ge gone. There is no re	ould be to try to determine if present or not; if he was was hallucinating, NA-E et him to come back, he's edirection." If R75 was				
	(EACH DEFICIENCY REGULATORY OR LA Physician. Intervent doctor if antidepress monitor for side effe interventions include visiting, assisting to feelings, listening to reporting depressive providers, offering to as well as ways to it care plan for halluch harming himself or offer time to reflect and ways to interact depression included prescribed medicate effects, notifying pro- referral to behaviora care plan failed to of has suicidal or hom On 6/12/18, at 8:52 and stated he had a hallucinations that b to die, and frequent observed on 6/2/18 up out of bed on his wheel chair over. R to the day room, an his room. On 6/14/18, at 12:2 (NA)-E was intervier heard R75 make how won't be here long,' NA-E stated she w R75 was mentally p hallucinating. If he stated you,''Can't ge gone. There is no ref	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 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. 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NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
MN VET	ERANS HOME SILVE	R RAY	ER DRIVE BAY, MN 5561	4			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21495	Continued From pa	age 5	21495				
	present, NA-E state made statements li him, and don't wan stated she would le suicidal or homicida would alert the faci were serious enoug determined whether watch, with observa 5 minutes, or whate determined. NA-E NA's by pulling the	ot hallucinating and mentally ed she would ask him why he ike that, and tell him they love t him to hurt anyone. NA-E et the nurse know about the al thoughts. NA-E or the nurse lity charge person if the threats gh, and then it would be er R75 needed to be put on a ations every 10 minutes, every ever the facility charge person stated she would alert other m aside, and telling them to 5 because he was having bad	5				
	(LPN)-B stated she regarding R75 date "HST Alert: depress that I (sik) he wishe of his gun because people and that (sil redirected away fro stated this docume chart so that all nur information and be suicidal/homicidal i was not concerned considering suicide carry through with stated R75 occasio statements, but wa had not followed th staff would perform risk of suicide or ho easily redirected an stated if she had fe	8 p.m. licensed practical nurse e had written a progress note ed 6/12/18, which included, sive statements: Res stated ed that he wouldn't have got rice he would use it on a few (k) him self. Res was easily om that conversation." LPN-B intation was flagged in the reses on duty would receive the aware of the deation. LPN-B stated she that R75 was seriously e or that he had the means to suicide or homicide. LPN-B onally made suicidal s easily redirected. LPN-B e facility policy which indicated an assessment to determine omicide, because he was so and had dementia. LPN-B ef R75 was unsafe, she would im and contacted his	1				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED	
	PROVIDER OR SUPPLIER	00381	DRESS, CITY, ST		06/	14/2018
		56 OUTER		TATE, ZIP CODE		
	ERANS HOME SILVER	R ΒΔΥ	AY, MN 5561	4		
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21495	Continued From pa	ge 6	21495			
	made suicidal/homi	ected exactly what to do if he icidal statements, or when to assess him for suicide plan or				
	(RN)-C stated when ideation (SI) or hom was to ensure resid staff are to notify th RN-C stated a staff with the resident to and update the psy case the situation end not be left alone, a alarm to call other se emergency. Once se staff would update se and psychiatry. If th would call 911. RN- became a target be resident's care plan the behavior all of the interventions, such the care plan. RN-C recreation staff and aware of the interver provide support. RN would be a team me team (IDT) would a reviewed an incider from 6/12/18, which wished he had a gut himself. RN-C state occurred. RN-C state occurred. RN-C state the incident into the charge was not not	7 p.m. registered nurse n a resident voices suicidal hicidal ideation (HI), the staff lent safety immediately. Then e nurse for further discussion. member would, "Talk it out" see if the resident had a plan, chiatrist and medical staff in scalated. If the resident could staff member could press their staff to the site of the safety had been established, supervisors, social services, he emergency continued, staff C further stated if SI/HI shavior for a resident, the would be updated to monitor he time, and non-medication as checks, would be part of C stated staff would make sure life enrichment coaches were entions so they could also N-C continued to state there eeting, the interdisciplinary ssess the incident. RN-C nt in R75's progress notes n indicated R75 stated he in to take out others and them ed she had no idea this had ted it appeared a staff comments, and an LPN wrote e chart, but the person in ified and should have been. ad been thriving on the special				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	E CONSTRUCTION		E SURVEY PLETED
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ΜΝ VET	ERANS HOME SILVE	R RAY	R DRIVE BAY, MN 5561	4		
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21495	Continued From pa	ige 7	21495			
	R75's care plan lac	nore quickly. RN-C verified ked any direction to staff on 75 if he made suicidal or nts.				
