

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered February 21, 2021

Administrator MN Veterans Home Silver Bay 56 Outer Drive Silver Bay, MN 55614

RE: CCN: 245628 Cycle Start Date: February 3, 2021

Dear Administrator:

On February 3, 2021, a 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 iwidespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

MN Veterans Home Silver Bay February 21, 2021 Page 2

The state agency may, in lieu of an onsite 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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Terri Ament, Unit Supervisor Duluth District Office 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 Office: (218) 302-6151 Mobile: (218) 766-2720

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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

MN Veterans Home Silver Bay February 21, 2021 Page 3

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.

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 May 3, 2021 (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).

In addition, if substantial compliance with the regulations is not verified by August 3, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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>https://mdhprovidercontent.web.health.state.mn.us/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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html</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.

MN Veterans Home Silver Bay February 21, 2021 Page 4 Feel free to contact me if you have questions.

Sincerely,

Kumala Fiske Downing

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

		& MEDICAID SERVICES				APPROVED . 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION		TE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN			MPLETED
						С
		245628	B. WING _		•	2/03/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE	
	ERANS HOME SILVER	R BAY		56 OUTER DRIVE SILVER BAY, MN 55614		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLÉTION DATE
F 000	INITIAL COMMENT	ſS	F 00	10		
	through 2/3/21, at y complaint investiga NOT to be in comp Requirements for L The following comp substantiated: H562 The following comp substantiated with r actions implemente H5628029C, H5628 However, as a resu deficiencies were ic The facility's plan o as your allegation of Department's accep enrolled in ePOC, y at the bottom of the form. Your electron be used as verificat	alaints were found to be no deficiencies cited due to ed by the facility prior to survey. 3030C, and H5628032C. It of the investigation other dentified. f correction (POC) will serve of compliance upon the otance. Because you are your signature is not required e first page of the CMS-2567 ic submission of the POC will tion of compliance. acceptable electronic POC, an ur facility may be conducted to				
F 563 SS=F	regulations has bee your verification. Right to Receive/De		F 56	;3		3/14/21
	visitors of his or her her choosing, subje	esident has a right to receive r choosing at the time of his or ect to the resident's right to n applicable, and in a manner				
	Y DIRECTOR'S OR PROVIE	ER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE 03/01/2021

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.

DEDADTMENT OF LIEALTH AND LIUMAN CEDVICES

PRINTED: 03/15/2021

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	r		<u>MB NO. 093</u>	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SUF COMPLET	
		245628	B. WING _		C 02/03/2	021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	02/00/2	<u></u>
MN VETE	ERANS HOME SILVER	R BAY		56 OUTER DRIVE SILVER BAY, MN 55614		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE CON	(X5) MPLETIO DATE
F 563	that does not imposively that does not imposively resident. (ii) The facility must a resident by imme of the resident, sub deny or withdraw core (iii) The facility must a resident by others consent of the resident by others consent of the resident by others consent of the resident by any provides health, so the resident, subject or withdraw consent (v) The facility must procedures regarding clinically necessary limitation or safety of such limitations marequirements of this need to place on su the clinical or safety This REQUIREMENT by: Based on interview facility failed to allow This practice had the text of the section of the	se on the rights of another t provide immediate access to diate family and other relatives ject to the resident's right to onsent at any time; t provide immediate access to s who are visiting with the dent, subject to reasonable estrictions and the resident's ndraw consent at any time; et provide reasonable access y entity or individual that cial, legal, or other services to ct to the resident's right to deny	F 56	The MN Veterans Homes Visitation protocol was updated to reflect in privisitation by persons other than ess caregivers and compassion visits p	erson ential	
	families. Findings include:			CMS COVID-19 guidance. Appropr staff were assigned review of protocols/educational materials per to visitation of residents.	iate	
	(DON) stated the fa	o.m. the director of nursing acility had no residents or staff ve COVID-19. The DON as testing for COVID-19 once		The tracking of education completic be reported and followed in our QA team meetings. This process will be	PI	

