

Protecting, Maintaining and Improving the Health of Minnesotans

March 19, 2008

Mr. Michael Bond, Administrator Mn Veterans Home Silver Bay 45 Banks Boulevard Silver Bay, Minnesota 55614

Re: Enclosed Reinspection Results - Project Number SL00381014

Dear Mr. Bond:

On March 12, 2008 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 January 16, 2008 with orders sent to you on January 28, 2008. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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,

Pat Halveum

Patricia Halverson, Unit Supervisor Licensing and Certification Program Division of Compliance Monitoring

Telephone: (218) 723-4637 Fax: (218) 723-4920

Enclosure(s)

cc: Original - Facility

Licensing and Certification File

SL00381014r08.rtf

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number 00381	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 3/12/2008
Name of Facility		Street Address, City, State, Zip Code	
MN VETERANS HOME SILVER BAY		45 BANKS BOULEVARD	

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
_ .	Correction		Correction			Correction
	Completed	}	Completed			Completed
ID Prefix	20555 03/12/2008	ID Prefix 21	410 03/12/2008	ID Prefix	_21530	03/12/2008
Reg. #	MN Rule 4658.0405 Subp.	Reg. # MN	Rule 4658.0815 Subp.		MN Rule 4658.1310 A	.B.C
LSC		LSC		LSC		
	Correction		Correction			Correction
	Completed		Completed			Completed
(D Prefix	21565 03/12/2008	ID Prefix	··	ID Prefix		
Reg.#	MN Rule 4658,1325 Subp.	Reg. #		Reg. #		
LSC	MIN Note 4000, 1020 Cubp.	LSC		LSC		
	Соглестіол		Correction			Correction
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Reg. #		Reg. #		Reg. #		
LSC		LSC		LSC		
	<u> </u>					
Reviewed	By Reviewed By	Date:	Signature of Surveyor:	i	Date:	
State Age	Pulco	3/19/0	· · · · · · · · · · · · · · · · · · ·	2547	9 3/	2/08
Reviewed		Date:	Signature of Surveyor:	-	Date:	7
CMS RO				•		
Followup	to Survey Completed on:		Check for any Uncorrected Del	iciencies. Was	Summary of	
	1/16/2008		Uncorrected Deficiencies (C	MS-2567) Sent to	the Facility? YES	NO



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7006 2760 0001 6642 3530

January 28, 2008

Mr. Michael Bond, Administrator MN Veterans Home Silver Bay 45 Banks Boulevard Silver Bay, MN 55614

Re: Enclosed State Nursing Home Licensing Orders - Project Number SL00381014

Dear Mr. Bond:

The above facility was surveyed on January 14, 2008 through January 16, 2008 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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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

Mn Veterans Home Silver Bay January 28, 2008 Page 2 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.

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 320 W 2nd Street #703 Duluth, Mn 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,

Pat Halverson, Unit Supervisor Licensing and Certification Program Division of Compliance Monitoring

Telephone: 218 723 4637 Fax: 218 723 4920

Enclosure(s)

