"Attachment A"

HE-01239-03 Rev. 1/97 **CORRECTION ORDER**

CERTIFIED MAIL #:

FROM: Minnesota Department of Health, Health Policy, Information and Compliance Monitoring Division
1645 Energy Park Drive, Suite 300, St. Paul, MN 55108-2970
Licensing and Certification Program

Ellie Laumark, Unit Supervisor (651) 643-2566

TO Mr. Alan C. Saatkamp **DATE** August 29, 2005

PROVIDER MN Veterans Home Minneapolis **COUNTY** Hennepin

ADDRESS 5101 Minnehaha Avenue South, Minneapolis, Minnesota 55417

On July 26, 27, 28, & 29, 2005, surveyor(s) 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 the form for your records and return the original to the above address.

Signed:_____ Date:_____

In accordance with Minnesota Stat. section 144.653, Minnesota Stat. section 144A.10, or Minnesota Stat. section 144A.45, this correction order has been issued pursuant to an inspection (survey)./an inspection (survey) including a complaint investigation./a complaint investigation. 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.

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.

1. MN Rule 4658.0110

Based on staff interview and record review the facility failed to complete a detailed incident report for 1 out of 1 Resident in the sample (#34) with a feeding tube. Findings include:

Resident #34 was treated at the hospital for dehydration and had a percutaneous endoscopic gastrostomy (PEG) feeding tube surgically implanted on 5/12/05. The resident returned to the facility 5/13/05.
On 5/15/05 the medical record progress notes documented that the resident "pulled his PEG tube out. The reside transported to the hospital, and remained at the hospital until 6/28/05. The medical record did not contain an inci the unit clerk and social worker were not able to locate an incident report. The assistant director of nursing was i 7/29/05 at 10:15 AM and was not aware of an incident report. She agreed that a report should have been filled ou able to locate a report.

TO COMPLY: All persons providing services in a nursing home must report any accident or injury to a resident, and the nursing home must immediately complete a detailed incident report of the accident or injury and the action taken after learning of the accident or injury.

SUGGESTED METHOD OF CORRECTION: The Administrator and the Director of Nursing could review the current policies and procedures for reporting accident/injuries, revise as needed and instruct all personnel in the revisions. The Administrator could designate a staff person to do ongoing monitoring to ensure compliance with accident /injury reporting.

TIME PERIOD FOR CORRECTION: Fourteen (14) days.

2. MN Rule 4658.0300 Subp. 4.

Based on observations, interviews, and record review, the facility failed to ensure that that the decision to apply restraints was based on a comprehensive assessment to ensure the restraint was the least restrictive, a plan for progressive removal, physician's order and appropriate consents for 4 out 7 residents in the sample with restraints. (#s 4, 9, 30 & 31). Findings include:

A lap buddy restraint was being used on resident #9 without a physician's order or a clear indication for its use. During evening observations on 7/26/05 from approximately 4:40 PM until 7:45 PM, resident #9 was observed to have a lap buddy type restraint on his wheelchair in addition to a re-closure type seat belt. Both devices remained on the resident during the meal. The registered nurse on the unit when questioned as to the reason for the lap buddy at 6:10 PM did not know and referred the surveyor to the LPN. The LPN interviewed at approximately 6:20 PM about the lap buddy did not know why the lap buddy was on thought that it had been discontinued. A review of the resident's current physician's orders indicated that the resident had orders for a lap buddy but it had been discontinued on 7/18/05. The current plan of care still referenced the lap buddy. The human service technician (HST) assignment sheet dated 7/22/05 indicated that the lap buddy had been taken off and was no longer needed. A review of the nursing policies and procedures for the facility as of 5/1990 related to resident safety, "Restraints are used only with GNP/MD (geriatric nurse practitioner/medical doctor) orders".

Resident #4 was not assessed for the least restrictive restraint, and did not have a program of progressive removal physician's order for the restraint to be used only when the resident was attempting to ambulate. Resident # 4 wa 7/26/05 at 4:30 PM in a wheelchair with thigh straps between his legs that were fastened by a belt behind his wai PM the Human Service Technician (HST) who unfastened the clip on the belt before transferring the resident ind resident could not unfasten the belt by himself. Review of the resident's medical record contained no comprehens assessment of the need for the restraint or attempts at least restrictive alternatives. The record did not contain a pl allowed for progressive removal of the restraint. The nurse practitioner ordered on 6/2/05 a "Broda "chair at all ti padded thigh belts "only if the resident is attempting unsafe ambulation ." The care plan did not specify allotted removal. During observations of the resident on 7/26/05 from 4:30 PM to 7:15 PM the resident
Slept in the chair, watched television and ate dinner with the restraint on. He made no attempt to ambulate durin At 7:15 PM the resident was taken to his room. An interview 7/27/05 at 11 AM with the registered nurse (RN) or revealed that the resident only walking a few steps in the bathroom. The RN stated that the resident should be rel the restraint every two hours.

The facility failed to ensure lap buddies for residents #30 & #31 were assessed for less restrictive devices or evaluated for progressive removal.

Resident #30 had diagnoses that included Alzheimer's disease, and history of falls. The resident had physician orders for a lap buddy dated 1/28/05, which stated, "Lap buddy when in wheelchair to prevent unsafe attempts to stand due to gait instability with dementia." The comprehensive assessment (MDS) dated 5/30/05 indicated the resident had a trunk restraint. The care plan dated 5/31/05 directed staff to apply the lap buddy when in the wheelchair to prevent unsafe attempts to stand. There was no indication in the record the resident had been assessed for the use of a less restrictive device such as a wheelchair alarm. The care plan did not contain any provision for the periodic release of the device or planned attempts at removal. Resident #30 was observed with the lap buddy on 7/26/05 (dinner), and 7/27/05 (breakfast, lunch.). Staff did not attempt to remove the restraint when the resident was supervised.

Resident #31 had diagnoses that included Parkinson's disease and history of falls. Physician orders dated 4/8/05 included the lap buddy to be on when the resident was in the wheelchair as a reminder not to lean forward. The resident's RAP (resident assessment profile) dated 7/5/05 indicated the resident could and did remove the lap buddy. However during observations on 7/26/05 at approximately 6:55 PM the resident was observed attempting to remove the lap buddy for 3-4 minutes without success. During observations on 7/26/05 at 5:40 PM the resident was assisted to the bathroom. The resident began to stand immediately after the lap buddy was removed. When the surveyor questioned how she felt about the lap buddy she replied, "I hate it". The resident's comprehensive MDS date 7/5/05 failed to identify the use of the lap buddy as a-restraint and therefore failed to assess less restrictive alternatives or implement a plan for the progressive removal of the device. The lap buddy was in place on 7/26/05 at dinner, and 7/27/05 at breakfast at times when the resident was supervised and could have been released.

