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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: LKLS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00381

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY 10/01/2015 (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds 83 (L18)

13.Total Certified Beds 83 (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: A* (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Kathie Killoran, HFE NE II 11/25/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Certification Specialist 12/03/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. (L31)

30. REMARKS
Sent to CMS / (RO)_____
As an Email notification.
Attached in ACO.

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM | STATE AGENCY REMARKS

CCN: Initial

Initial certification survey for MN Veterans Home Silver Bay was completed on October 1, 2015 to determine the facility's compliance with federal certification requirements as a Skilled Nursing Facility/Nursing Facility. Standard deficiencies were issued.

A Health PCR was completed on November 25, 2015 and the facility was in compliance effective October 20, 2015. Therefore, we are recommending Medicare certification be effective October 20, 2015.

Attached are the following documents: Health CMS-2567 including the plan of correction, Health CMS-2567B, Life Safety Code CMS-2567, CMS-2786R and crucial data extract, CMS-671, CMS-672, CMS-1561, email confirmation that the Office for Civil Rights was submitted, Transfer Agreement, CMS-855 including the approval letter from National Government Services dated October 7, 2015.

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00381	A. Building B. Wing	11/25/2015

Name of Facility	Street Address, City, State, Zip Code
MN VETERANS HOME SILVER BAY	45 BANKS BOULEVARD SILVER BAY, MN 55614

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0425 Reg. # 483.60(a),(b) LSC	Correction Completed 10/20/2015	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	CC/SD	12/01/2015	29625	11/25/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
10/1/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00381	A. BUILDING _____ B. WING _____	10/01/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This was an initial on-site certification survey completed on October 1, 2015 by surveyors of the Minnesota Department of Health, Division of Health Regulation. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.	F 425	The facility understands the need to provide pharmaceutical services to meet the needs of each resident. As noted previously we had 1 resident during our survey review that had a transcription error that resulted in a medication not being provided as ordered by the physician's assistant. ***Our corrective action plan for R5's transcription error occurred as follows:*** The order for Budersonide 0.5 milligrams (mg)/2 milliliter (ml) vial to be given twice a day (BID) is now documented on R5's MAR and being provided as ordered. A medication error follow up report was also completed and reviewed by nursing leadership. All transcription error reports are being followed by our quality improvement team.	**CORRECTED 9-30-2015**

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

Carol A. Gilbertson 10-26-2015 Administrator 10/26/15

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00381	A. BUILDING _____ B. WING _____	10/01/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 9 residents (R5) received medication as ordered by the physician. Findings include: R5's face sheet printed on 9/30/15, indicated diagnoses included asthma. C5's comprehensive significant change Minimum Data Set assessment (MDS) dated 9/15/15, indicated C5 had shortness of breath with exertion, at rest and when lying flat. R5's care plan revised 9/11/15, indicated R5 had shortness of breath related to asthma at times and had an order for nebulizer treatments and directed staff to administer medications for asthma as ordered by the physician. Progress Notes revealed on 9/23/15, R5 had a visit with his practitioner for a one month follow up to address an asthma flare up. Based on his assessment the physician's assistant (PA) chose to continue with R5's twice daily (BID) nebulizer (inhaled medication) treatments. The practitioner order directed staff to continue Budersonide nebulizer (for asthma) 0.5 milligrams (mg)/2 milliliters (ml) vial BID. Review of the current electronic medication administration record (MAR) did not include the Budersonide nebulizer. The MAR for 9/15,	F 425	***Our corrective action plan to assure medication transcription compliance for all of our residents is as follows:*** All licensed nurses and medical records personal have been updated on the: a) Physician's Orders-Transcription Policy changes, b) Transcription Audit Form, c) all resident records will be reviewed for transcription errors daily as noted below and d) resident records are being reviewed for transcription errors prior to implementation of this process. **If transcription errors are noted in our retro-review corrections will be addressed as appropriate.** *The facilities policy and procedure for Physician's Orders-Transcription was updated to include the following process:* 1. 24 hour review by night shift licensed nursing to assure all new orders are transcribed as ordered. **IMPLEMENTED** 2. The night shift licensed nurse will draw a black line beneath the last order identifying their verification of all orders. **IMPLEMENTED** 3. The licensed nurse shall also sign their name on the back line	**CORRECTED 10-20-2015** **CORRECTED 10-20-2015**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00381	A. BUILDING _____ B. WING _____	10/01/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 2 indicated R5's BID Budersonide inhaler was discontinued on 9/24/15 per physician order. The MAR identified the medication was not received after 9/24/15. The MAR was not updated to include the new practitioner order to continue with the Budersonide nebulizer. When observed on 9/30/15, at 10:10 a.m, R5 had audible wheezing which decreased as R5 dozed. When seen again at 3:20 p.m. R5 was lying in bed with the head of bed elevated he was heavily wheezing. During an interview on 9/30/15, at 9:45 a.m. registered nurse (RN)-E verified the nebulizer was omitted so R5 had not received the Budersonide nebulizer since 9/24/15. RN-E verified it was a medication error due to a transcription error. The facility policy and procedure for Physician's Orders-Transcription reviewed 4/15, directed licensed nurses will assure that physician orders are transcribed as ordered. Practitioner's orders were to be accurately and completely transcribed according to facility protocol to ensure appropriate implementation.	F 425	along with date and time of their review. **IMPLEMENTED** *We are monitoring order transcriptions for accuracy using the attached transcription audit form.* See attachment. The review of all resident records for transcription concerns including corrections if noted will be **COMPLETED BY 11/16/2015** We will be monitoring this process in our QAPI program as follows: 1. For 3 consecutive months until 100% compliance is achieved. **November 2015** will be our first monthly review to be reported at our QAPI meeting. 2. Every other month for 6 months to assure 100% compliance is maintained.	**CORRECTED 10-20-2015** **Will be completed 11-16-2015** **QAPI reviews as noted.**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00381	A. BUILDING **01 - MN VETS. HOME SILVER BAY** B. WING _____	**08/25/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETS HOME-SILVER BAY	**45 BANKS BLVD. SILVER BAY, MN 55614**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety State Fire Marshal Division. At the time of this survey Minnesota Veterans Home-Silver Bay was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.. Minnesota Veterans Home-Silver Bay is a one story building, partial basement original year of construction 1960's, and it was converted into a nursing home in the early 1990's. The original building and additions are all Type II(111) construction. The building is fully sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 83 beds and had a census of 80 the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is MET.	K 000		

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

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