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Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7289

**NOTICE OF TOTAL AMOUNT OF ASSESSMENT
FOR NURSING HOMES**

November 25, 2013

Ms. Carol Gilbertson, Administrator
Minnesota Veterans Home Silver Bay
45 Banks Boulevard
Silver Bay, Minnesota 55614

RE: Project Number SL00381021

Dear Ms. Gilbertson:

On September 24, 2013, a Notice of Assessment for Noncompliance with Correction Orders was issued to the above facility. That Notice, which was received by the facility on September 24, 2013, imposed a daily fine in the amount of \$500.00.

On September 24, 2013, a written notification was received by the Department stating that the violations had been corrected. A reinspection was held on September 24, 2013 and it was determined that compliance with the licensing rules was attained. A copy of the State Form: Revisit Report from this visit is attached.

Therefore, the total amount of the assessment is \$500.00. In accordance with Minnesota Statutes, section 144A.10, subdivision 7, the costs of the reinspection, totaling \$928.00, are to be added to the total amount of the assessment. You are required to submit a check, made payable to the Commissioner of Finance, Treasury Division, in the amount of \$1,428.00 within 15 days of the receipt of this notice. That check should be forwarded to the Department of Health, Division of Compliance Monitoring, 85 East Seventh Place, Suite 220, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

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.

Mn Veterans Home Silver Bay

November 25, 2013

Page 2

Sincerely

Pat Halverson

Pat Halverson, Duluth District Office Unit Supervisor
Minnesota Department of Health
Licensing and Certification Program
Division of Compliance Monitoring
11 E Superior Street #290, Duluth, Minnesota 55802
Telephone: 218-302-6151

cc: Licensing and Certification File
Pat Halverson, Duluth District Office Survey and Review Unit
Shellae Dietrich, Licensing and Certification Program
Penalty Assessment Deposit Staff



Protecting, Maintaining and Improving the Health of Minnesotans

October 30, 2013

Ms. Carol Gilbertson, Administrator
Mn Veterans Home Silver Bay
45 Banks Boulevard
Silver Bay, MN 55614

RE: Project Number SL00381021
Licensing Followup

Dear Ms. Gilbertson:

This is to inform you of the results of a facility visit completed by staff of the Minnesota Department of Health, Licensing and Certification Program, on September 24, 2013.

The documents checked below are enclosed.

CMS-2567 or CMS-2567L, Statement of Deficiencies and Plan of Correction

This Federal form is enclosed if deficiencies were not corrected or new deficiencies were noted at the time of the post certification revisit. The right side of the form is to be completed with your written plan for corrective action. The plan must be specific, realistic, include date for correction of each deficiency and signed by the administrator or authorized official of the facility. Please make a copy of the form for your records and return the original to the above address within ten calendar days of the receipt of this letter.

X CMS-2567B, Post Certification Revisit Form

If your facility was cited for one or more deficiencies at the time of the last full survey, those in compliance on reinspection are cited on this form.

H.R. 2620, Information Memorandum

Items noted and discussed at the facility visit including status of outstanding licensing correction orders.

HE-01239-02, Correction Order

Correction order(s) issued pursuant to visit of your facility.

Assessment Notices

- FPC2696 Notice of Assessment of Supervised Living Facility
- FPC2697 Notice of Assessment of Assisted Living Home Care Providers

Mn Veterans Home Silver Bay

October 30, 2013

Page 2

- FPC2698 Notice of Assessment of Home Care Providers

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.

Feel free to call me if you have any questions.

Sincerely,



Pat Halverson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
11 E Superior St #290, Duluth, MN 55802
Telephone: 218 308 6151 Fax: 218 723 2359

Enclosure

cc: Licensing and Certification File
Pat Halverson, Unit Supervisor

L00381R2.let



Protecting, Maintaining and Improving the Health of Minnesotans

**NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS
FOR NURSING HOMES**

Hand Delivered on September 24, 2013.

September 24, 2013

Ms. Carol Gilbertson, Administrator
Mn Veterans Home Silver Bay
45 Banks Boulevard
Silver Bay, MN 55614

Re: Project # SL00381021

Dear Ms. Gilbertson:

On August 15, 2013, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 23, 2013 with orders received by you on June 4, 2013.

