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.

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

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: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245628	A. BUILDING _____ B. WING _____	C 02/03/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An abbreviated survey was completed on 2/2/21, through 2/3/21, at your facility to conduct complaint investigations. Your facility was found NOT to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be substantiated: H5628031C. The following complaints were found to be substantiated with no deficiencies cited due to actions implemented by the facility prior to survey. H5628029C, H5628030C, and H5628032C. However, as a result of the investigation other deficiencies were identified. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 563 SS=F	Right to Receive/Deny Visitors CFR(s): 483.10(f)(4)(ii)-(v) §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner	F 563		3/14/21

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

Electronically Signed | 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.

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F 563	Continued From page 1 that does not impose on the rights of another resident. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to allow residents to receive visitors. This practice had the potential to affect all 58 residents who resided at the facility, and their families. Findings include: On 2/2/21, at 1:07 p.m. the director of nursing (DON) stated the facility had no residents or staff diagnosed with active COVID-19. The DON stated the facility was testing for COVID-19 once	F 563	The MN Veterans Homes Visitation protocol was updated to reflect in person visitation by persons other than essential caregivers and compassion visits per CMS COVID-19 guidance. Appropriate staff were assigned review of protocols/educational materials pertaining to visitation of residents. The tracking of education completion will be reported and followed in our QAPI team meetings. This process will be	

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F 563	Continued From page 2 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 on 1/4/21. On 2/3/21, at 10:53 a.m. the DON was interviewed and states she believed the facility was in crisis staffing. The DON stated under guidance, certain exceptions to visitation were allowed which included crisis staffing. The DON stated since the facility had mandated staff, the facility was staffed appropriately to provide resident care. The DON stated crisis staffing was when the facility was unable to provide resident cares. The DON verified the required 14-day quarantine would had allowed the facility to permit visitation after 1/18/21. The DON confirmed the facility was only allowing virtual visits, essential caregiver visits, and compassionate care givers visits. 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. On 2/3/21, at 11:28 a.m. R6's family member (FM)-B was interviewed and stated the facility only allowed one essential caregiver to visit R6. FM-B stated he wished his wife could visit R6.	F 563	followed monthly x3, if no concerns are noted it will be followed quarterly x 3 if no concerns, we will use a spot audit approach Family/Responsible parties were sent a communication letter regarding visitation options on 2/26/2021. Tracking of visitation occurrence will be reported and followed in our QAPI team meetings. This process will be followed monthly x3, if no concerns are noted it will be followed quarterly x 3 if no concerns, we will use a spot audit approach	

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F 563	Continued From page 3 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 was interviewed and stated the facility was only allowing essential caregiver visits and compassionate caregiver visits. SW-A stated the facility was trying to limit how many outside visitors were entering the facility. The Centers for Medicare/Medicaid services (CMS) Quality Safety and Oversight (QSO) memo 20-39-NH (nursing homes) dated 9/17/20, directed, "...facilities may not restrict visitation without a reasonable clinical or safety cause, consistent with §483.10(f)(4)(v). For example, if a facility has had no COVID-19 cases in the last 14 days and its county positivity rate is low or medium, a nursing home must facilitate in-person visitation consistent with the regulations, which can be done by applying the guidance stated above. Failure to facilitate visitation, without adequate reason related to clinical necessity or resident safety, would constitute a potential violation of 42 CFR 483.10(f)(4), and the facility would be subject to citation and enforcement actions." The facility policy titled MN Veterans Home - Essential Caregiver Visit Protocol dated 8/27/20, directed, "The facility will work with each individual resident and family to designate 1 essential caregiver for each resident."	F 563		
F 626 SS=D	Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2) §483.15(e)(1) Permitting residents to return to facility.	F 626		3/14/21

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F 626	Continued From page 4 A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. This 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)	F 626	The policies regarding Bed Hold/Transfers were reviewed. A review of Bed Hold/Transfers and Resident Rights were assigned to appropriate staff.	