Facility ID: 00381

If continuation sheet Page 2 of 7

STATEMENT	OF DEFICIENCIES OF CORRECTION	KANNER CALCULAR SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION	(X3) DATE COM	0938-039 E SURVEY PLETED C
		245628	B. WING _				_ 03/2021
NAME OF F	PROVIDER OR SUPPLIER	•		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
MN VET	ERANS HOME SILVE	R BAY			6 OUTER DRIVE ILVER 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 563	Continued From pa	age 2	F 56	53			
p 0 f; 1 0 0 iii v 9 a s f; 7 v v 9 a s s f; 7 v v 0 0 v v f; 1 0 0 iii v v 9 a s s f; 1 0 0 iii v v v 9 a s s f; 1 0 0 iii v v v v v v v v v v v v v v v v	weekly due to the Cook County COVID-19 positivity rate being low. On 2/3/21, at 10:33 a.m. the DON stated the last facility resident tested positive for COVID-19 on 12/18/20, and the last staff-person tested positive				followed monthly x3, if no concerns noted it will be followed quarterly x concerns, we will use a spot audit		
					approach		
	on 1/4/21.	n 1/4/21.			Family/Responsible parties were s communication letter regarding vis options on 2/26/2021.		
	On 2/3/21, at 10:53 interviewed and sta was in crisis staffin guidance, certain e allowed which inclu- stated since the fac- facility was staffed resident care. The when the facility was cares. The DON ve quarantine would h visitation after 1/18 facility was only allo caregiver visits, an visits.			Tracking of visitation occurrence w reported and followed in our QAPI meetings. This process will be follo monthly x3, if no concerns are note be followed quarterly x 3 if no conc we will use a spot audit approach	team wed ed it will		
	On 2/3/21, at 11:06 a.m. R5's family member (FM)-A was interviewed and stated the facility was only allowing essential caregiver visits. FM-A stated she had asked for additional family members to be allowed to visit R3, however, she was told only essential caregivers and compassionate care visits were allowed. FM-A stated R3's health had declined, and she felt it was important for additional family members to visit R3.						
	(FM)-B was intervie only allowed one e	8 a.m. R6's family member ewed and stated the facility ssential caregiver to visit R6. shed his wife could visit R6.					

If continuation sheet Page 3 of 7

		AND HUMAN SERVICES				FORM	03/15/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245628	B. WING				C 03/2021
NAME OF F	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	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 563	FM-B stated he was caregiver could visi On 2/3/21, at 1:00 p was interviewed an allowing essential of compassionate care facility was trying to visitors were enterin The Centers for Me (CMS) Quality Safe memo 20-39-NH (r directed, "facilities without a reasonabl consistent with §48 facility has had no 0 days and its county medium, a nursing visitation consistent can be done by app above. Failure to fa adequate reason re resident safety, wor violation of 42 CFR would be subject to actions."	s told only one essential it. p.m. the social worker (SW)-A d stated the facility was only caregiver visits and egiver visits. SW-A stated the o limit how many outside ng the facility. edicare/Medicaid services ety and Oversight (QSO) nursing homes) dated 9/17/20, s may not restrict visitation le clinical or safety cause, i3.10(f)(4)(v). For example, if a COVID-19 cases in the last 14 v positivity rate is low or home must facilitate in-person t with the regulations, which olying the guidance stated neilitate visitation, without elated to clinical necessity or uld constitute a potential 483.10(f)(4), and the facility o citation and enforcement	F 5	563			
F 626 SS=D	Essential Caregiver directed, "The facili individual resident a essential caregiver Permitting Residen	ts to Return to Facility	F€	626			3/14/21
	§483.15(e)(1) Perm facility.	nitting residents to return to					

If continuation sheet Page 4 of 7

		AND HUMAN SERVICES			F	FORM	03/15/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			X3) DATE COMF	SURVEY PLETED
		245628	B. WING			02/0	;)3/2021
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
MN VETE	RANS HOME SILVER	R BAY			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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 626	on permitting reside after they are hospit therapeutic leave. If following. (i) A resident, whos leave exceeds the b State plan, returns room if available or availability of a bed resident- (A) Requires the se and (B) Is eligible for Me services or Medicai nursing facility serv (ii) If the facility that who was transferre- returning to the faci facility, the facility m requirements of par discharges. §483.15(e)(2) Reac distinct part. When returns is a compos § 483.5), the reside to an available bed composite distinct p previously. If a bed at the time of return availability of a bed This REQUIREMEN by: Based on interview facility failed to reac transferring the reside	bish and follow a written policy ents to return to the facility italized or placed on The policy must provide for the e hospitalization or therapeutic bed-hold period under the to the facility to their previous immediately upon the first in a semi-private room if the ervices provided by the facility; edicare skilled nursing facility id ices. t determines that a resident d with an expectation of ility, cannot return to the nust comply with the ragraph (c) as they apply to dmission to a composite the facility to which a resident site distinct part (as defined in ent must be permitted to return in the particular location of the part in which he or she resided is not available in that location h, the resident must be given to that location upon the first there. NT is not met as evidenced w and document review, the dmit a resident after ident to an emergency	F	326	The policies regarding Bed Hold/Transfers were reviewed. A revi Bed Hold/Transfers and Resident Rig		
	transferring the resi						