cc: Original - Facility

Path alver

Licensing and Certification File

L0381s08.let

RECEIVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTR EED 2 2 2	2008 (X3) DAT	08 (X3) DATE SURVEY COMPLETED	
		00381		B. WING		ealth 0	1/16/2008	
NAME OF P	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
MN VETI	ERANS HOME SILVE	R BAY		S BOULEVAI BAY, MN 556				
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2 000	Initial Comments			2 000				
	 *****ATTE 	ENTION*****						
	NH LICENSING	CORRECTION ORD	DER					
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.								
	corrected requires requirements of the number and MN R When a rule contain comply with any of lack of compliance re-inspection with a result in the assess	thether a violation has compliance with all a rule provided at the ule number indicated ins several items, fail the items will be con. Lack of compliance any item of multi-part sment of a fine even it uring the initial inspect.	tag below. ure to sidered upon rule will if the item					
	that may result fror orders provided tha the Department wit	hearing on any assem non-compliance with a written request is thin 15 days of receipent for non-compliance.	th these made to t of a		. '			
	surveyors of this Do above provider and orders are issued, completed, please these orders and re	TS: aru January 16th, 200 epartment's staff, visit the following correct When corrections ar sign and date, make eturn the original to the	ited the tion e a copy of ne					
	epartment of Health	1 RA			TITLE	6	(XG) DATE	
ABORATORY		DERİSUPPLIER REPRESEN			administ this	r 2/,	14/08	
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2 000	Continued From page 1			2 000			
	Compliance Monitoring, Licensing and Certification Program; 320 West Second St. Suite 703, Duluth, MN 55803.						
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development			2 555			,
	must develop a con each resident within completion of the co assessment as defi comprehensive plan by an interdisciplina attending physician responsibility for the appropriate staff in the resident's needs practicable, with the	elopment. A nursing inprehensive plan of a seven days after the omprehensive reside ined in part 4658.040 in of care must be deary team that includes a registered nurse of eresident, and other disciplines as determined as a determined as	care for e ent 00. The veloped s the with mined by				
	by: The plan of care for	ent is not met as evi r prevention of press r 1 of 3 (#2) resident nolude:	ure ulcers	•			
	keep the resident of in bed. The plan of staff (human service the resident with the	dent #2 was not provided a wedge cushion to the resident off the coccyx area while lying d. The plan of care dated 12/2/07 indicated (human service technicians) should position esident with the use of a wedge cushion to o right and left side and back.					
	indicated, "When in cushion alternating	sician's orders dated bed, use foam wedo R/L (right and left) si sure on the coccyx."	ge ides and				

Minnesota Department of Health STATE FORM

HRTF11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIE IDENTIFICATION NU			(X2) MULTIPL A. BUILDING B. WING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED 01/16/2008		
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2 555	when he was assis wedge cushion wa off his coccyx. The have a red buttock over his coccyx. Or resident was observithout the use of relieve pressure from 1/16/08 the resident without the use of position him off the 1/16/08 the nurse resident should have aid in positioning was manager noted two resident's buttock, length and the other company of the state	bserved at 6:25 PM sted into bed; however so to provided to pose resident was observed laying in bed or a foam wedge cushiom the coccyx. At 8 states at a coccyx. At 8:35 AM manager confirmed we a foam wedge cushion to open slits in the cropper slits in the cropper stated he can wedge cushion was at 8:45 AM on 1/16 upervisor stated he can wedge cushion was at 8:45 AM on 1/16 upervisor stated the open 12/2/07. THOD OF CORRECT and revise the policy state ulcer prevention of work with the direct of systems of monitors with interventions of the country of with interventions of the country	er, the sition him rved to m dressing /15/08 the his back on to 100 AM on ing in bed hion to 100 AM on the ease of the com in 100 AM on the ease of the com in 100 AM on the ease of the com in 100 AM on the ease of the com in 100 AM on the ease of the com in 100 AM on the ease of the com in 100 AM on the ease of the com in 100 AM on the ease of the com in 100 AM on the ease of the com in 100 AM on the ease of the com in 100 AM on the ease of the ease of the com in 100 AM on the ease of the ease	2 555			
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21410	10 Continued From page 3 Subpart 1. Responsibility of nursing home. A			21410			
	nursing home mus prior to employmenth this part, show free according to this prestablish a tubercular and prevention produced accordance with MR Report (MMWR), CRR-13; section ILJ Preventing the Tratuberculosis in Heissued by the Centing Prevention. This greference. It is averaged to employ the manufactured to the prevention.	nsibility of nursing host ensure that all emport and as otherwise in edom from active tuberart. A nursing home culosis counseling, scrogram for all employed forbidity and Mortality October 28, 1994, Vol. of the "Guidelines for Salth-Care Facilities, ters for Disease Conguideline is incorpora ailable through the Mostem. It is not subjective.	ployees, andicated in perculosis must reening, pes, in y Weekly pl. 43, No. for acterium 1994," trol and inted by linitex				
	by: Based on record r did not ensure free	nent is not met as everyiew and interview to edom from active tub ployees (E and H) in include:	the facility perculosis				
	history of positive exposure to TB). At the employee on 3 documentation da	sonnel record indicat Mantoux (skin test to A chest x-ray was co 3/25/02. Follow-up ated 3/23/05 and 6/1/0 bloyee had no sympto	o determine mpleted for 06	-			
	history of positive completed on 9/3/ dated 3/14/05 and employee had no	sonnel record indicate Mantoux. A chest x-1/93. Follow-up docurted 3/31/06 indicated the symptoms of active 100 AM the RN super-	ray was mentation ne TB.				