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F 626	Continued From page 5 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 facility to hold R1's bed. On 10/2/20, at 2:40 p.m. a progress note indicated the hospital where R1 was admitted to had attempted to coordinate R1's return to the facility. The note further indicated social worker (SW)-A had spoken with both the director of nursing (DON) and the administrator. It was determined the facility was unable to readmit R1, as a quarantine bed was unavailable. On 10/9/20, at 7:14 p.m. a progress note indicated R1 was admitted to a different skilled nursing facility. On 2/3/21, at 1:00 p.m. SW-A stated she was the primary contact between the facility and the hospital. SW-A stated R1 was transferred to the ED on 9/15/21, due to having aggressive behaviors. SW-A verified R1's family had requested a bed hold be put in place. SW-A stated the facility did not allow R1 to return to the	F 626	The tracking of education completion will be reported and followed in our QAPI team meetings. This process will be followed monthly x3 if no concerns are noted it will be followed quarterly x 3 if no concerns, we will use a spot audit approach. Monitoring of Bed holds, and Transfers will be tracked and reported in our QAPI team meetings. Reporting will be monthly x 3, if no concerns then quarterly x 3 and if no concerns we will monitored on an intermittent basis.	

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F 626	Continued From page 6	F 626		

facility, per the family request, as indicated on R1's bed hold. SW-A stated R 1 was not allowed to return to the facility when the hospital had indicated R1 was ready for discharge. SW-A stated she had discussions with the administrator and the DON, and the decision was made that R 1 was unable to return to the facility due to a COVID-19 outbreak at the facility.

On 2/3/21, at 1:38 p.m. the DON was interviewed and confirmed R1 had been sent to the ED to be evaluated for increased aggressive behaviors. The DON stated R1 had been involved in two different resident to resident incidents, and was sent out for a mental health evaluation, and to manage his aggressive behaviors. The DON stated the intent was to have R1 return to the facility, however, when R1 was stable and ready to discharge back to the facility, there had not been a room for R1 to quarantine for 14 days due to the facility in a COVID-19 outbreak.

A policy on readmission was requested and not provided.

DEPARTMENT OF HEALTH

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at 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

"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,

Kamala 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: Kamala.Fiske-Downing@state.mn.us

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 2/2/21, through 2/3/21,, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5628031C. The following complaints were found to be substantiated with no deficiencies cited: H5628029C, H5628030C, and H5628032C Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to	2 000		

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	00381	A. BUILDING: _____ B. WING _____	C 02/03/2021

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2 000	Continued From page 2 the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 375	MN Rule 4658.0200 Subp. 1 Policies Concerning Residents;Visitors Subpart 1. Visitors. A nursing home must provide access to a resident by relatives and guardians, and to any entity or individual that provides health, social, legal, advocacy, or religious services to the resident, subject to the resident's right to deny or withdraw consent at any time. A nursing home must also provide access to others who are visiting the resident with the resident's consent. A nursing home may restrict visits when the visits pose a health or safety risk to a resident or otherwise violate a resident's rights. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to allow residents to receive visitors. This practice had the potential to affect all 58 residents who resided at the facility, and their families. Findings include: On 2/2/21, at 1:07 p.m. the director of nursing	2 375	The Visitation protocol was updated to reflect in person visitation by persons other than essential caregivers and compassion visits per CMS COVID 19 guidance. Appropriate staff were assigned review of protocols/educational materials pertaining to visitation of residents. The tracking of education completion will	3/14/21

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2 375	Continued From page 3 (DON) stated the facility had no residents or staff diagnosed with active COVID-19. The DON stated the facility was testing for COVID-19 once 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 on 1/4/21. On 2/3/21, at 10:53 a.m. the DON was interviewed and states she believed the facility was in crisis staffing. The DON stated under guidance, certain exceptions to visitation were allowed which included crisis staffing. The DON stated since the facility had mandated staff, the facility was staffed appropriately to provide resident care. The DON stated crisis staffing was when the facility was unable to provide resident cares. The DON verified the required 14-day quarantine would had allowed the facility to permit visitation after 1/18/21. The DON confirmed the facility was only allowing virtual visits, essential caregiver visits, and compassionate care givers visits. 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. On 2/3/21, at 11:28 a.m. R6's family member (FM)-B was interviewed and stated the facility	2 375	be reported and followed in our QAPI team meetings. This process will be followed monthly x3 if no concerns are noted it will be followed quarterly x 3 if no concerns, we will use a spot audit approach Family/Responsible parties were sent a communication letter regarding visitation options on 2/26/2021. Tracking of visitation occurrence will be reported and followed in our QAPI team meetings. This process will be followed monthly x3 if no concerns are noted it will be followed quarterly x 3 if no concerns, we will use a spot audit approach	