Facility ID: 00381

If continuation sheet Page 5 of 7

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT		(X3) DAT	0938-0391 E SURVEY
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG		PLETED
		245628	B. WING _			C 03/2021
NAME OF F	ROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
	RANS HOME SILVER	R 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	BE	(X5) COMPLETION DATE
F 626	Continued From pareviewed for hospital Findings include: R1's Admission Real included dementian psychotic disorder was eizures. On 9/15/20, at 10:3 indicated R1 had ag sent to the ED. R1 was the hospital. On 9/15/20, a verbal Bed Hold by R1's far form indicated R1's facility to hold R1's On 10/2/20, at 2:40 indicated the hospita had attempted to con facility. The note fur (SW)-A had spoken nursing (DON) and determined the faci as a quarantine bed On 10/9/20, at 7:14 indicated R1 was ad nursing facility. On 2/3/21, at 1:00 p primary contact bet hospital. SW-A stat ED on 9/15/21, due behaviors. SW-A v	ge 5 alizations. cord indicated R1's diagnoses with behavioral disturbance, with hallucinations, and 3 p.m. a progress note ggressive behaviors, and was was subsequently admitted to al consent was obtained for a amily member (FM)-A. The family had requested the bed. p.m. a progress note al where R1 was admitted to bordinate R1's return to the orther indicated social worker with both the director of the administrator. It was lity was unable to readmit R1, d was unavailable. p.m. a progress note dmitted to a different skilled o.m. SW-A stated she was the ween the facility and the ted R1 was transferred to the to having aggressive erified R1's family had	F 62	DEFICIENCY)	on will PI are 3 if no fers QAPI oonthly 3 and	
	requested a bed ho	erified R1's family had Id be put in place. SW-A d not allow R1 to return to the				

If continuation sheet Page 6 of 7

PRINTED: 03/15/2021

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	03/15/2021 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245628	B. WING				C 03/2021
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
	ERANS HOME SILVE	R BAY			6 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 626	facility, per the fami R1's bed hold. SW- to return to the facil indicated R1 was re- stated she had disc and the DON, and t 1 was unable to ret COVID-19 outbreak On 2/3/21, at 1:38 p and confirmed R1 h evaluated for increa The DON stated R2 different resident to sent out for a menta manage his aggres stated the intent wa facility, however, wh to discharge back to been a room for R1 to the facility in a C	 ily request, as indicated on A stated R 1 was not allowed lity when the hospital had eady for discharge. SW-A cussions with the administrator the decision was made that R curn to the facility due to a k at the facility. p.m. the DON was interviewed had been sent to the ED to be ased aggressive behaviors. 1 had been involved in two b resident incidents, and was al health evaluation, and to as to have R1 return to the hen R1 was stable and ready to the facility, there had not 1 to quarantine for 14 days due 	F 6	526			

Facility ID: 00381

If continuation sheet Page 7 of 7



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered February 21, 2021

Administrator MN Veterans Home Silver Bay 56 Outer Drive Silver Bay, MN 55614

Re: State Nursing Home Licensing Orders Event ID: TR3O11

Dear Administrator:

The above facility was surveyed on February 2, 2021 through February 3, 2021 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. 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

MN Veterans Home Silver Bay February 21, 2021 Page 2

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Terri Ament, Unit Supervisor Duluth District Office 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 Office: (218) 302-6151 Mobile: (218) 766-2720

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,

Kumala Fiske Downing

Kamala Fiske-Downing Minnesota Department of Health Licensing and Certification Program