	nursing (ADON) wa if there was anythin plan. The ADON st change MDS docur plans were written of instructions that we stated staff can ask or if what he is talki could also reassure incident when R75 to shoot peers and incident did not get staff were able to re would be appropria a plan for coping w the ADON stated th hand the situation of 6/12/18, incident, th information to the L further behaviors, s it further. If the beh continued, staff wo they always reported the ability to put cus When asked if she plan not having spe when R75 has SI/H would see staff red one would see that	p.m. the assistant director of as interviewed and was asked ag about SI/HI on R75's care ated there was a significant ment completed for R75, and onto the sheet of care ere left in his closet. The ADON K R75 if he is playing games, ing about really exists. Staff e him. Regarding the 6/12/18, was talking about using a gun himself, the ADON stated the to R75's care plan because edirect him. When asked if it the for staff to ask if there was ith R75's SI/HI verbalizations, ne NAs would redirect R75 or off to a supervisor. With the ne NA did hand off the .PN. Since there were no staff may have just not reported haviors continued, the ADON uld know to report further, as ad behaviors. Then staff have stom alerts on the resident. was comfortable with the care ecific interventions identified fo II, the ADON answered if one irecting or reorienting R75, staff were doing a good job N asserted the life enrichment				
	doing well with the his unit. The ADON	ot of time with R75, and he is extra attention he receives on I stated residents with a attention. The ADON also				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
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21495	Continued From pa	ige 8	21495				
	noted staff report b	ehaviors to the psychiatrist.					
		otes from January to May tify any suicidal or homicidal					
	responsible for upd why R75 had nothin SI/HI when the CAA significant change I regular thoughts of generated did not in interventions or res of SI or HI. RN-B o stated social servic	ponse to try when R75 spoke shecked the care plan and es completes the mood plan and was responsible for					
	stated redirection w he made suicidal of that was not addres plan to direct staff. why the facility polic R75. SW-A stated	p.m. social worker (SW)-A vas appropriate for R75 when r homicidal statements, but ssed specifically on the care SW-A stated he was unsure cy was not being followed for he would check with the other ding this. No further response SW-A.					
	Others dated 2018, "Provide guidelines timely, effective and interventions while individuals within th policy included guid intervention of suici which directed staff	tesident Danger to Self and/or , included a purpose to for the implementation of d safe assessment, and providing safety for all the facility at all times." The delines for assessment and idal behavior/harm to self f to assess the risk by, "a.					

IAME OF PROV IAME OF PROV IN VETERA (X4) ID PREFIX TAG 21495 Co the his abo a p	VIDER OR SUPPLIER SUMMARY STAT (EACH DEFICIENCY REGULATORY OR LS ontinued From page e area. b. Intervis s or her intentions	R BAY 56 OUT SILVER TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		TATE, ZIP CODE	DATE SURVEY COMPLETED 06/14/2018 (X5) COMPLETE DATE
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(X4) ID PREFIX TAG 21495 Co the his abo a p	SUMMARY STA SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS ontinued From page e area. b. Intervie s or her intentions	STREET STREET SF BAY SILVER TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) ge 9	ADDRESS, CITY, S ER DRIVE BAY, MN 5561 ID PREFIX TAG	4 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	(X5) COMPLETE
(X4) ID PREFIX TAG 21495 Co the his abo a p	SUMMARY STA SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS ontinued From page e area. b. Intervie s or her intentions	BAY 56 OUT SILVER TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) ge 9	ER DRIVE BAY, MN 5561 ID PREFIX TAG	4 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETE
(X4) ID PREFIX TAG 21495 Co the his abo a p	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS ontinued From page e area. b. Intervies or her intentions	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) ge 9	BAY, MN 5561	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETE
21495 Co the his abo a p	(EACH DEFICIENCY REGULATORY OR LS ontinued From page e area. b. Intervies or her intentions	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) ge 9	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETE
21495 Co the his abo a p	(EACH DEFICIENCY REGULATORY OR LS ontinued From page e area. b. Intervies or her intentions	BUST BE PRECEDED BY FULL CONTINING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETE
the his abo a p	e area. b. Intervi s or her intentions	-	21495		
his abo a p	s or her intentions	ew the resident to determine			
Wh rec stru life pre giv arr hal sui dire be	plan (i.e. time, pla lected and is the hat are, if any, the cent losses/increa resses/depression e changes)? iv. H eparations for his ving away posses rangements)? v. illucinations (audit icidal or harm to s rected the care pla e reviewed and the	: i. Is the resident thinking erself? ii. Does he/she have ce and opportunity, method method readily available)? ii e precipitating factors (i.e. ased n/difficulty with adaptation to Has the resident made any /her death (i.e. suicide note, sions, making final Any presence of tory or visual) encouraging self? The policy further an and medical record was to e DON was to be notified. The by a debriefing session.	i.		