STATEMENT OF DEFICIENCIES (X1) I		(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI	R/CLIA MBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED	
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21410	1410 Continued From page 4			21410			i
21410	that all employees with a history of positive Mantoux were assessed annually for symptoms of active TB. She verified that employees E and H were not assessed in 2007.						
	Screening, Evalua Employees dated employees with a have a chest x-ray they have a docum x-ray performed a initial evaluation o The policy and pro-	ocedure for Tuberculo tion and Managemer 4/9/01 indicated, "All previous positive Ma y prior to employment mentation of a negative t any time during or so f the positive Mantous cocedure did not addressymptoms of TB infec- positive Mantoux.	ntoux shall t unless ve chest since the ix test."				
	administrator could nursing to review procedure for screed of positive mantor could work with the systems of monitors.	ETHOD OF CORRECT Id work with the direct and revise the policy eening employees with the admining director of nursing oring to ensure comparts CORRECTION: To	and tha history strator to develop bliance.				
2153	A. The drug reg reviewed at least currently licensed This review must Appendix N of th Surveyor Proced Requirements in the Department	imen of each resider monthly by a pharm d by the Board of Phat be done in accordance State Operations Nures for Pharmaceut Long-Term Care, prof Health and Human incorporated by references	nt must be acist armacy. nce with Manual, tical Service ublished by n Services, n, April 1992				

Minnesota Department of Health
STATE FORM

6899

NAME OF PROVIDER OR SUPPLIER MN VETERANS HOME SILVER BAY SIMMARY STATEMENT OF DEFICIENCIES SILVER BAY, MN 55614 (X4) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) 21530 Continued From page 5 available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician does not concur with the pharmacists recommendation, or does not provide adequate justification, and the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician ones not have adequate justification for the order and if the attending physician obes not have adequate justification for the order and if the attending physician obes not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee required by safe sources and interview, the facility's consultant pharmacist did not identify irregularities in the drug regimen for 1 of 8 (#2) resident's in the sample. Findings include:			(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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PREFIX TAG 21530 Continued From page 5 available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director of review if the medical director determines that the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658 0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on record review and interview, the facility's consultant pharmacist did not identify irregularities in the drug regimen for 1 of 8 (#2)			L		BROVIDER'S PLAN OF CO	RRECTION	(X5)	
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Resident #2's physician's orders included scheduled and PRN (as needed) doses of Tylenol with the potential to exceed 4000 mg of		facility's consultar irregularities in the resident's in the seriodent #2's physicheduled and P	nt pharmacist did not e drug regimen for 1 sample. Findings incl ysician's orders includ RN (as needed) dose	identify of 8 (#2) lude: ded es of				