MN Veterans Home Silver Bay February 21, 2021 Page 3 Program Assurance Unit Health Regulation Division Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: <u>Kamala.Fiske-Downing@state.mn.us</u>

Minnesc	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(X3) DATE COMP	SURVEY PLETED
		00381	B. WING		02/0	C 3/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
	ERANS HOME SILVER	56 OUTER	R DRIVE			
		SILVER B	AY, MN 556	14		_
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not correct 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 hin 15 days of receipt of a nt for non-compliance.				
	was conducted to d State Licensure. Yo NOT in compliance Please indicate in y correction that you and identify the date	TS: 2/3/21,, an abbreviated survey etermine compliance with ur facility was found to be with the MN State Licensure. our electronic plan of have reviewed these orders, e when they will be completed.				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVID ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE 03/01/21

Electronically Signed

STATE FORM

6899

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		00381	B. WING	· · · · · · · · · · · · · · · · · · ·	02/	03/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
	ERANS HOME SILVE	R BAY	R DRIVE BAY, MN 5561	4		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 000	Continued From pa	ige 1	2 000			
	The following comp SUBSTANTIATED:	plaint was found to be H5628031C.				
	substantiated with	plaints were found to be no deficiencies cited: 8030C, and H5628032C				
	the State Licensing federal software. Ta assigned to Minnes Nursing Homes. Th appears in the far la Tag." The state stat listed in the "Summ column and replace the correction orde the findings which a statute after the stat as evidence by." For	hent of Health is documenting Correction Orders using ag numbers have been sota state statutes/rules for he assigned tag number eft column entitled "ID Prefix atute/rule out of compliance is hary Statement of Deficiencies" es the "To Comply" portion of r. This column also includes are in violation of the state tement, "This Rule is not met pollowing the surveyors findings Method of Correction and rrection.				
	receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s obul.htm. The State delineated on the a Department of Hea you electronically. is necessary for Sta enter the word "CO	tin 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE COMP	SURVEY
		00381	B. WING		C 02/03/2021	
JAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE	02/0	5/2021
		56 OUTE	ER DRIVE			
	ERANS HOME SILVE	SILVER	BAY, MN 556	514		
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
2 000	Continued From pa	ige 2	2 000			
	is enrolled in ePOC	artment of Health. The facility c and therefore a signature is bottom of the first page of				
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	ARD THE HEADING OF THE N WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE.				
2 375	MN Rule 4658.020 Residents;Visitors	0 Subp. 1 Policies Concerning	2 375			3/14/21
	provide access to a guardians, and to a provides health, so religious services to resident's right to d any time. A nursing access to others with the resident's conse restrict visits when	A nursing home must a resident by relatives and any entity or individual that cial, legal, advocacy, or the resident, subject to the eny or withdraw consent at g home must also provide ho are visiting the resident with ent. A nursing home may the visits pose a health or dent or otherwise violate a	1			
	by: Based on interview facility failed to allow This practice had th	ent is not met as evidenced and document review, the w residents to receive visitors. he potential to affect all 58 led at the facility, and their		The Visitation protocol was used reflect in person visitation by other than essential caregive compassion visits per CMS guidance. Appropriate staff review of protocols/educatio pertaining to visitation of res	v persons ers and COVID 19 were assigned nal materials	
	On 2/2/21. at 1:07 t	p.m. the director of nursing		The tracking of education co	mpletion will	
	,,,,,,,					