Th	ne director of nurs view and/or revise	HOD FOR CORRECTION: ing (DON) or designee could policies and procedures to properly cared for if they			
hav	ive suicidal or hor	nicidal ideations.			
		ee could educate the the policies/procedures.			
		ee could develop a monitorir ngoing compliance.	g		
	ME PERIOD FOF 1) days.	R CORRECTION: Twenty-on	9		
	N St. Statute 144. esidents of HC Fa	651 Subd. 20 Patients & c.Bill of Rights	21880		7/6/18
		nces. Patients and residents d and assisted, throughout			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00381	B. WING		06/	14/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
IN VET	ERANS HOME SILVE	R BAY 56 OUTE SILVER E	R DRIVE BAY, MN 5561	4		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21880	Continued From pa	ge 10	21880			
	to understand and o patients, residents, residents may voice changes in policies and others of their o interference, coerci including threat of o grievance procedur well as addresses a Office of Health Fa nursing home ombo Americans Act, sec posted in a conspice Every acute care residential program 253C.01, every nor facility employing m provides outpatient	y or their course of treatment, exercise their rights as and citizens. Patients and e grievances and recommend and services to facility staff choice, free from restraint, on, discrimination, or reprisal, discharge. Notice of the re of the facility or program, as and telephone numbers for the ticlity Complaints and the area udsman pursuant to the Older tion 307(a)(12) shall be uous place.				
	at a minimum, sets followed; specifies limits for facility res or resident to have advocate; requires grievances; and pro an impartial decisio otherwise resolved. residential program 253C.01 which are treatment programs centers with section health maintenance 62D.11 is deemed to	forth the process to be time limits, including time ponse; provides for the patient the assistance of an a written response to written ovides for a timely decision by n maker if the grievance is not Compliance by hospitals, ns as defined in section hospital-based primary s, and outpatient surgery n 144.691 and compliance by e organizations with section to be compliance with the rritten internal grievance				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE S COMPL	
		00381	B. WING		06/14/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
MN VETE	ERANS HOME SILVE	R RAY	ER DRIVE BAY, MN 556	514		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLET DATE
21880	Continued From pa	ige 11	21880			
	by: Based on observat review, the facility f	ent is not met as evidenced ion, interview, and document ailed to ensure grievances ted upon for 1 of 2 residents grievances.		Corrected		
	Findings include:					
	sitting at a dining ro Strong body odors	p.m. R10 was observed oom window eating lunch. were noted coming from R10 ed into the connecting lounge				
	council meeting, R3 his roommate's (R3 stated he did not lik of the pervasive bo could get R10 to ta	5 a.m. during the resident 33 stated he was unhappy with 10) personal body odor. R33 te to be around R10 because dy order, and none of the staff ke a bath. R33 stated all of the R10's body odor, and nothing but it.	f			
	indicated R33's dia	ecord printed 6/14/18, gnoses included major r and paranoid schizophrenia.				
	4/18/18, indicated F	imum Data Set (MDS) dated R33 was cognitively intact, hac nptoms, and displayed no	ł			
	indicated R33 had symptoms and had depression. R33's	e plan printed 6/14/18, the potential for behavioral minimal symptoms of care plan directed staff to express feelings, allow him				

TATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00381	B. WING		06/14/2018	
IAME OF F	ROVIDER OR SUPPLIER		ADDRESS, CITY, ST	TATE, ZIP CODE	00/	14/2010
	RANS HOME SILVE	56 OUT	ER DRIVE			
	RANS HOME SILVE	SILVER	BAY, MN 5561	4		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21880	Continued From pa	age 12	21880			
	offer to sit with him and paranoid. R33 irritability, and use o others. R10's admission re R10's diagnoses in schizophrenia, vaso	e initiated conversation, and when he was feeling anxious 's target behaviors included of negative language toward ecord printed 6/14/18, indicate icluded paranoid cular dementia with behaviora mental disorder due to knowr	d			
	physiological condi R10's annual MDS was independent w decision making, and of depression, no p care. R10's MDS in with activities of da					
	record occurrences indicated R10 requ and set up for bath often declined wee	tiated 6/13/18, directed staff to s of paranoia. R10's care plan ired one assist to supervise ing or showering, but R10 kly bathing or showers, and himself at the skink with <i>v</i> ipes.				