State licensing orders issued pursuant to the last survey completed on May 23, 2013 and found corrected at the time of this August 15, 2013 revisit, are listed on the attached Revisit Report Form.

State licensing orders issued pursuant to the last survey completed on May 23, 2013, found not corrected at the time of this August 15, 2013 revisit and subject to penalty assessment are as follows:

0000-Initial Comments-

1390-\$300 Infection Control-Mn Rule 4658.0800 Subp. 4 A-I

1400-\$200 Resident Tuberculosis Program-Mn Rule 4658.0810 Subp. 1

The details of the violations noted at the time of this revisit completed on August 15, 2013 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, sign and date this form or return it to the Minnesota Department of Health if there are no new orders issued.

Therefore, in accordance with Minnesota Statutes, section 144A.10, you will be assessed an amount of \$500 per day beginning on the day you receive this notice.

The fines shall accumulate daily until written notification from the nursing home is received by the

Department stating that the orders have been corrected. This written notification shall be mailed or delivered to the Department at the address below or to , Minnesota Department of Health, Licensing and Certification Program, Division of Compliance Monitoring, 11 E Superior St #290, Duluth, Mn 55802.

When the Department receives notification that the orders are corrected, a reinspection will be conducted to verify that acceptable corrections have been made. If it is determined that acceptable corrections have not been made, the daily accumulation of the fines shall resume and the amount of the fines which otherwise would have accrued during the period prior to resumption shall be added to the total assessment. The resumption of the fine can be challenged by requesting a hearing within 15 days of the receipt of the notice of the resumption of the fine.

If the accumulation of the fine is resumed, the fines will continue to accrue in the manner described above until a written notification stating that the orders have been corrected is verified by the Department.

The costs of all reinspections required to verify whether acceptable corrections have been made will be added to the total amount of the assessment.

You may request a hearing of any of the above noted penalty assessments provided that a written request is made within 15 days of the receipt of this Notice. Any request for a hearing shall be sent to Mary Henderson, Minnesota Department of Health, Licensing and Certification Program, Division of Compliance Monitoring, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

Once the penalty assessments have been verified as corrected the facility will receive a notice of the total amount of the penalty assessment including the costs of any reinspections.

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.

Sincerely,



Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File
Duluth District Office Survey and Review Unit
Shellae Dietrich, Licensing and Certification Program
Penalty Assessment Deposit Staff

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number 00381	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 9/24/2013
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Name of Facility MN VETERANS HOME SILVER BAY	Street Address, City, State, Zip Code 45 BANKS BOULEVARD SILVER BAY, MN 55614
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This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (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 <u>21390</u> Reg. # <u>MN Rule 4658.0800 Subp.</u> LSC _____	Correction Completed <u>09/24/2013</u>	ID Prefix <u>21400</u> Reg. # <u>MN Rule 4658.0810 Subp.</u> LSC _____	Correction Completed <u>09/24/2013</u>	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: _____
Reviewed By _____ CMS RO	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: 5/23/2013	<input type="checkbox"/> Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? <table style="display: inline-table; vertical-align: middle;"> <tr> <td style="text-align: center;">YES</td> <td style="text-align: center;">NO</td> </tr> </table>	YES	NO
YES	NO		