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 00381		D MILLO	:	(X3) DATE SURVEY COMPLETED C	
NAME OF PROVIDER OR SUPPLIER STRE			B. WING		02/0	3/2021
IAME OF PRO	VIDER OR SUPPLIER			STATE, ZIP CODE		
IN VETERA	ANS HOME SILVER	R ΒΔΥ	TER DRIVE R BAY, MN 550	514		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
2 375 C	ontinued From pa	ge 3	2 375			
di st we po O fa 12 or O in wa gu al st fa re wi ca vis fa ca vis fa ca vis fa ca st st st st or O fa 12 or O fa fa fa fa fa fa fa fa fa fa fa fa fa	agnosed with acti ated the facility we eekly due to the C ositivity rate being n 2/3/21, at 10:33 icility resident test 2/18/20, and the la n 1/4/21. n 2/3/21, at 10:53 terviewed and sta as in crisis staffing uidance, certain e lowed which inclu ated since the fac icility was staffed esident care. The hen the facility wa ares. The DON ve uarantine would he sitation after 1/18, icility was only allo aregiver visits, and sits. n 2/3/21, at 11:06 M)-A was intervie as only allowing e ated she had ask embers to be allo as told only esser ompassionate car ated R3's health h	acility had no residents or star ve COVID-19. The DON as testing for COVID-19 once Cook County COVID-19 once Cook County COVID-19 low. • a.m. the DON stated the las ed positive for COVID-19 on ast staff-person tested positiv • a.m. the DON was tes she believed the facility g. The DON stated under xceptions to visitation were ded crisis staffing. The DON sility had mandated staff, the appropriately to provide DON stated crisis staffing wa is unable to provide resident wified the required 14-day ad allowed the facility to perm /21. The DON confirmed the owing virtual visits, essential d compassionate care givers a.m. R5's family member wed and stated the facility issential caregiver visits. FM ed for additional family wed to visit R3, however, she stal caregivers and e visits were allowed. FM-A had declined, and she felt it dditional family members to	e t ve as nit	be reported and followed in team meetings. This process followed monthly x3 if no constant noted it will be followed quat concerns, we will use a spot approach Family/Responsible partiess communication letter regard options on 2/26/2021. Tracking of visitation occurr reported and followed in our meetings. This process will monthly x3 if no concerns a be followed quarterly x 3 if no we will use a spot audit app	ss will be oncerns are arterly x 3 if no ot audit were sent a ding visitation rence will be r QAPI team be followed are noted it will no concerns,	

STATEMEN	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _		COM	E SURVEY PLETED
		00381	B. WING			C 03/2021
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
MN VETI	ERANS HOME SILVE	R RAY	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 T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
2 375	Continued From pa	ige 4	2 375			
	only allowed one essential caregiver to visit R6. FM-B stated he wished his wife could visit R6. FM-B stated he was told only one essential caregiver could visit. On 2/3/21, at 1:00 p.m. the social worker (SW)-A					
<pre></pre>	was interviewed an allowing essential o compassionate car	d stated the facility was only caregiver visits and egiver visits. SW-A stated the b limit how many outside				
	(CMS) Quality Safe memo 20-39-NH (directed, "facilitie without a reasonab consistent with §48 facility has had no days and its county medium, a nursing visitation consisten can be done by app above. Failure to fa adequate reason re resident safety, wo violation of 42 CFR	edicare/Medicaid services ety and Oversight (QSO) nursing homes) dated 9/17/20 s may not restrict visitation le clinical or safety cause, i3.10(f)(4)(v). For example, if a COVID-19 cases in the last 14 y positivity rate is low or home must facilitate in-person t with the regulations, which olying the guidance stated acilitate visitation, without elated to clinical necessity or uld constitute a potential 483.10(f)(4), and the facility o citation and enforcement	ı			
	Essential Caregive directed, "The facili	tled MN Veterans Home - r Visit Protocol dated 8/27/20, ity will work with each and family to designate 1 for each resident."				
	The Director of Nur designee could dev	THOD OF CORRECTION: rsing and/or administrator or velop, review, and/or revise dures to ensure residents'				

If continuation sheet 5 of 9

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PLAN OF CORRECTION (X1) 00381			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		B. WING		C 02/03/2021		
					02/	03/2021
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST R DRIVE	IATE, ZIP CODE		
MN VETI	ERANS HOME SILVE	R BAY	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	TION SHOULD BE COM THE APPROPRIATE	
2 375	Continued From page 5		2 375			
	Nursing or designe staff on the policies Director of Nursing monitoring systems compliance.	s upheld. The Director of e could educate all appropriate s and procedures. The or designee could develop s to ensure ongoing R CORRECTION: Twenty-one				
21925	(21) days.	.651 Subd. 29 Patients &	21925			3/14/21
	shall not be arbitra Residents must be proposed discharg justification no late discharge from the transfer to another notice shall include the proposed actio telephone number ombudsman pursu Act, section 307(a) of this right, may cl notice period ends shortened in situati control, such as a c review, the accommod residents, a change treatment program resident's welfare, prohibited by the pup paying for the resident the medical record	ers and discharges. Residents rily transferred or discharged. notified, in writing, of the e or transfer and its r than 30 days before e facility and seven days before room within the facility. This e the resident's right to contest n, with the address and of the area nursing home ant to the Older Americans (12). The resident, informed noose to relocate before the . The notice period may be ons outside the facility's determination by utilization modation of newly-admitted e in the resident's medical or , the resident's own or another or nonpayment for stay unless ublic program or programs lent's care, as documented in . Facilities shall make a p accommodate new residents oom assignments.				