Review of the Resident Safety policy dated 5/10/02 identified the "lap buddy" as a restraint. The policy stated all residents who had a restraint would be reviewed on a quarterly basis to determine if they were candidates for restraint reduction, less restrictive restraining measures, or total restraint elimination. The ultimate goal was elimination of restraints or reduction to the least restrictive device. Upon interview with the nurse on 7/27/05 at approximately 9 AM she reported the lap buddies had not been assessed on a regular basis. She reported the lap buddies could probably be taken off at meal times.

TO COMPLY: The decision to apply a restraint must be based on the comprehensive resident assessment. The least restrictive restraint must be used and incorporated into the comprehensive plan of care. The comprehensive plan of care must allow for progressive removal or the progressive use of less restrictive means. A nursing home must obtain an informed consent for a resident placed in a physical or chemical restraint. A physician's order must be obtained for a physical or chemical restraint, which specifies the duration, and circumstances under which the restraint is to be used, including the monitoring interval.

SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review the current policies and procedures for assessment of resident restraints, revise as necessary and instruct the appropriate personnel in the revisions. The Director of Nursing could designate a staff person to do ongoing monitoring to ensure compliance of resident assessment with use of restraints.

TIME PERIOD FOR CORRECTION: Fourteen (14) days.

3. MN Rule 4658.0300 Subp. 5 C.

Based on observation and interview the facility failed to ensure resident an opportunity for motion, exercise and elimination every 2 hours while restrained 4 out 7 residents (#s 4, 9, 11 & 18) in the sample. Findings include:

Resident #18 was not released from the restraint every two hours.

Per record review, resident #18 was admitted to the facility on 6/10/03 and was diagnosed with senile delusions, history of myocardial infarction and strokes, incontinence of bowel and bladder, and history of pressure ulcers. The nursing assistant work sheet stated: assist with all activities of daily living. The resident was to lay down three times a day due to pressure area. The resident's care plan stated to check seat belt when in wheelchair every half hour and release and reposition resident every two hours.

Resident #18 was observed on 7/26/05 at approximately 5:10 PM sitting in the dining room at her assigned table with her seat belt on in a broda chair leaning to the right side. She remained in the chair leaning to the right until shortly after 7:00 PM when a nursing assistant took the resident to her room. The restraint was released at 7:40 when she was transferred. The resident's buttock was reddened. The incontinent product the resident had been wearing before she was toileted was soaked with urine and a strong urine odor was present. The nursing assistant was interviewed on 7/26/05 at 7:25 PM and confirmed that he did not know when the resident had last been toileted or repositioned. The nursing assistant stated that he started his shift at 3 PM and this was the first time he toileted the resident and repositioned her. The nursing assistant confirmed that the incontinent pad he removed was very wet.

Resident #18 was observed again on 7/27/05 at 12:45 PM sleeping at her assigned dining room table in her broad chair with her chin on her chest. At 1:07 PM the nurse manager went over to the resident and said, "it's time for your nap" and wheeled the resident to he room in the broda chair. At 1:13 PM the nursing assistant went into the resident's room. The incontinent pad that was removed was soaked with urine. The nursing assistant interviewed at 1:20 PM confirmed that the resident's incontinent pad was soaked and also additional cares such as oral cares, repositioning with release of seat belt had not been done for this resident today. The nursing assistant stated " I'm just too busy to get all the cares done." I have 12 residents that I am giving care to today by myself.

Resident #9 was observed the evening of 7/26/05 from approximately 4:40 PM until 7:45 PM (3 hours 5 minutes) with a lap buddy restraint on his wheelchair as well as a seat belt. The restraints were not released to provide the resident with free movement.

Resident # 4 was observed on 7/26/05 from 4:30 PM to 7:30 PM in a wheelchair with thigh straps between his legs that were fastened by a belt behind his waist. At 7:30 PM the Human Service Technician (HST) who unfastened the clip on the belt before transferring the resident indicated the resident could not unfasten the belt by himself. The restraint was not released every two hours.

Resident #11 had diagnoses that included anoxic brain damage, and history of falls. The care plans directed staff to release and reposition the resident every 2 hours. The resident had physician orders dated 5/29/05 for a locked Posey belt when in bed and wheelchair to enhance safety. The physician directed staff to monitor and release every 2 hours. Resident #11 was continuously observed on 7/26/05 from 4:30 PM until 7:50

PM without being toileted or repositioned, (3 hours, 20 minutes). The surveyor alerted staff at 7:30 PM, and at 7:50 PM the resident was assisted to bed. The resident's incontinent pad was wet.

TO COMPLY: At a minimum for a resident placed in a restraint a nursing home must also provide an opportunity for motion, exercise, and elimination for not less than ten minutes during each two-hour period in which a restraint is employed.

SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review the current policies and procedures for assessment of resident restraints, revise as necessary and instruct the appropriate personnel in the revisions. The Director of Nursing could designate a staff person to do ongoing monitoring to ensure compliance of resident assessment with use of restraints.

TIME PERIOD FOR CORRECTION: Fourteen (14) days

4. MN 4685.0400 Subp. 2 I.

Based on record review the facility failed to assess dental needs for 1 out of 27 residents in the sample (#20). Findings include:

Resident #20 was not assessed for dental needs.

Resident #20 was admitted to the facility on 5/22/00 with Huntington's chorea. Per record review the resident's dental condition had not been assessed and oral cares were not listed on the nursing assistant sheets. The resident was totally dependent on staff for all cares.

TO COMPLY: The comprehensive resident assessment must include I. Dental condition.

SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review the current resident assessment policies and procedures, revise as needed and instruct appropriate personnel. The Director of Nursing could designate a staff person to do ongoing monitoring to ensure assessment compliance.

TIME PERIOD FOR CORRECTION: Fourteen (14) days.

5. MN Rule 4658.0405 Subp. 1.

Based on interview and record review, the facility failed to develop comprehensive plans for care for 2 out of 27 residents in the sample (#s 19 & 35). The findings include:

Resident #35 did not have a care plan to address risky smoking behaviors.
Resident #35 was admitted to the facility with the diagnoses of dementia, Parkinson's disease, and stroke. An incident report dated 4/14/05 revealed that the resident was found smoking in the hallway near the nurses' station (a non smoking area) and that he attempted to light a cigarette for another resident as well.

The resident known to be a frequent smoker, and according to the care plan dated 6/05 he "leaves the meal early to seek cigs." Some behaviors documented on the care plan include wandering, resistance to care, refusal of assistance, and both short term and long term memory loss. A notation was made on the resident's care plan dated 4/14/05 "incident of unsafe smoking." No specifics were detailed. One approach was listed; "enc. to not take cig out till off the floor." The specific smoking care plan form used by the facility was not evident in the chart.

On 7/28/05 at approximately 10:30AM the RN covering for the nurse manager stated that she would expect to see the smoking assessment form and the specific smoking care plan in the chart. When asked if this information was available in the computer she stated that it was not. Resident #19 had a history of dehydration to include be hospitalized dehydration. Staff was not monitoring and recording fluid intake.