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number 00381	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 8/15/2013
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Name of Facility MN VETERANS HOME SILVER BAY	Street Address, City, State, Zip Code 45 BANKS BOULEVARD SILVER BAY, MN 55614
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This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (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 20560 Reg. # MN Rule 4658.0405 Subp. LSC	Correction Completed 08/15/2013	ID Prefix 20565 Reg. # MN Rule 4658.0405 Subp. LSC	Correction Completed 08/15/2013	ID Prefix 20895 Reg. # MN Rule 4658.0525 Subp. LSC	Correction Completed 08/15/2013
ID Prefix 21525 Reg. # MN Rule 4658.1305 A.B.C LSC	Correction Completed 08/15/2013	ID Prefix 21565 Reg. # MN Rule 4658.1325 Subp. LSC	Correction Completed 08/15/2013	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 PH/KJ	Date: 9-5-2013	Signature of Surveyor: 12831	Date: 8-15-2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 5/23/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00381	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 08/15/2013
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NAME OF PROVIDER OR SUPPLIER MN VETERANS HOME SILVER BAY	STREET ADDRESS, CITY, STATE, ZIP CODE 45 BANKS BOULEVARD SILVER BAY, MN 55614
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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{2 000}	<p>Initial Comments</p> <p style="text-align: center;">*****ATTENTION*****</p> <p style="text-align: center;">NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: On 8/14/2013 through 8/15/2013, surveyor of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and</p>	{2 000}		
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Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00381	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/15/2013
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NAME OF PROVIDER OR SUPPLIER MN VETERANS HOME SILVER BAY	STREET ADDRESS, CITY, STATE, ZIP CODE 45 BANKS BOULEVARD SILVER BAY, MN 55614
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 000}	Continued From page 1 Certification Program; 11 East Superior Street, Suite 290, Duluth, MN 55802	{2 000}		
{21390}	<p>MN Rule 4658.0800 Subp. 4 A-I Infection Control</p> <p>Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following:</p> <ul style="list-style-type: none"> A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. <p>This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop an infection control</p>	{21390}		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00381	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/15/2013
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NAME OF PROVIDER OR SUPPLIER MN VETERANS HOME SILVER BAY	STREET ADDRESS, CITY, STATE, ZIP CODE 45 BANKS BOULEVARD SILVER BAY, MN 55614
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{21390}	<p>Continued From page 2</p> <p>surveillance plan to identify and monitor resident infections.</p> <p>Findings included:</p> <p>The east unit Infection control Daily Operations Report dated from 7/18/13, through 8/11/13, had 5 new acute infections documented. Although the facility had indicated that the organism was non applicable there was no information regarding the of the infection type or site, and no evidence to indicate if the infection was nosocomial.</p> <p>Interview on 8/14/13, at 3:45 pm with the infection control nurse RN-A stated that he could not tell what type of infection the antibiotics (three Cipros, Microbiol and amoxicillin) listed on the east units form, were treating. When asked if he had data indicating if the infections were nosocomial, he said, that he would review that monthly, however, had no data indicating if the infections were nosocomial or not.</p> <p>The facility policy and procedure on Infection Control Program was requested on 8/14/13 at 3:45 pm and on 8/15/13 at 2:00 pm. The infection control nurse provided a E-mail that indicated they would use a daily infection control report form. Staff were to complete the form on every shift. The form (Infection Control Daily Operations Report) included date, resident initials, acute/chronic, new, organism, antibiotic and comments.</p> <p>Time Period for Correction: Twenty one (21) days.</p>	{21390}		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00381	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/15/2013
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NAME OF PROVIDER OR SUPPLIER MN VETERANS HOME SILVER BAY	STREET ADDRESS, CITY, STATE, ZIP CODE 45 BANKS BOULEVARD SILVER BAY, MN 55614
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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{21400}	<p>MN Rule 4658.0810 Subp. 1 Resident Tuberculosis Program</p> <p>Subpart 1. Pursuant to Minnesota Rule 4658.0040, and as defined in Minnesota Department of Health Informational Bulletin 09-02 Tuberculosis Prevention and Control Guidelines: Nursing Homes, Minnesota Rule 4658.0810 Subpart 1 Resident Tuberculosis Program is waived.</p> <p>Conditions of Waiver:</p> <ul style="list-style-type: none"> - All residents must receive baseline TB screening within 72 hours of admission or within 3 months prior to admission. TB Screening must include an assessment of the resident's risk factors for TB, and any current TB symptoms, and a two-step TST or a single interferon gamma release assay (IGRA) for M. tuberculosis (e.g., QuantiFERON® TB Gold or TB Gold In Tube, T-SPOT®.TB). Routine serial TB screening of residents may be done at the discretion of the infection control team. - All reports and copies of resident tuberculin skin tests (TSTs), results from IGRAs for M. tuberculosis, medical evaluations, and chest radiograph results must be maintained in the resident's medical record. Consult current CDC recommendations for the diagnosis of TB for recommended follow-up of residents who display signs or symptoms of active TB disease. 	{21400}		
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00381	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/15/2013
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NAME OF PROVIDER OR SUPPLIER MN VETERANS HOME SILVER BAY	STREET ADDRESS, CITY, STATE, ZIP CODE 45 BANKS BOULEVARD SILVER BAY, MN 55614
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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{21400}	<p>Continued From page 4</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 4 residents (R1, R2) were screened for active tuberculin (TB) symptoms according to the Centers for Disease Control (CDC) guidelines.</p> <p>Findings include:</p> <p>The CDC Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health-Care Settings, 2005, (MMWR) directed all residents must receive a baseline TB screening within 72 hours of admission or within 3 months prior to admission. The screening must include an assessment of the resident's risk factors for TB, and any current TB symptoms.</p> <p>On 8/14/13, four resident records were reviewed for baseline TB screening upon admission. The medical records for R1, and R2, lacked evidence a physical screening for active symptoms of TB had been completed within 72 hours of admission.</p> <p>R1 was admitted to the facility on 8/1/13. R1's "Active TB Symptoms/Signs-Annual Review MVH" form which was the facility's physical screening for active symptoms of TB had been completed on 8/14/13.</p> <p>R2 was admitted to the facility on 8/8/13. R2's</p>	{21400}		
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00381	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/15/2013
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NAME OF PROVIDER OR SUPPLIER MN VETERANS HOME SILVER BAY	STREET ADDRESS, CITY, STATE, ZIP CODE 45 BANKS BOULEVARD SILVER BAY, MN 55614
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{21400}	<p>Continued From page 5</p> <p>"Active TB Symptoms/Signs-Annual Review MVH" form which was the facility's physical screening for active symptoms of TB had been completed on 8/14/13.</p> <p>On 8/15/13, at 12:00 noon, registered nurse in charge of infection control confirmed the facility did not routinely complete symptom screening on residents within 72 hours of admission.</p> <p>The facility policy and procedure on Tuberculosis Screening, Evaluation and Management: Residents revised 8/20/09, directed the facility to screen and evaluate residents for tuberculosis and manage the results, and all residents will complete the baseline screening tool upon admission to the facility.</p> <p>Time Period for Correction: Twenty one (21) days.</p>	{21400}		