If continuation sheet 6 of 9

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00381		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00381	B. WING		C 02/03/2021	
	PROVIDER OR SUPPLIER			STATE, ZIP CODE	02/0	0/2021
		56 OUTE	ER DRIVE			
MN VETI	ERANS HOME SILVE	R BAY	BAY, MN 556	614		
(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 ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLET DATE
21925	Continued From pa	ige 6	21925			
	 Continued From page 6 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to readmit a resident after transferring the resident to an emergency department (ED) for 1 of 3 residents (R1) reviewed for hospitalizations. Findings include: R1's Admission Record indicated R1's diagnoses included dementia with behavioral disturbance, psychotic disorder with hallucinations, and seizures. On 9/15/20, at 10:33 p.m. a progress note indicated R1 had aggressive behaviors, and was sent to the ED. R1 was subsequently admitted to the hospital. On 9/15/20, a verbal consent was obtained for a Bed Hold by R1's family member (FM)-A. The form indicated R1's family had requested the 			Policies regarding Bed Hol were reviewed. Review of Hold/Transfers and Reside assigned to appropriate sta The tracking of education of be reported and followed in team meetings. This proce followed monthly x3 if no co noted it will be followed qu concerns, we will use a sp approach. Monitoring of Bed holds, a be tracked and reported in meetings. Reporting will be no concerns then quarterly concerns we will monitored intermittent basis.	Bed ent Rights were aff. completion will n our QAPI ess will be concerns are arterly x 3 if no ot audit nd Transfers will our QAPI team e monthly x 3, if x 3 and if no	
	indicated the hospir had attempted to ca facility. The note fu (SW)-A had spoker nursing (DON) and determined the faci as a quarantine bea On 10/9/20, at 7:14 indicated R1 was a nursing facility.	p.m. a progress note tal where R1 was admitted to oordinate R1's return to the urther indicated social worker on with both the director of the administrator. It was ility was unable to readmit R1,				

Minnesc	ota Department of He	ealth				
AND PLAN OF CORRECTION IDENTIF		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED C 02/03/2021	
		00381				
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	• -	
	ERANS HOME SILVE	B BAY 56 OUTE				
		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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21925	Continued From page 7		21925			
	hospital. SW-A sta ED on 9/15/21, due behaviors. SW-A v requested a bed ho stated the facility di facility, per the fam R1's bed hold. SW- to return to the faci indicated R1 was re- stated she had disc and the DON, and 1 was unable to ret COVID-19 outbreat On 2/3/21, at 1:38 and confirmed R1 H evaluated for increat The DON stated R different resident to sent out for a ment manage his aggress stated the intent wa facility, however, w to discharge back to been a room for R1 to the facility in a C A policy on readmiss provided. SUGGESTED MET The administrator of review, and/or reviss ensure staff are ed notice, and to ensu- include the residen are appropriately in or designee could of the bed hold and ref	ated R1 was transferred to the e to having aggressive verified R1's family had old be put in place. SW-A id not allow R1 to return to the ily request, as indicated on -A stated R 1 was not allowed lity when the hospital had eady for discharge. SW-A cussions with the administrator the decision was made that R turn to the facility due to a k at the facility. p.m. the DON was interviewed had been sent to the ED to be ased aggressive behaviors. 1 had been involved in two o resident incidents, and was al health evaluation, and to easive behaviors. The DON as to have R1 return to the hen R1 was stable and ready to the facility, there had not 1 to quarantine for 14 days due				

If continuation sheet 8 of 9

PRINTED: 03/15/2021 FORM APPROVED

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		A. BUILDING.		С		
		00381	B. WING			03/2021
AME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	TATE, ZIP CODE		
N VETE	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 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21925	Continued From page 8		21925			
	develop monitoring systems to ensure ongoing compliance.					
	TIME PERIOD FOR CORRECTION: Twenty-one (21) Days.		e			

TR3011