The facility did not develop a care plan to monitor fluid intake for resident #19 with a recent history of dehydration.

Resident #19 was transferred to this facility in 10/04 due to increased need for skilled care. The resident was observed during the meal on 7/26/05 at 5:45 PM. The resident's skin and mucus membranes appeared dry. The Nurse Practitioner's note dated 2/10/05 stated: will increase scheduled free water to 250 cc 4 times a day times 3 days . The assessment/plan by the nurse practitioner on 2/14/05 was urinary tract infection, continue quinolone until 2/19/05 and continue scheduled free water. On 4/5/05 the nurse practitioner assessed the resident with possible dehydration. On 4/13/05, the nurse practitioner spoke with family about resident's likely hood of becoming dehydrated because of his poor fluid intake of thickened water. The family wished for the resident to receive thin free water and thin coffee at meals for quality of life. There was no documentation that the resident was offered or took in the scheduled water.
Per interview with the nurse manager of the unit on 7/27/05 at approximately 5:30 PM it was confirmed that the resident should be on fluid tracking in order to assess the resident's intake.

TO COMPLY: A nursing home must develop a comprehensive plan of care.

SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review the current policies and procedures, revise as needed and instruct appropriate personnel. The Director of Nursing could designate a staff person to do ongoing monitoring to care plans are complete.

TIME PERIOD FOR CORRECTION: Twenty-(20) days

6. MN Rule 4658.0405 Subp. 3.

Based on observation, interview and record review 15 out of 27 residents in the sample (#2, #5, #6, #7, #9, #10, #11, #12 , #13 , #15, #17, #18, #20, 33 & 36) and 5 out 5 in the expanded sample (#50, 51, 52, 53, & 54) did not receive services in accordance with their plan of care and policies. Findings include:

Resident #17 did not have his catheter bag emptied as needed. Per record review, resident #17 was admitted to the facility on 08/26/03 with diagnoses that included neurogenic bladder, and diabetes. According to the residents care plan, the staff was to empty and record Foley catheter output every shift and complete

catheter care per physician order. The nursing assistant sheet instructed the nursing assistant to empty Foley every shift and report and to "check bag often – fills quickly."

Resident #17 was observed on 7/27/05 at 7:45 AM while lying in bed in his room. The resident had a leg bag on for urine collection that was full. The resident's sweat pants were soaked in the groin area. Resident #17 was interviewed at 7/27/05 at 7:45 AM and stated "cares are not very good, you have to wait a long time to get help." The staff does not empty my urine bag when they should so it overflowed. The spillage happens so often that I don't feel real good about it. The night staff went home today without emptying my bag and now I am all wet.

The nursing assistant came into the resident's room on 7/27/05 at approximately 7:47 AM and started AM cares. The resident said to the nursing assistant as she tried to remove the residents wet sweat pants, "why don't you empty my bag first?" The nursing assistant replied to the resident, "I was going to get these wet pants off you first. The nursing assistant emptied the leg bag of 500 milliliters of urine. The maximum capacity of the leg bag was 500 milliliters.

The nursing assistant was interviewed after cares at approximately 8:00 AM and confirmed that resident #17's urine leg bag had not been emptied by the night staff. Resident #9 who required thickened liquids was given unthickened juice.

A review of the current physician's orders for resident #9 as of 7/7/05 indicated, "Diet: Pureed with nectar thick liquids, ok for regular bananas, French toast, and pancakes." The plan of care dated 10/24/04 indicated the resident should have a pureed diet with nectar thick liquids.

During observations of a medication pass on 7/27/05 at 11:25 AM a licensed practical nurse (LPN) was noted to give resident #9 regular thin cranberry juice with two regular strength Tylenol. The resident proceeded to choke and cough and spit. Earlier observations of the resident receiving an evening meal on 7/26/05 revealed that the resident was to receive nectar thickened liquids. The LPN stated after having given the thin juice to the resident that, "My fault, he should have thickened liquids.

During observations of resident #6 and #7 on 7/26/05 from 4:40 PM until 7:55 PM, it was noted that the residents were not repositioned or toileted during that time. Both residents were totally dependent on others to reposition and toilet. According to their plans of care (#6 – 1/10/05) and (#7 – 12/7/04) staff were directed to toilet and reposition the residents every two hours. An interview with the human service technician (HST) at 7:55 PM, who had been assigned to these residents, revealed that the last time the residents had been repositioned or toileted was around 4:30 PM just before dinner.

Observations of resident #10 on 7/26/05 from 4:40 PM until 7:45 PM revealed that the resident was not toileted, checked or changed. The resident was totally dependent on others for toileting, check and change at intervals of at least every two hours and as needed related to incontinence of bowel and bladder, according to the current plan of care dated 12/30/04. An interview with the HST at 7:45 Pm revealed that the HST had not toileted, checked or changed the resident since the resident's nap at approximately 3:30 PM. (4 hours and 15 minutes).

Observations of resident #10 on 7/27/05 from approximately 7:30 Am until 10:25 AM revealed that the resident was not toileted, checked or changed. The resident did have a Broda-type wheelchair and position changes had been observed during breakfast and afterwards when the resident had been wheeled back to her room and the hospice nurse spent time with the resident. An interview with the hospice nurse, at 9:50 A to follow up on what was done for the resident revealed the hospice nurse adjusted the resident's position in the Broda –type wheelchair but did not toilet, check or change the resident at the time. The nurse stated that usually the resident was placed in bed after meals as a preventative measure for skin breakdown. An interview with the HST at approximately 10:25 AM revealed that the resident had not been checked or changed since before breakfast at approximately 7:30 AM

Resident #11 was not repositioned, toileted for checked for incontinence every two hours.
Resident #11 had diagnoses that included anoxic brain injury and history of falls. The resident had physician orders dated 5/29/05 for a locked Posey belt when in the bed or wheelchair. According to the care plan dated 5/12/05, the resident was to be repositioned, toileted or checked for incontinence every 2 hours. Resident #11 was observed on 7/26/05 from 4:30 PM until 7:50 PM without being released or repositioned, for a total of 3 hours, 20 minutes. At 7:30 PM the surveyor informed the Human Services Technician (HST), who then assisted the resident to bed at 7:50 PM. The resident's incontinent pad was changed, and was noted to be wet.

Resident #12 was not repositioned in a timely manner. Resident #12 had diagnoses that included dementia, and Alzheimer's disease. The RAP (resident assessment profile) identified the resident's skin as being at risk for breakdown, with an intervention of assisting with repositioning every 2 hours while in the wheelchair. According to the care plan dated 7/8/05 the resident was to be repositioned every 2 hours. On 7/26/05 at 4:30 PM, resident #12 was observed visiting with her husband in her room until 6 PM, at which point she was escorted to the dining room. Upon interview with the husband at 6 PM he reported he had arrived at 2:45 PM. Upon further discussion with the husband he reported staff had not changed the resident's position since his arrival. At approximately 7:15 PM the surveyor questioned when resident #12 was repositioned, and was told it was at 3:45 PM. The surveyor informed the HST the husband reported he had arrived at 2:45 PM and resident #12 had not been repositioned. The HST acknowledged resident #12 was past due for repositioning and assisted the resident to bed.