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 3717

June 4, 2013

Ms. Carol Gilbertson, Administrator
Minnesota Veterans Home Silver Bay
45 Banks Boulevard
Silver Bay, Minnesota 55614

Re: Enclosed State Nursing Home Licensing Orders - Project Number SL00381021

Dear Ms. Gilbertson:

The above facility was surveyed on May 20, 2013 through May 23, 2013 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 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 deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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 after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

Mn Veterans Home Silver Bay

June 4, 2013

Page 2

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.

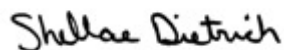
When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 11 East Superior Street, #290, Duluth, Minnesota 55802. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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,



Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

L00381s13.rtf

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00381	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/23/2013
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NAME OF PROVIDER OR SUPPLIER MN VETERANS HOME SILVER BAY	STREET ADDRESS, CITY, STATE, ZIP CODE 45 BANKS BOULEVARD SILVER BAY, MN 55614
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2 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: On 5/20/2013 through 5/23/2013, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and</p>	2 000		
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Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00381	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/23/2013
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2 000	Continued From page 1 Certification Program; 11 East Superior Street, Suite 290, Duluth, MN 55802	2 000		
2 560	<p>MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents</p> <p>Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b).</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop a comprehensive care plan related to self administration of medication for 1 of 3 residents (R3) reviewed for self administration of medication.</p> <p>Findings include:</p> <p>R3's care plan dated 4/13, did not include interventions related to self administration of medication.</p> <p>R3's diagnoses included: Alzheimer's disease, chronic airway obstruction disease(COPD)and emphysema. The significant change Minimum Data Set (MDS)dated 4/15/13, indicated R3 had severe cognitive deficits and needed extensive assist with activities of daily living(ADLs.)</p> <p>On 5/20/13, at 4:28 p.m. R3 was observed</p>	2 560		

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2 560 Continued From page 2

sleeping in bed with his head elevated approximately 60 degrees. Licensed Practical Nurse (LPN)-A placed a nebulizer medication into the the nebulizer cup, turned on the machine, placed the nebulizer over R3's face and left the room. No staff were present during the inhalation of the medication. At 5:00 p.m. the nebulizer medication was empty, however, the mask remained on R3's face. At 5:05 p.m. (34 minutes later)LPN-A returned to R3's room and removed the nebulizer mask from his face. At 7:20 p.m. LPN-A stated R3 had been assessed for self administration of the nebulizer, but could not find the physicians order.