	R33 had reported to concerns about the his roommate. R33 a bath. It's getting be in my room. It n	tes dated 3/28/18, indicated o a nurse that he had e difficulty he had being around s stated, "He [R10] really need so I can hardly barely stand to nakes it hard to live here." Inted that his concerns would	s			
nanata Di		rices progress notes dated 33 expressed concern				

	IT OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00381	B. WING		06/14/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
MN VETE	ERANS HOME SILVE	R BAY	ER DRIVE BAY, MN 5561	4		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21880	Continued From pa	age 13	21880			
	regarding his room	mate's poor hygiene.				
	was offered a bath provided cleansing	tes dated 6/5/18, indicated R10 weekly and as necessary, was cloths and encouraged to use refuse to bathe, and would be couraged to bathe.	5			
	frequently refused	te dated 6/1/18, indicated R10 bathing, was provided with ould be examined as he				
	had not bathed in p	te dated 5/15/18, indicated R10 bast 7 days, and refused oproached by 2 different staff.)			
		tes from 4/18/18, through R10 continuously refused a				
	nurse practitioner (R10 was dishevele long dirty hair, and	vices progress note by the NP) dated 4/25/18, indicated d, had ripped clothing, had continued to refuse bathing, rying to provide different				
	bedroom with a wa	l a.m. R33 walked out of his Ilker, and stated he was still no g body odor came from the /ay.	t			
	technician (HST)-F shower or wash up clothes for him. HS different intervention told her R33 dislike	2 a.m. human services 5 stated she tried to get R10 to 6 every day, and set out clean 6T-F stated the facility has tried ons. HST-F stated the nurse ed his roommate. HST-F stated o report his concerns to social	1			

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00381	B. WING		06/	06/14/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
	ERANS HOME SILVE	R RAY	ER DRIVE BAY, MN 5561	4			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21880	Continued From pa	age 14	21880				
	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.						
	was interviewed an filed a grievance re was no official griev concerns. SW-A s R33 a different room different room. SW R10 about his odor concerns regarding facility has tried pro	p.m. social worker (SW)-A d stated residents have not garding R10's odor, and there vance form for R33's tated the facility has offered m, but he did not want a /-A stated he has spoken with and told R10 about visitor's his odors. SW-A stated the oviding different shower and R10. SW-A stated it was very					
	explained to R33 th had not wanted to f R10's odors have b residents, and she with these resident to try different optic are trying to provide	5 p.m. SW-B stated she has nat R10 has rights, and R33 file a grievance. SW-A stated been brought up by other reviewed the resident's rights s. SW-B stated they continue ons for R10. SW-A stated they e some guidelines for R10, to be independent as much as					
		a.m. outside of R33 and ng body odor was noted into					
	roommate needs to annoying." R33 st R33 stated he did r different room, but is in, and wanted a	a.m. R33 stated his take a shower stating, "It is ated he gets enough sleep. not remember being offered a wanted to stay in the room he different roommate. R33 others complained about					

STATEME	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00004	B. WING		00/44/2048		
		00381			06/14/2018		
NAME OF	PROVIDER OR SUPPLIER	56 OUTE	DRESS, CITY, ST R DRIVE	TATE, ZIP CODE			
MN VET	ERANS HOME SILVE	R RAY	BAY, MN 5561	4			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21880	Continued From pa	age 15	21880				
	clean clothes, but h had talked to one of told R10 had rights are infringed upon shower. R33 stated with R10, and the r R10, but he won't ta On 6/14/18, at 9:35 stated they have tri R10's body odors. I and R33, along with have complained. F about R33's rights RN-C stated they h fresheners/neutraliz private room for R1 On 6/14/18, at 4:08 (DON) stated they grievance, think ab and document on a stated if a resident talk, and do not do stated they had trie wipes, offering a pr interventions. The I R33 a room change advocate for both r verified she had no informal grievances On 6/14/18, at 1:52 know if a room deo tried. SW-A stated medical needs. SV residents' rights are	2 p.m. SW-A stated he did not odorizer/neutralizer had been private rooms were used for V-A acknowledged other e being infringed upon, and the SW office every day talking					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00381	B. WING		06/14/2018	
AME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE	1	
IN VETE	RANS HOME SILVE	R BAY 56 OUTE				
		SILVER E	3AY, MN 5561			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21880	Continued From pa	ige 16	21880			
	ordered a room dec about it. SW-A stat informal resident co at what the facility h concerns regarding they do not have m of grievance logs fr date, indicated ther	p.m. SW-A stated he had odorizer, after asking R33 ted they have not tracked oncerns, so was unable to look had done to address resident's r R10's odors. SW-A stated any formal grievances. Review om 1/18, through the current e had been only one formal as not R33's grievance with				
	2/17, directed resid their concerns and may file a verbal or with any staff mem made to address ve directed the design resolution to the resolution to the r	Resident Grievances dated ents are encouraged to make recommendations known, written concern or grievance ber, and every effort should be erbal complaints. The policy ated staff to report the sident who originated the e working days of the concern, orking days for a grievance.				