Resident #12 did not receive assistance with oral cares. According to the care plan dated 7/8/05, the resident's teeth were to be brushed. On 7/26/05 at approximately 7 PM, bedtime cares were observed. The Human Services Technician (HST) used a pink swab to cleanse the oral cavity. Upon interview with the HST immediately following the cares she reported the resident had a full set of teeth, but she did not brush the teeth anymore because she swallowed the toothpaste

Resident #13 with a pressure sore was not repositioned for over 2 hours. Resident #13 had diagnoses that included Parkinson's disease and arthritis. The resident was identified on 7/14/05 as having a stage 2 pressure ulcer (a partial thickness loss of skin layers that presents as an abrasion, blister, or crater) on his coccyx. According to the care plan dated 5/20/05 the resident was to be repositioned while in the wheelchair every 2 hours. The care plan identified the resident as having fragile skin and at risk for breakdown. On 7/26/05 resident #13 was observed from 4:30 PM until 7:15 PM (2 hours, 45 minutes) without being repositioned. The surveyor entered another resident's room at 7:15 PM. Resident #18 was not released from the restraint every two hours.

Per record review, resident #18 was admitted to the facility on 6/10/03 and was diagnosed with senile delusions, history of myocardial infarction and strokes, incontinence of bowel and bladder, and history of pressure ulcers. The nursing assistant work sheet stated: assist with all activities of daily living. The resident was to lay down three times a day due to pressure area. The resident's care plan stated to check seat belt when in wheelchair every half hour and release and reposition resident every two hours.

Resident #18 was observed on 7/26/05 at approximately 5:10 PM sitting in the dining room at her assigned table with her seat belt on in a broda chair leaning to the right side. She remained in the chair leaning to the right until shortly after 7:00 PM when a nursing assistant took the resident to her room. The restraint was released at 7:40 when she was transferred. The resident's buttock was reddened. The incontinent product the resident had been wearing before she was toileted was soaked with urine and a strong urine odor was present. The nursing assistant was interviewed on 7/26/05 at 7:25 PM and confirmed that he did not know when the resident had last been toileted or repositioned. The nursing assistant stated that he started his shift at 3 PM and this was the first time he toileted the resident and repositioned her. The nursing assistant confirmed that the incontinent pad he removed was very wet.

Resident #18 was observed again on 7/27/05 at 12:45 PM sleeping at her assigned dining room table in her broad chair with her chin on her chest. At 1:07 PM the nurse manager went over to the resident and said, "it's time for your nap" and wheeled the resident to he room in the broda chair. At 1:13 PM the nursing assistant went into the resident's room. The incontinent pad that was removed was soaked with urine. The nursing assistant interviewed at 1:20 PM confirmed that the resident's incontinent pad was soaked and also additional cares such as oral cares, repositioning with release of seat belt had not been done for this resident today. The nursing assistant stated, I'm just too busy to get all the cares done. I have 12 residents that I am giving care to today by myself.

The facility did not follow the comprehensive care plan for resident #20 by not documenting fluid intake on a form in resident's room and did not complete oral cares.

Resident #20 was admitted to the facility on 5/22/00 diagnosed with Huntington's chorea, failure to thrive, dysphasia, and dementia without behaviors. The resident was admitted into the hospital on 2/16/05 for failure to thrive with concerns of malnutrition and dehydration. Resident #20 was observed on 7/26/05 at approximately 6:10 PM in the dining room. The nursing assistant fed the resident. The resident had sunken eyes and was very thin.

The physician ordered on 2/28/05 honey thick water 200 milliliters 4 times a day and as needed and to encourage fluids. The resident's care plan and nursing assistant sheet stated to document fluids on the form in resident's room. Honey thickened water was to be given whenever staff was with resident.

On 7/28/05 at 8:45 AM there was no intake record posted in the resident's room and there were no fluids available to offer the resident. The nursing assistant taking care of resident #20 on 7/28/05 was interviewed at approximately 8:45 AM in the resident's room. The nursing assistant confirmed that there was no sheet in the resident's room to document fluids and there were no fluids in the room to offer the resident. The nursing assistant stated she only documented the output at the end of the shift.

The HUK was interviewed on 7/28/05 at approximately 9:10 AM and confirmed that there were no oral intake records in the resident's chart, only the output sheets were in the chart.

Resident #20's sister was interviewed on 7/27/05 at approximately 6:45 PM. The resident' s sister stated that she was concerned that when she was not in the facility the staff did not offer fluids to the resident. The resident's sister stated that when she visited her brother, staff did not come in and offer fluids. The resident's sister stated that she had talked to the nurse manager in the past about her concerns.

Resident #20's sister was interviewed on 7/27/05 at approximately 6:45 PM. Both the resident and his sister were in the resident's room. The resident's sister was concerned that the staff did not give her brother oral care and stated that she did not think it was being done because the resident did not like staff getting close to his face and mouth and had become agitated in the past during mouth cares.

During record review it was noted that neither the nursing assistant care sheet states nor care plan listed oral cares as a need. The dental consults listed that the resident was resistive to exams and the exams could not be completed. The nursing assistant on 7/28/05 at approximately 8:45 AM was interviewed. The nursing assistant stated that she did not do the residents oral care this AM. This surveyor asked the nursing assistant to check the resident's mouth. The nursing assistant gloved and checked the resident's mouth by parting his lips. During this observation of the resident's mouth a large buildup of plague on all teeth was noted. The nursing assistant replied that she would do his oral cares. At 9:00 AM the nursing assistant reported back to me that she had not completed the resident's oral care.

Resident #15's teeth were not brushed. Resident #15 had diagnoses that included dementia, and esophageal reflux. The nursing assistant assignment sheet indicated the resident was total care for grooming. During observations of bedtime cares on 7/26/05 at approximately 7:30 PM, the resident's teeth were not brushed. Upon interview with the HST immediately following cares she reported the resident did have natural teeth. The HST reported she used glycerine swabs for oral care, instead of brushing her teeth.

Upon interview with the nurse manager on 7/28/05 at approximately 9 AM, she reported she would expect resident's teeth brushed, if they have them.

Review of the facilities oral care policy, dated 4/16/04 directed natural teeth to be brushed at least twice daily.