The director of nursing(DON)was interviewed on 5/23/13, at 11:00 a.m. and stated she would expect all residents who have been assessed for the safe use of administrating medications would have a care plan addressing the interventions. The DON verified the care plan lacked any interventions related to self administration of medication.

The Medication/Treatments, Self-Administered policy with a revised date of 3/13, indicated self administration of medication/treatment shall be addressed on the resident's care plan.

Time Period for Correction: Twenty one (21) days.

2 560

2 565 MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use

Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident.

2 565

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2 565	<p>Continued From page 3</p> <p>This MN Requirement is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to provide nursing rehabilitation services for 1 of 7 residents in the sample (R11) as directed in his care plan.</p> <p>Findings include:</p> <p>R11 was admitted to the facility on 12/6/12. R11's care plan dated 4/26/13 directed staff to provide the NuStep (a recumbent, cross training exercise machine) training 3-5 times weekly. The Care Guide (a care plan summary for HSTs [Human Services Technician] to follow for their assigned residents daily cares) for R11 directed staff to provide NuStep exercises 3-5 times weekly. A physician's order, dated 12/21/12, directed staff to provide rehab services utilizing NuStep 3-5 times weekly. The Minimum Data Sets, dated 12/12/12, 3/12/13 and 5/16/13, noted R11 had maintained the same functional limitation on one side of his body (hemiplegia.) Nursing and rehab progress notes lacked evidence R11 was receiving the rehab service as directed. Restorative aide (RA)- B provided dates written on two small post-it notes that indicated she provided R11 with the NuStep exercises a total of 19 days from February 28 through May 23. RA-B was interviewed on 5/23/13, at 10:00 a.m.. She said she had been on vacation for a while and the services were not being done as ordered. She stated that the rehab aides would get pulled from their duties on occasion to work the floor as HSTs (Human Services Technician.)</p> <p>The director of nursing was interviewed on</p>	2 565		

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2 565	Continued From page 4 5/23/12 at 11:00 a.m. and stated the rehab program is available seven days per week, and if one RA is not available, another can step in to provide the service. She said since the RAs work in pairs, each should know when to cover for the other. She added the schedule of 3-5 times a week provides the extra days every week to pick up missed days when an RA is not available. She said the rehab aides are expected to provide the services as as directed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 565		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide range of motion for 1 of 7 residents (R11) in the sample on a nursing rehabilitation (rehab) program.	2 895		

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2 895	<p>Continued From page 5</p> <p>Findings include:</p> <p>R11, whose diagnoses included peripheral neuropathy, hemiplegia (a total paralysis of the arm, leg, and trunk on the same side of the body) and edema, was not provided nursing rehab services as ordered.</p> <p>R11 was admitted to the facility on 12/6/12. A physician's order, dated 12/21/12, directed staff to provide rehab services utilizing NuStep (a recumbent, cross training exercise machine) 3-5 times weekly.</p> <p>The Minimum Data Sets dated 12/12/12, 3/12/13 and 5/16/13, noted R11 had maintained the same functional limitation on one side of his body (hemiplegia.) Nursing and rehab progress notes lacked evidence that R11 was receiving the rehab service as directed. R11's care plan dated 4/26/13 directed staff to provide the NuStep training 3-5 times weekly. Restorative aide - B (RA-B) provided dates written on two small post-it notes, which established she provided R11 with the NuStep exercises. A total of 19 days of exercises were written for R11, from February 28 through May 23, a total of 11 weeks (33-55 opportunities for NuStep exercises.)</p> <p>RA-B was interviewed on 5/23/13 at 10:00 a.m.. She said she had been on vacation for a while and the services were not being done as ordered. She stated that the rehab aides would get pulled from their duties, on occasion, to work the floor as HSTs (Human Services Technician.)</p> <p>The director of nursing was interviewed on 5/23/12 at 11:00 a.m. and stated the rehab program is available seven days per week, and if</p>	2 895		