	SUGGESTED MET	HOD FOR CORRECTION:				
	review and/or revise ensure resident grie	sing (DON) or designee could e policies and procedures to evances, both voiced and in sed in a timely and satisfactory				
		nee could educate the n the policies/procedures.				
		nee could develop a monitoring ngoing compliance.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X3) DATE SURVEY COMPLETED
		00381	B. WING		06/14/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
	ERANS HOME SILVE	R BAY 56 OUTER SILVER B	R DRIVE AY, MN 556	14	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
21995	Maltreatment of Vu Subd. 4a. Interna (a) Each facility sh ongoing written pro applicable licensing of suspected maltre facility has an intern mandated reporter requirements of this internally. Howeve responsible for con reporting requireme by: Based on interview facility failed to ens resident to resident the administrator at of 10 residents (R2 R2, R26, and R55) care units and had resident altercation Findings include: R27's quarterly Min 4/4/18, indicated R2 impairment, and had	I reporting of maltreatment. all establish and enforce an ocedure in compliance with g rules to ensure that all cases eatment are reported. If a nal reporting procedure, a may meet the reporting s section by reporting r, the facility remains nplying with the immediate ents of this section. ent is not met as evidenced and document review, the ure incidents of alleged t abuse had been reported to nd the State Agency (SA) for 9 7, R281, R79, R16, R44, R6, who resided on the memory been involved in resident to	21995	Corrected	7/6/18
	indicated R27 had assistance, and dis aggressive behavio the assessment pe				
		are Area Assessment (CAA) ated R27 had a history of being			

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION					E SURVEY PLETED
		00381	B. WING		06/	14/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE		
MN VETI	ERANS HOME SILVE	R RAY	FER DRIVE R BAY, MN 5561	4		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	TION SHOULD BE	(X5) COMPLET DATE
21005			24005	DEFICIENC	Y)	
21995	verbally and physic	cally aggressive towards dicated R27 displayed	21995			
	indicated R27 had aggressive behavio assessment indicat from others due to confusion, and disc unable to report ab	Assessment dated 4/4/18, a history of verbal and physic ors towards others. The ted R27 was at risk for abuse difficulty findings words, prientation that made him ouse. The plan directed the ve environment for R27.				
	R27 displayed dep hallucinations due vascular dementia. offer behavioral inte snacks, listening to redirect to tasks or therapy. The plan of	rovided on 6/14/18, indicated ressive statements, visual to Alzheimer's Disease, and The plan directed staff to erventions such as gardening stories or books, movies, activities when agitated, or p directed the staff monitor and 7 displayed behaviors.	et			
	through 6/14/18, o director of nurses (cident reports from 1/1/18, on 6/14/18 at 8:20 a.m. with th (DON) and registered nurse e following information:	ie			
	right forearm and s go of R281's arm, a remove R27's hand sustained injury. R have to be reported as the altercations	5:25 p.m. R27 grabbed R281' squeezed it. R27 would not le and staff members had to d off of R281. Neither resider N-A stated the incident did no d to the administrator of the S did not result in injury. RN-A t that strong so he was unable o others.	t ht SA			
		6:59 p.m. R27 was found in ad R27 pushed up against a				

	NT OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00381	B. WING		06/	14/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY, S	TATE, ZIP CODE		
NN VETI	ERANS HOME SILVE	R BAY 56 OUTE SILVER B	R DRIVE BAY, MN 5561	4		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
21995		-	21995			
	stomach." Staff sep physical injury was investigated the inc determined the dire witnessed a punch therefore, the incide	beceeded to "Punch (R27) in the barated the residents, and no noted. RN-A stated she had bident on 1/22/18, and bect care staff had not between the two residents ent was not reportable. RN-A ers were provided education ate and accurate				
	the dining room tab R27's plate. R27 be residents began ye up and R27 grabbe and grabbed onto F go. Staff members residents and redire	5:48 p.m. R281 reached across ole to remove an item from ecame agitated, and the two lling at each other. They stood ed and pinched R281's arm R281's shirt, and would not let intervened to separate the ect them. RN-A stated the use physical harm, so the portable.				