Observations during the initial tour of building 6 on 7/26/05 from approximately 11:30 AM until 1:43 PM revealed 7 male residents (#50, #5, #51, #52, #53, #2, #54) who had not been shaved. Observations during the evening shift on 7/26/05 revealed that resident #6 and resident #9 were not shaved. A review of current plans of care for resident #6 (1/10/05) and resident #9 (8/11/04) indicated that both were dependent with grooming and required assistance to shave. An interview with a human service technician (HST) to follow up on ability of residents (#52, #5, #50, #51, #53 and #2)) to shave on 7/29/05 at 9:45 AM revealed that a[1] needed assist to shave. A review of the standards of practice for the nursing department related to quality resident care, which was received from the administrator on 7/28/05, indicated, "Shaving daily and as needed".

Resident #33 was not transferred with the mechanical lift in accordance with the plan of care.

A review of the HST assignment sheet last updated as of 7/22/05 indicated that the resident was non-ambulatory, needed assistance of 1-2 staff, was dependent in all cares, was incontinent of urine – needs help to toilet, check, toilet or change, mechanical lift used for transfers as needed. A review of the resident's current plan of care as of 11/3/04 indicated: "Provide for safety"; "12/29/04, May use mechanical lift as needed due to residents inability to stand."

Evening cares were observed for resident #33 on 7/26/05 at approximately 7:06 PM, the resident was observed to be dangling over a trash can while attached to a manual Sara-type standing lift The fleece sling was located directly underneath the resident's armpits and the resident was not holding onto the lift bar. The resident was not bearing any weight on the lift stand that left the resident unsupported in the air (no safety belt was noted). The resident's face was reddened, eyes open and his expression was a frowning type scowl.

An interview with the HST when the evening cares had been completed to follow up on what the usual practice was the resident for repositioning and toileting to find that usually the HST would have a second HST to assist but the HST stated my partner was on break and the resident needed to be changed.

An additional observation of resident #33during evening cares on 7/28/05 at 4:20 PM revealed a similar picture as the evening before; the resident was again hanging over the trash can while attached to the manual Sara lift as the HST was changing the incontinence pad over the trash can. The resident was able to hold onto the lift bar with his left hand and was able to partially bear weight on his feet. The resident was awake and stated to the HST, "what in the hell do you think you're doing?" and the HST replied, "just cleaning you up". "An interview with a second HST on 7/28/05 at 10:30 AM, that had cared for the resident on both the day and evening shifts in the past, as to how resident #33 was transferred revealed that the electric Sara or hand (manual) lift could be used. The HST preferred to use the electric Sara as it had a safety belt. The resident required assistance of 1-2 staff depending on mood, behavior or sleepiness. The manual (hand) Sara was totally unsafe for the resident and if used would definitely need another staff to assist.

Review of the care plan dated 5/4/05 direct staff to assist resident #36 by setting up the tray, opening packages ar eat. Observation of resident #36 on 7/26/05 at 8:30 AM the resident was in the dining room waiting for his breal was seated in a chair against the wall with an over bed table in front on him. At 8:40 AM the trays had been serv and resident #36 had his breakfast, there was no staff near him to assist with eating. His milk and juice had not been opened. Resident #36 was observed to lift his empty fork to his mouth and then put it down. At 9:0 the resident had eaten just two bites of food on his own and had been unable to open his beverage containers. Af minutes this surveyor asked staff to assist the resident. His beverages were opened and he was encouraged to eat AM a staff member sat next to the resident and assisted to feed the resident, no offer was made to heat up the foo charge nurse was interviewed 7/27/05 at 10:00 AM and stated that this resident should have received assistance v set up of his meal and had his beverages opened

TO COMPLY: all personnel involved in the care of the resident must use a comprehensive plan of care.

SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review the current resident care plan policies and procedures, revise as needed and instruct appropriate personnel. The Director of Nursing could designate a staff person to do ongoing monitoring to ensure compliance of resident care plans.

TIME PERIOD FOR CORRECTION: Fourteen (14) days.

7. MN Rule 4658.0405 Subp. 4.

Based on record review and staff interview the facility failed to revise the plan of care for 1 out 1 resident's in th a change of diet texture, (# 34). Findings include:

Resident #34 had been hospitalized for dehydration and removing his feeding tube. He was returned to the facili 6/28/05. Review of the record for resident #34 revealed that his plan of care that included thickened liquids and r ground foods. A swallowing guide dated 7/12/05 signed by the speech therapist recommends nectar thickened l six times a day, and remain upright 60 minutes after meals. Review of the care plan updated 7/12/05 stated modi with regular fluids contradicting the thickened liquid plan. Interview with the nurse on the unit revealed she was assigned to this resident, and was not familiar with this resident's needs.

TO COMPLY: A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff.

SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review the current resident care plan policies and procedures, revise as needed and instruct appropriate personnel. T Director of Nursing could designate a staff person to do ongoing monitoring to ensure resident care plan compliance.

TIME PERIOD FOR CORRECTION: Fourteen (14) days.

8. MN Rule 4658.0470 Subp. 2.

Based on observation and interview the facility failed to assure that the current medical records were stored to safeguard confidential information in one out of three buildings surveyed #6. Findings include:

During the initial tour of Building 6 on 7/26/05 at 1:40 PM on the second floor the nurses station was unattended any staff, all of the medical records for the 28 residents on that unit were located on a rack behind the nurse's de There was no door to the nurse's station or a lock on the cart to protect the medical records, the records were eas accessible and in plain view. There was no staff around this area; several residents were in the area, five in the d room and two in the hallway. A staff was located leaving room 245 at 1:53 PM. On 7/27/05 between 11 AM and 11:30 AM on the third floor of Building 6 it was observed that the staff were not available at the nurses station a medical records were not secured. A half door with a latch was on the nurse station but this was not secur- -whe left the desk area. The Director of medical records was interviewed 7/29/05 at 10:15 AM and stated that t.e w policy about leaving the medical records unsecured in the nurse stations.

TO COMPLY: Space must be provided for the safe and confidential storage of residents' clinical records.

SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review the current resident record storage procedures, revise as needed and instruct appropriate personnel. The Director of Nursing could designate a staff person to do ongoing monitoring to ensure resident record security or provide secure areas for records to be stored.

TIME PERIOD FOR CORRECTION: Seven (7) days.

9. MN Rule 4658.0505 Subp. I. Based on observation, interview and record review the Director of Nursing failed to ensure that the comprehensive plan of care was carried out for 15 out of 27 residents in the sample. (#2, #5, #6, #7, #9, #10, #11, #12 , #13 , #15, #17, #18, #20, 33 & 36) and 5 out 5 in the expanded sample (#50, 51, 52, 53, & 54). Findings include:

Resident #17 did not have his catheter bag emptied as needed. Per record review, resident #17 was admitted to the facility on 08/26/03 with diagnoses that included neurogenic bladder, and diabetes. According to the residents care plan, the staff was to empty and record Foley catheter output every shift and complete catheter care per physician order. The nursing assistant sheet instructed the nursing assistant to empty Foley every shift and report and to "check bag often – fills quickly."