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2 895	Continued From page 6 one RA is not available, another can step in to provide the service. She said since the RAs work in pairs, each should know when to cover for the other. She added the schedule of 3-5 times a week provides the extra days every week to pick up missed days when an RA is not available. She said the rehab aides are expected to provide the services as as directed. Time Period for Correction: Twenty one (21) days.	2 895		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and	21390		

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21390	<p>Continued From page 7</p> <p>I. methods for maintaining awareness of current standards of practice in infection control.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop an infection control surveillance plan to identify and monitor infections in residents.</p> <p>Findings included:</p> <p>Registered nurse (RN)-D, interviewed on 5/23/13, at 8:17 a.m., stated he reviews infections monthly, but had not established a surveillance system to monitor and identify organisms. RN-D indicated he monitored what residents had infections, the site of the infection, and the medication used to treat the infection. RN-D indicated he did not track microorganisms that caused the infection, duration of the medication, if the infections were resolved, or if there was a pattern of infections.</p> <p>On 5/23/13, at 9:47 a.m., the administrator was interviewed, and verified she would expect the infection control program would have a surveillance system for data collection, evaluation and reporting.</p> <p>The facility policy and procedure on Infection Control Program reviewed/revised 8/19/11, directs the infection control program will include surveillance of infections (identifying, investigation and reporting of infections). The policy further directs the infection preventionist is responsible for surveillance data collection, evaluation and reporting.</p>	21390		

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21390	Continued From page 8 Time Period for Correction: Twenty one (21) days.	21390		
21400	<p>MN Rule 4658.0810 Subp. 1 Resident Tuberculosis Program</p> <p>Subpart 1. Pursuant to Minnesota Rule 4658.0040, and as defined in Minnesota Department of Health Informational Bulletin 09-02 Tuberculosis Prevention and Control Guidelines: Nursing Homes, Minnesota Rule 4658.0810 Subpart 1 Resident Tuberculosis Program is waived.</p> <p>Conditions of Waiver:</p> <ul style="list-style-type: none"> - All residents must receive baseline TB screening within 72 hours of admission or within 3 months prior to admission. TB Screening must include an assessment of the resident's risk factors for TB, and any current TB symptoms, and a two-step TST or a single interferon gamma release assay (IGRA) for M. tuberculosis (e.g., QuantiFERON® TB Gold or TB Gold In Tube, T-SPOT®.TB). Routine serial TB screening of residents may be done at the discretion of the infection control team. - All reports and copies of resident tuberculin skin tests (TSTs), results from IGRAs for M. tuberculosis, medical evaluations, and chest radiograph results must be maintained in the resident's medical record. Consult current CDC recommendations for the diagnosis of TB for recommended follow-up of residents who display signs or symptoms of active TB disease. 	21400		

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21400	<p>Continued From page 9</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 3 of 5 residents (R6, R7, R8) were screened for active tuberculin (TB) symptoms according to the Centers for Disease Control (CDC) guidelines.</p> <p>Findings include:</p> <p>The CDC Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health-Care Settings, 2005, (MMWR) directed all residents must receive a baseline TB screening within 72 hours of admission or within 3 months prior to admission. The screening must include an assessment of the resident's risk factors for TB, and any current TB symptoms. A two-step TST, or a single interferon gamma release assay (IGRA), or chest x-ray results must be maintained in the resident's record.</p> <p>On 5/23/13, five resident records were reviewed for baseline TB screening upon admission. The medical records for R6, R7, and R8, lacked evidence a physical screening for active symptoms of TB had been completed.</p> <p>R6 was admitted to the facility on 2/20/13. R6's medical record lacked evidence a physical screening for active symptoms of TB had been completed.</p>	21400		

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21400 Continued From page 10

R7 was admitted to the facility on 10/23/12. R7's medical records lacked evidence a physical screening for active symptoms of TB had been completed.

R8 was admitted to the facility on 1/2/13. R8's medical records lacked evidence a physical screening for active symptoms of TB had been completed.

On 5/23/13, at 10:35 a.m., the director of nursing (DON) confirmed the facility did not routinely complete symptom screening on residents within 72 hours of admission.

The facility policy and procedure on Tuberculosis Screening, Evaluation and Management: Residents revised 8/20/09, directed the facility to screen and evaluate residents for tuberculosis and manage the results, and all residents will complete the baseline screening tool upon admission to the facility.