	ambulating towards resident's paths crowalker towards R27 and made contact. stated R27 was not incident, therefore i 2/5/18, the interdisc incident, contacted	0 p.m. R27 was observed s R16. When the two ossed, R16 "Lunged" his 7, "Took a few swings at [R27]" No injury was noted. RN-A t injured as a result of the it was not reportable. On ciplinary team reviewed the R27's physican for possible anges, and the psychologist				
	room while he was teeth. R27 argued R44 several times i chest. Neither resid	00 p.m. R27 entered R44's in the bathroom brushing his briefly with R44, then struck in the back of his arm and dent sustained injury or of the altercations. RN-A				

STATEMEN	ota Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00381	B. WING		06/	14/2018
	PROVIDER OR SUPPLIER		DDRESS, CITY, SI		00/	14/2010
		56 OUTE	R DRIVE			
MN VETI	ERANS HOME SILVER	SILVER E	BAY, MN 5561	4		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21995	Continued From pa	ge 20	21995			
	was not reportable.	s noted therefore, the incident A "STOP" sign was added to wandering residents from n.				
	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.					
	who was seated in living room. R27 at by tapping him on the swinging his arms a struck "More than c	:01 p.m. R27 approached R16 a recliner in the neighborhood tempted to get R16's attention he chest. R16 responded by and kicking at R27 . R27 was once in his upper leg area." ercation did not result in injury, reportable.				
	the neighborhood li handled cup as he got entangled in R6 get it out. R6 grabb let go. Staff member R6. No injury was altercation did not r not reportable. The temporarily moved	:49 p.m. R27 was packing in ving room. R27 was holding a approached R6. R27's cup i's shirt and R27 was unable to bed R27's wrist and would not ers had to separate R27 and sustained. RN-A stated the esult in injury, therefore it was DON stated R27 had been off of the Birch neighborhood on project. After this occurred, d back to the Birch	,			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		Alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00381	B. WING		06/	14/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
IN VETI	ERANS HOME SILVE	R BAY	ER DRIVE BAY, MN 5561	4		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21995	Continued From pa	age 21	21995			
	wrist while he was a members had to re R27 was not injured did not result in injured did not result in injured reportable. 10. On 5/22/18, at R26 while R26 was began yelling at R2 face, and grabbed redirected R27 awa	 7:18 p.m. R2 grabbed R27's sitting in the living room. Staff direct R2 away from R27. d. RN-A stated the altercation ary, therefore it was not 6:25 p.m. R27 approached a seated in a wheelchair. R27 and "Put his hands in R26's his lift wrist." Direct care staff ay from R26. No injury was the altercation did not result in 				
	injury, therefore it w On 6/14/18, at 9:28 aforementioned inc physical injury or m of the incidents we					
	suffered from sever actions could not be stated the altercation mental anguish, the to be reported to the discussion, the DO suffered from deme make willful actions incidents should ha	a.m. the DON stated R27 re dementia, therefore, his e considered willful. The DON ons did not result in injury or erefore, they were not required e State Agency. Upon further N confirmed residents who entia did have the ability to s therefore, the identified ave been reported to the he SA as directed by the				
	Plan policy dated 2 allegations of abus and state laws. The allegations are repo	ble Adult/Resident Protection /23/17, directed staff to report e in accordance to the federal policy further directed abuse prted immediately. The policy e as the individual must have				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00381	B. WING		06/	14/2018
	PROVIDER OR SUPPLIER		ADDRESS, CITY, ST			14/2010
		56 OUTI	ER DRIVE			
	ERANS HOME SILVE	SILVER	BAY, MN 5561	4		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21995	Continued From pa	age 22	21995			
	have intended to in further directed sta immediately to the administrator, and to the State and Fe SUGGESTED ME ^T The director of nur- review and/or revis ensure allegations administrator and t The DON or design appropriate staff or The DON or design system to ensure of	THOD FOR CORRECTION: sing (DON) or designee could se policies and procedures to of abuse are reported to the	g			