Resident #17 was observed on 7/27/05 at 7:45 AM while lying in bed in his room. The resident had a leg bag on for urine collection that was full. The resident's sweat pants were soaked in the groin area. Resident #17 was interviewed at 7/27/05 at 7:45 AM and stated "cares are not very good, you have to wait a long time to get help." The staff does not empty my urine bag when they should so it overflowed. The spillage happens so often that I don't feel real good about it. The night staff went home today without emptying my bag and now I am all wet.

The nursing assistant came into the resident's room on 7/27/05 at approximately 7:47 AM and started AM cares. The resident said to the nursing assistant as she tried to remove the residents wet sweat pants, "why don't you empty my bag first?" The nursing assistant replied to the resident, "I was going to get these wet pants off you first. The nursing assistant emptied the leg bag of 500 milliliters of urine. The maximum capacity of the leg bag was 500 milliliters.

The nursing assistant was interviewed after cares at approximately 8:00 AM and confirmed that resident #17's urine leg bag had not been emptied by the night staff. Resident #9 who required thickened liquids was given unthickened juice.

A review of the current physician's orders for resident #9 as of 7/7/05 indicated, "Diet: Pureed with nectar thick liquids, ok for regular bananas, French toast, and pancakes." The plan of care dated 10/24/04 indicated the resident should have a pureed diet with nectar thick liquids.

During observations of a medication pass on 7/27/05 at 11:25 AM a licensed practical nurse (LPN) was noted to give resident #9 regular thin cranberry juice with two regular strength Tylenol. The resident proceeded to choke and cough and spit. Earlier observations of the resident receiving an evening meal on

7/26/05 revealed that the resident was to receive nectar thickened liquids. The LPN stated after having given the thin juice to the resident that, "My fault, he should have thickened liquids.

During observations of resident #6 and #7 on 7/26/05 from 4:40 PM until 7:55 PM, it was noted that the residents were not repositioned or toileted during that time. Both residents were totally dependent on others to reposition and toilet. According to their plans of care (#6 – 1/10/05) and (#7 – 12/7/04) staff were directed to toilet and reposition the residents every two hours. An interview with the human service technician (HST) at 7:55 PM, who had been assigned to these residents, revealed that the last time the residents had been repositioned or toileted was around 4:30 PM just before dinner.

Observations of resident #10 on 7/26/05 from 4:40 PM until 7:45 PM revealed that the resident was not toileted checked or changed. The resident was totally dependent on others for toileting, check and change at intervals of at least every two hours and as needed related to incontinence of bowel and bladder, according to the current plan of care dated 12/30/04. An interview with the HST at 7:45 Pm revealed that the HST had not toileted, checked or changed the resident since the resident's nap at approximately 3:30 PM. (4 hours and 15 minutes).

Observations of resident #10 on 7/27/05 from approximately 7:30 Am until 10:25 AM revealed that the resident was not toileted checked or changed. The resident did have a Broda-type wheelchair and position changes had been observed during breakfast and afterwards when the resident had been wheeled back to her room and the hospice nurse spent time with the resident. An interview with the hospice nurse, at 9:50 AM, to follow up on what was done for the resident revealed the hospice nurse adjusted the resident's position the Broda –type wheelchair but did not toilet, check or change the resident at the time. The nurse stated that usually the resident was placed in bed after meals as a preventative measure for skin breakdown. An interview with the HST at approximately 10:25 AM revealed that the resident had not been checked or changed since before breakfast at approximately 7:30 AM

Resident #11 was not repositioned, toileted for checked for incontinence every two hours.
Resident #11 had diagnoses that included anoxic brain injury and history of falls. The resident had physician orders dated 5/29/05 for a locked Posey belt when in the bed or wheelchair. According to the care plan dated 5/12/05, the resident was to be repositioned, toileted or checked for incontinence every 2 hours. Resident #11 was observed on 7/26/05 from 4:30 PM until 7:50 PM without being released or repositioned, for a total of 3 hours, 20 minutes. At 7:30 PM the surveyor informed the Human Services Technician (HST), who then assisted the resident to bed at 7:50 PM. The resident's incontinent pad was changed, and was noted to be wet.

Resident #12 was not repositioned in a timely manner. Resident #12 had diagnoses that included dementia, and Alzheimer's disease. The RAP (resident assessment profile) identified the resident's skin as being at risk for breakdown, with an intervention of assisting with repositioning every 2 hours while in the wheelchair. According to the care plan dated 7/8/05 the resident was to be repositioned every 2 hours. On 7/26/05 at 4:30 PM, resident #12 was observed visiting with her husband in her room until 6 PM, at which point she was escorted to the dining room. Upon interview with the husband at 6 PM he reported he had arrived at 2:45 PM. Upon further discussion with the husband he reported staff had not changed the resident's position since his arrival. At approximately 7:15 PM the surveyor questioned when resident #12 was repositioned, and was told it was at 3:45 PM. The surveyor informed the HST the husband reported he

had arrived at 2:45 PM and resident #12 had not been repositioned. The HST acknowledged resident #12 was past due for repositioning and assisted the resident to bed.

Resident #12 did not receive assistance with oral cares. According to the care plan dated 7/8/05, the resident's teeth were to be brushed. On 7/26/05 at approximately 7 PM, bedtime cares were observed. The Human Services Technician (HST) used a pink swab to cleanse the oral cavity. Upon interview with the HST immediately following the cares she reported the resident had a full set of teeth, but she did not brush the teeth anymore because she swallowed the toothpaste

Resident #13 with a pressure sore was not repositioned for over 2 hours. Resident #13 had diagnoses that included Parkinson's disease and arthritis. The resident was identified on 7/14/05 as having a stage 2-pressure ulcer (a partial thickness loss of skin layers that presents as an abrasion, blister, or crater) on his coccyx. According to the care plan dated 5/20/05 the resident was to be repositioned while in the wheelchair every 2 hours. The care plan identified the resident as having fragile skin and at risk for breakdown. On 7/26/05 resident #13 was observed from 4:30 PM until 7:15 PM (2 hours, 45 minutes) without being repositioned. The surveyor entered another resident's room at 7:15 PM. Resident #18 was not released from the restraint every two hours.

Per record review, resident #18 was admitted to the facility on 6/10/03 and was diagnosed with senile delusions, history of myocardial infarction and strokes, incontinence of bowel and bladder, and history of pressure ulcers. The nursing assistant work sheet stated: assist with all activities of daily living. The resident was to lay down three times a day due to pressure area. The resident's care plan stated to check seat belt when in wheelchair every half hour and release and reposition resident every two hours.

Resident #18 was observed on 7/26/05 at approximately 5:10 PM sitting in the dining room at her assigned table with her seat belt on in a broda chair leaning to the right side. She remained in the chair leaning to the right until shortly after 7:00 PM when a nursing assistant took the resident to her room. The restraint was released at 7:40 when she was transferred. The resident's buttock was reddened. The incontinent product the resident had been wearing before she was toileted was soaked with urine and a strong urine odor was present. The nursing assistant was interviewed on 7/26/05 at 7:25 PM and confirmed that he did not know when the resident had last been toileted or repositioned. The nursing assistant stated that he started his shift at 3 PM and this was the first time he toileted the resident and repositioned her. The nursing assistant confirmed that the incontinent pad he removed was very wet.