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2 375	Continued From page 4 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 was interviewed and stated the facility was only allowing essential caregiver visits and compassionate caregiver visits. SW-A stated the facility was trying to limit how many outside visitors were entering the facility. The Centers for Medicare/Medicaid services (CMS) Quality Safety and Oversight (QSO) memo 20-39-NH (nursing homes) dated 9/17/20, directed, "...facilities may not restrict visitation without a reasonable clinical or safety cause, consistent with §483.10(f)(4)(v). For example, if a facility has had no COVID-19 cases in the last 14 days and its county positivity rate is low or medium, a nursing home must facilitate in-person visitation consistent with the regulations, which can be done by applying the guidance stated above. Failure to facilitate visitation, without adequate reason related to clinical necessity or resident safety, would constitute a potential violation of 42 CFR 483.10(f)(4), and the facility would be subject to citation and enforcement actions." The facility policy titled MN Veterans Home - Essential Caregiver Visit Protocol dated 8/27/20, directed, "The facility will work with each individual resident and family to designate 1 essential caregiver for each resident." SUGGESTED METHOD OF CORRECTION: The Director of Nursing and/or administrator or designee could develop, review, and/or revise policies and procedures to ensure residents'	2 375		

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2 375	Continued From page 5 rights to visitation is upheld. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 375		
21925	MN St. Statute 144.651 Subd. 29 Patients & Residents of HC Fac.Bill of Rights Subd. 29. Transfers and discharges. Residents shall not be arbitrarily transferred or discharged. Residents must be notified, in writing, of the proposed discharge or transfer and its justification no later than 30 days before discharge from the facility and seven days before transfer to another room within the facility. This notice shall include the resident's right to contest the proposed action, with the address and telephone number of the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12). The resident, informed of this right, may choose to relocate before the notice period ends. The notice period may be shortened in situations outside the facility's control, such as a determination by utilization review, the accommodation of newly-admitted residents, a change in the resident's medical or treatment program, the resident's own or another resident's welfare, or nonpayment for stay unless prohibited by the public program or programs paying for the resident's care, as documented in the medical record. Facilities shall make a reasonable effort to accommodate new residents without disrupting room assignments.	21925		3/14/21

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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 facility to hold R1's bed. On 10/2/20, at 2:40 p.m. a progress note indicated the hospital where R1 was admitted to had attempted to coordinate R1's return to the facility. The note further indicated social worker (SW)-A had spoken with both the director of nursing (DON) and the administrator. It was determined the facility was unable to readmit R1, as a quarantine bed was unavailable. On 10/9/20, at 7:14 p.m. a progress note indicated R1 was admitted to a different skilled nursing facility. On 2/3/21, at 1:00 p.m. SW-A stated she was the primary contact between the facility and the	21925	Policies regarding Bed Hold/Transfers were reviewed. Review of Bed Hold/Transfers and Resident Rights were assigned to appropriate staff. The tracking of education completion will be reported and followed in our QAPI team meetings. This process will be followed monthly x3 if no concerns are noted it will be followed quarterly x 3 if no concerns, we will use a spot audit approach. Monitoring of Bed holds, and Transfers will be tracked and reported in our QAPI team meetings. Reporting will be monthly x 3, if no concerns then quarterly x 3 and if no concerns we will monitored on an intermittent basis.	

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21925	Continued From page 7	21925		

hospital. SW-A stated R1 was transferred to the ED on 9/15/21, due to having aggressive behaviors. SW-A verified R1's family had requested a bed hold be put in place. SW-A stated the facility did not allow R1 to return to the facility, per the family request, as indicated on R1's bed hold. SW-A stated R 1 was not allowed to return to the facility when the hospital had indicated R1 was ready for discharge. SW-A stated she had discussions with the administrator and the DON, and the decision was made that R 1 was unable to return to the facility due to a COVID-19 outbreak at the facility.

On 2/3/21, at 1:38 p.m. the DON was interviewed and confirmed R1 had been sent to the ED to be evaluated for increased aggressive behaviors. The DON stated R1 had been involved in two different resident to resident incidents, and was sent out for a mental health evaluation, and to manage his aggressive behaviors. The DON stated the intent was to have R1 return to the facility, however, when R1 was stable and ready to discharge back to the facility, there had not been a room for R1 to quarantine for 14 days due to the facility in a COVID-19 outbreak.

A policy on readmission was requested and not provided.

SUGGESTED METHOD OF CORRECTION:
The administrator or designee could develop, review, and/or revise policies and procedures to ensure staff are educated on the bed hold policy notice, and to ensure resident rights, which include the resident's rights to return to the facility are appropriately implemented. The administrator or designee could educate all appropriate staff on the bed hold and reasons for transfer policies and procedures. The administrator or designee could

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21925	Continued From page 8 develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days.	21925		