AND PLAN OF CORRECTION IDENTIFICATION		(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	ER/CLIA IMBER:	(X2) MULTIP A. BUILDING B. WING	LE CONSTRUCTION	(X3) DATE S COMPLI 01/1	
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NAME OF P	PROVIDER OR SUPPLIER			BOULEVAR			
MN VET	ERANS HOME SILVE	R BAY		AY, MN 5561			
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21530	Tylenol in a 24-hour period. This irregularity had not been identified by the consultant pharmacist. Resident #2 received one Tylenol Extra Strength (500 mg) three times a day since 1/19/07 for a total of 1500 mg of Tylenol daily. The standing orders indicated the resident could also receive Tylenol 650 mg by mouth or suppository every 3 to 4-hours as needed. This could total 6700 mg in a 24-hour period of time. Review of the medication administration record indicated the resident received Tylenol 1500 mg daily and also received an extra Tylenol 650 mg on 1/12/08. Review of the consultant pharmacist's monthly reviews indicated the potential for receiving more than 4000 mg of Tylenol had not been addresse by the pharmacist.		a Strength 07 for a standing o receive ry every 3 6700 mg the ated the ly and also /12/08. monthly eiving more addressed	21530			
	at approximately 2 lack of notice to the overdose of Tylen physicians would	narmacist, interviewe 2:30 PM on 1/16/08, the physician for the pool. She further state "normally" include dited 4000 mg in 24-h	verified the ootential d the rection for				
	administrator counursing, the consimedical director to and procedure for administrator counursing, consulta	ETHOD OF CORRECT work with the direct with the direct with the direct and revised for the direct work with the direct pharmacist and/or p systems of monito its work with the direct pharmacist and/or p systems of monito its work with the direct pharmacist and/or p systems of monito its work with the direct pharmacist and/or p systems of monito its work with the direct pharmacist and/or p systems of monito its work with the direct pharmacist and/or page 1.	ctor of d/or the the policy w. The ctor of medical				
	TIME PERIOD O (21) days.	F CORRECTION: T	wenty-one				
2156	MN Rule 4658.13	325 Subp. 4 Adminis Admin	tration of	21565			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIES IDENTIFICATION NUM		ER/CLIA IMBER:	(X2) MULTIP A. BUILDING B. WING	LE CONSTRUCTION			
		00381				01/1	6/2008
NAME OF P	ROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·		DRESS, CITY, S			
MN VETE	ERANS HOME SILVE	R BAY	45 BANK SILVER E	S BOULEVAR BAY, MN 5561	14 		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY SC IDENTIFYING INFORM	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	COMPLETE DATE
21565	Continued From pa	age 7		21565			
	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 observa and policy review, safety or obtain ph	tion, record review, i the facility did not as nysician's orders for a medications for 1 of 4 ample. Findings inclu	nterview ssess self 4 (#7)				
	self-administration In addition, there was self administration diagnoses include two diabetes melliquarterly MDS day resident was cognassistance with ac	not assessed for safe of Zinc Oxide topical were no physician's of n of medications. The ed congestive heart f itus and morbid obes ted 11/24/07 indicate nitively intact, require ctivities of daily living by incontinent of blad	al ointment orders for e resident's ailure, type sity. The ed the ed staff (ADL's)		·		
	7/14/07 indicated around the rectal urine; had DuoDe could use some z protect the rest of dated 7/16/07, dir	nt #7's progress note the resident had red area; was frequently arm on the coccyx ar- tinc oxide after wash f the skin." Physicial rected to apply "zinc neum with brief char	, raw skin "wet" with ea "but ing to n's orders oxide to				
	1/15/08 identified bladder incontine	re plan for elimination the resident had occurred, "Z ince and directed, "Z ineum with brief chai	casional inc oxide to				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00381		B. WING _		01/1	6/2008
NAME OF P	ROVIDER OR SUPPLIER				STATE, ZIP CODE		
				BOULEVAI AY, MN 556			. <u>.</u> .
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
21565	Continued From page 8			21565			
	Remind resident to apply." The care guide for toileting dated 1/15/08 directed staff to remind resident to apply zinc oxide to buttocks and perineum with brief changes.						
	On 1/14/08 at approinitial tour, an open- zinc oxide was obse Resident #7 stated, bottom, I have a ras the tube of zinc oxid bedside. At 10:30 a nurse (LPN) confirmed remind the resident The LPN confirmed self-administer med to self-administer med to self-administer med to self-administer med self-administration of physician order to self-administration of administrator could nursing to review at self-administration of regards to assessing medications and physician self-administrator could nursing to develop- ensure compliance medications.	eximately 2:30 PM due and partially used erved next resident # "I put it on my groin sh." On 1/15/08 at 8:3 de was observed to band, the licensed practice and the care plan directions and no assembled to apply his own zing there was no order dications and no assembled to a point and the care plan directions and no assembled to a point and the care plan directions for resident and the care plan direction assessed from the care the care the policy and procedure the procedure the policy and procedure the pro	tube of try's bed. and my 50 AM, be at the citical ected to coxide. to essment ent #7. ursing ad a sment and eations. FION: The profession of the citical ected to coxide.				

Minnesota Department of Health STATE FORM