Resident #18 was observed again on 7/27/05 at 12:45 PM sleeping at her assigned dining room table in her broad chair with her chin on her chest. At 1:07 PM the nurse manager went over to the resident and said, "it's time for your nap" and wheeled the resident to he room in the broda chair. At 1:13 PM the nursing assistant went into the resident's room. The incontinent pad that was removed was soaked with urine. The nursing assistant interviewed at 1:20 PM confirmed that the resident's incontinent pad was soaked and also additional cares such as oral cares, repositioning with release of seat belt had not been done for this resident today. The nursing assistant stated, I'm just too busy to get all the cares done. I have 12 residents that I am giving care to today by myself.

The facility did not follow the comprehensive care plan for resident #20 by not documenting fluid intake on a form in resident's room and did not complete oral cares.

Resident #20 was admitted to the facility on 5/22/00 diagnosed with Huntington's chorea, failure to thrive, dysphasia, and dementia without behaviors. The resident was admitted into the hospital on 2/16/05 for failure to thrive with concerns of malnutrition and dehydration. Resident #20 was observed on 7/26/05 at approximately 6:10 PM in the dining room. The nursing assistant fed the resident. The resident had sunken eyes and was very thin.

The physician ordered on 2/28/05 honey thick water 200 milliliters 4 times a day and as needed and to encourage fluids. The resident's care plan and nursing assistant sheet stated to document fluids on the form in resident's room. Honey thickened water was to be given whenever staff was with resident.

On 7/28/05 at 8:45 AM there was no intake record posted in the resident's room and there were no fluids available to offer the resident. The nursing assistant taking care of resident #20 on 7/28/05 was interviewed at approximately 8:45 AM in the resident's room. The nursing assistant confirmed that there was no sheet in the resident's room to document fluids and there were no fluids in the room to offer the resident. The nursing assistant stated she only documented the output at the end of the shift.
The HUK was interviewed on 7/28/05 at approximately 9:10 AM and confirmed that there were no oral intake records in the resident's chart, only the output sheets were in the chart.

Resident #20's sister was interviewed on 7/27/05 at approximately 6:45 PM. The resident' s sister stated that she was concerned that when she was not in the facility the staff did not offer fluids to the resident. The resident's sister stated that when she visited her brother, staff did not come in and offer fluids. The resident's sister stated that she had talked to the nurse manager in the past about her concerns.

Resident #20's sister was interviewed on 7/27/05 at approximately 6:45 PM. Both the resident and his sister were in the resident's room. The resident's sister was concerned that the staff did not give her brother oral care and stated that she did not think it was being done because the resident did not like staff getting close to his face and mouth and had become agitated in the past during mouth cares.

During record review it was noted that neither the nursing assistant care sheet states nor care plan listed oral cares as a need. The dental consults listed that the resident was resistive to exams and the exams could not be completed. The nursing assistant on 7/28/05 at approximately 8:45 AM was interviewed. The nursing assistant stated that she did not do the residents oral care this AM. This surveyor asked the nursing assistant to check the resident's mouth. The nursing assistant gloved and checked the resident's mouth by parting his lips. During this observation of the resident's mouth a large buildup of plague on all teeth was noted. The nursing assistant replied that she would do his oral cares. At 9:00 AM the nursing assistant reported back to me that she had not completed the resident's oral care.

Resident #15's teeth were not brushed. Resident #15 had diagnoses that included dementia, and esophageal reflux. The nursing assistant assignment sheet indicated the resident was total care for grooming. During observations of bedtime cares on 7/26/05 at approximately 7:30 PM, the resident's teeth were not brushed. Upon interview with the HST immediately following cares she reported the resident did have natural teeth. The HST reported she used glycerine swabs for oral care, instead of brushing her teeth.

Upon interview with the nurse manager on 7/28/05 at approximately 9 AM, she reported she would expect resident's teeth brushed, if they have them.

Review of the facilities oral care policy, dated 4/16/04 directed natural teeth to be brushed at least twice daily.

Observations during the initial tour of building 6 on 7/26/05 from approximately 11:30 AM until 1:43 PM revealed 7 male residents (#50, #5, #51, #52, #53, #2, #54) who had not been shaved. Observations during the evening shift on 7/26/05 revealed that resident #6 and resident #9 were not shaved. A review of current plans of care for resident #6 (1/10/05) and resident #9 (8/11/04) indicated that both were dependent with grooming and required assistance to shave. An interview with a human service technician (HST) to follow up on ability of residents (#52, #5, #50, #51, #53 and #2)) to shave on 7/29/05 at 9:45 AM revealed that all needed assist to shave. A review of the standards of practice for the nursing department related to quality resident care, which was received from the administrator on 7/28/05, indicated, "Shaving daily and as needed".

Resident #33 was not transferred with the mechanical lift in accordance with the plan of care.
A review of the HST assignment sheet last updated as of 7/22/05 indicated that the resident was non-ambulatory, needed assistance of 1-2 staff, was dependent in all cares, was incontinent of urine – needs help to toilet, check, toilet or change, mechanical lift used for transfers as needed. A review of the resident's current plan of care as of 11/3/04 indicated: "Provide for safety"; "12/29/04, May use mechanical lift as needed due to residents inability to stand."

Evening cares were observed for resident #33 on 7/26/05 at approximately 7:06 PM, the resident was observed to be dangling over a trash can while attached to a manual Sara-type standing lift The fleece sling was located directly underneath the resident's armpits and the resident was not holding onto the lift bar. The resident was not bearing any weight on the lift stand that left the resident unsupported in the air (no safety belt was noted). The resident's face was reddened, eyes open and his expression was a frowning type scowl.

An interview with the HST when the evening cares had been completed to follow up on what the usual practice was the resident for repositioning and toileting to find that usually the HST would have a second HST to assist but the HST stated my partner was on break and the resident needed to be changed.

An additional observation of resident #33during evening cares on 7/28/05 at 4:20 PM revealed a similar picture as the evening before; the resident was again hanging over the trash can while attached to the manual Sara lift as the HST was changing the incontinence pad over the trash can. The resident was able to hold onto the lift bar with his left hand and was able to partially bear weight on his feet. The resident was awake and stated to the HST, "what in the hell do you think you're doing?" and the HST replied, "just cleaning you up". "An interview with a second HST on 7/28/05 at 10:30 AM, that had cared for the resident on both the day and evening shifts in the past, as to how resident #33 was transferred revealed that the electric Sara or hand (manual) lift could be used. The HST preferred to use the electric Sara as it had a safety belt. The resident required assistance of 1-2 staff depending on mood, behavior or sleepiness. The manual (hand) Sara was totally unsafe for the resident and if used would definitely need another staff to assist.