Time Period for Correction: Twenty one (21) days.

21400

21525 MN Rule 4658.1305 A.B.C Pharmacist Service Consultation

A nursing home must employ or obtain the services of a pharmacist currently licensed by the Board of Pharmacy who:

- A. provides consultation on all aspects of the provision of pharmacy services in the nursing home;
- B. establishes a system of records of receipt

21525

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21525	<p>Continued From page 11</p> <p>and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and</p> <p>C. determines that drug records are accurately maintained and that an account of all controlled drugs is maintained.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure controlled medications were securely accounted for in 4 of 4 narcotic medication three ring binders. This had the potential to affect 80 of 80 residents in the facility.</p> <p>Findings include:</p> <p>During the medication storage tour on 5/22/13 at 9:30 a.m. with Registered Nurse (RN)- A the narcotic medication ledgers were observed to be loose leaf three-ring binders in which the quantities of medications and missing doses could not be readily detected. The binders were divided alphabetically by residents and the pages were not numbered, allowing potential removal of medication sheets. RN-A, interviewed at 9:30 a.m. on 5/22/13, stated that when a controlled medication was discontinued, the medication sheet was removed from the binder, wrapped with the medication and placed in the locked box until the pharmacist and Director of Nursing destroy them. RN-A indicated there was no way of knowing if a medication was missing if both the controlled medication and the medication sheet were to go missing.</p> <p>The Director of Nursing stated, at 9:45 a.m. on 5/22/13, the 3-ring binders were the only reconciliation for the controlled medications. She</p>	21525		
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21525	Continued From page 12 acknowledged there was really no way of assuring that sheets weren't taken out, and narcotics removed. She acknowledged the medication sheet and controlled drugs could be missing without the facility's knowledge. Time Period for Correction: Twenty one (21) days.	21525		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 3 residents (R3) had a physician's order for self administration of a nebulizer medication. Findings include: R3 was left alone in his room with a nebulizer treatment. There was no physician's order for self administration of the nebulizer medication. R3's diagnoses included: Alzheimer's disease, chronic airway obstruction disease (COPD) and emphysema. The significant Minimum Data Set (MDS) dated 4/15/13, indicated R3 had severe cognitive deficits and needed extensive assist with activities of daily living (ADLs.)	21565		

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21565	<p>Continued From page 13</p> <p>The signed Physician Orders dated 4/25/13, included Duoneb(medication relaxes muscles in the airways and increases air flow to the lungs)3 milligrams per milliliter to be administered four times daily for COPD.</p> <p>The nebulizer compliance assessment dated 4/26/13, indicated R3 had left the nebulizer device in place during three different observations of the medication. The assessment also indicated R3 was compliant and staff was to request a physicians order for nebulizer treatment per the facilities protocol.</p> <p>On 5/20/13, at 4:28 p.m. R3 was observed sleeping in bed with his head elevated approximately 60 degrees. Licensed practical nurse (LPN)-A placed a nebulizer medication into the the nebulizer cup, turned on the machine, placed the nebulizer over R3's face and left the room. No staff were present during the inhalation of the medication. At 5:00 p.m. the nebulizer medication was empty, however, the mask remained on R3's face. At 5:05 p.m. (34 minutes later)LPN-A returned to R3's room and removed the nebulizer mask from his face. At 7:20 p.m. LPN-A stated R3 had been assessed for self administration of the nebulizer, but could not find the physicians order.</p> <p>The director of nursing(DON)was interviewed on 5/23/13, at 11:00 a.m. and stated she would expect all residents who have been assessed for the safe use of administrating medications would have a physicians order. The DON verified the medical record lacked a physicians order for self administration of the nebulizer.</p> <p>The Medication/Treatments, Self-Administered policy with a revised date of 3/13, indicated if a resident is compliant with leaving the nebulizer</p>	21565		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00381	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/23/2013
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NAME OF PROVIDER OR SUPPLIER MN VETERANS HOME SILVER BAY	STREET ADDRESS, CITY, STATE, ZIP CODE 45 BANKS BOULEVARD SILVER BAY, MN 55614
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21565	Continued From page 14 device in place, staff will request a physicians order. Time Period for Correction: Twenty one (21) days.	21565		