Review of the care plan dated 5/4/05 direct staff to assist resident #36 by setting up the tray, opening packages a eat. Observation of resident #36 on 7/26/05 at 8:30 AM the resident was in the dining room waiting for his breal Was seated in a chair against the wall with an over bed table in front on him. At 8:40 AM the trays had been serv And resident #36 had his breakfast; there was no staff near him to assist with eating. His milk and juice Had not been opened. Resident #36 was observed to lift his empty fork to his mouth and then put it down. At 9:0 The resident had eaten just two bites of food on his own and had been unable to open his beverage containers. A minutes this surveyor asked staff to assist the resident. His beverages were opened and he was encouraged to eat AM a staff member sat next to the resident and assisted to feed the resident, no offer was made to heat up the foc Charge nurse was interviewed 7/27/05 at 10:00 AM and stated that this resident should have received assistance set up of his meal and had his beverages opened

TO COMPLY: The written job description for the director of nursing services must include responsibility for:
Assuring that a comprehensive plan of care is established and implemented for each resident.

SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review the current scheduling and resident care plan policies and procedures, revise as needed and instruct appropriate personnel. The Director of Nursing could designate a staff person to do ongoing monitoring to ensure compliance of resident care plans.

TIME PERIOD FOR CORRECTION: Fourteen (14) days.

10. MN Rule 4658.0510 Subp. 1.

Based on observations, record review and family, staff and resident interviews the facility failed to provide sufficient staff to meet the needs of 21 out of 27 residents in the sample (#s 2, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 17, 18, 19, 20, 30, 31, 33, 34, 35, 36) plus 6 of 6 in the expanded sample (#s 50, 51, 52, 53, 54 & 55) Findings include:

A. Staff reported there were with insufficient staff to meet resident needs.

During an interview with a Human Service Technician (HST) on 7/27/05 at approximately 10:25 AM related to resident #10 not being checked and changed for approximately 3 hours the HST reported that they were responsible for 14 residents and that they were short one HST today. The HST stated they had not been able to change a resident's clothing who had spilled juice on his pants. The HST reported that management staff was aware of the frustrations related to the heavy workload and that HST would skip breaks in order to do their best to try to meet the needs of the residents. The HST stated that the administration had known that the current nursing care model for the unit had not been working was looking at a new care model.

In an interview with a HST on unit 17-3 on 7/29/05 at 10:30 AM, the HST reported that 4 HSTs were not adequate to care for 50 residents who needed "lots of care". The HST reported that over the last two weeks the unit had been staffed with 2 nurses and 3 HSTs. The HST stated that there are approximately 10 residents who would need assistance to eat on the unit and their tray's are served but no one helps them to

eat until all are served this is especially true of the breakfast meal. "Eventually everyone gets fed, but no one should have to sit with a try in front of them and watch others eat." The HST relayed an incident from an evening shift as 2 days ago. "A pool HST had worked on the night shift and the day HST noted that during rounds that all the residents in the group were soaked (with urine). The HST discovered that the night HST not only came late to the shift but did not do the work."

A review of the human service technician (HST) assignment sheets updated as of 7/22/05 on unit 6-1 indicated that there were 3 workgroups for the day and evening shifts. Group 1 consisted of 9 residents, 4 of the 9 required a Sara-type standing lift or full mechanical lift with 1-2 staff to assist; 8 of the 9 residents required assistance with toileting or a check and change at intervals of every two hours related to incontinence of bowel and bladder. Group 2 consisted of 8 residents, 4 of the 8 required a Sara-type standing lift with 1-2 staff to assist; 7 of the 8 residents required assistance with toileting or a check and change at intervals of at least every two hours and as needed, related to incontinence of bowel and bladder. Group 3 consisted of 14 residents, 3 of the 14 required a Sara-type standing lift or full mechanical lift with 1-2 staff to assist; 10 of the 14 residents required assistance with toileting or a check and change at intervals of at least every two hours and as needed, related to incontinence of bowel and bladder. In interviews with various staff throughout the survey staff reported that residents who required assistance of two for a lift transfer were being transferred with the assistance of one because of being short of staff or there partners were on their breaks.

A staff member on 3 North approached this surveyor on 7/26/05 at approximately 6:10 PM. During the interview, the staff member stated, "We are real short of help" and indicated that sometimes residents wait up to 30 minutes before a staff member can assist the resident' s who require assistance with feeding. Residents have to wait on a daily basis to receive assistance. The staff reported that the previous Sunday, 7/24/05 there were 2 nursing assistants between 6:30 – 8:00 AM and we were told that a third aide would start at 8:00AM. The third nursing assistance never showed up. The staff reported that during the survey there were people helping that never come up to the floor. The staff stated "You can 't give adequate care and I go home feeling guilty. I go home in tears because residents ask for help and I can' t give it to them because we are short on help." The indicated that there was a lot of falls occurring.

An interview with a licensed practical nurse (LPN) on 7/26/05 at approximately 6:20 PM revealed that there was no consistency with staffing and that they worked "short staff" on a regular basis.

An interview with an administrative staff on 7/29/05 at approximately 10:10 AM related to staffing concerns, mandated overtime and the staff's ability to meet the needs of the residents. The staff stated that there are staff who have jobs outside of the home and they may have already worked 8 hours prior to their shift at the facility and then may be mandated to work an extra shift on top of that. The staff indicated that if a day shift staff worked into the evening shift the officer of the day would allow the staff to go home as soon as the work was done. The staff indicated that the mandated overtime staff would hurry to get their residents to bed and forgo the evening cares so they wouldn't have to work the full second shift. The administrative staff stated that residents have been receiving poor care over the last 5 months. The staff indicated that residents weren't being shaved, soiled clothes weren't changed, and nourishments were not being passed.

B. The Resident Council in the February 16, 2005, April 6, 2005, and May 4, 2005 meetings reported that snacks were not being passed out on the unit. The resident group interviewed on 7/27/05 at 10:00 AM although composed of residents who were independent in their cares reported that they had concerns about the evening shift. "Don't seem to care." They also indicated the pool staff were not very good.

A nurse manager interviewed on 7/27/05 at 2:15 PM reported there were 67 current vacant shifts for nurses and HSTs on the schedule to be filled for the weeks 8/10/05 – 8/23/05. During the period of 7/27-8/9/05 there were 56 vacant shifts.

C. Family Members reported insufficient staff to meet resident needs.
During an interview on 7/29/05 at 12:50 PM a family member stated that oral cares and shaving are not given da "Sometimes there is not enough staff to get things done." It was stated the resident is not changed every two hou And that he had not been changed since before breakfast today until the family member left the unit at 12:30 PM.

During a meeting with representatives from the family council on 7/27/05 at 1:40 PM when asked if their grievances were being resolved reported that this was a problem with regard to the "short staff issue". Seven out of seven family members present stated that they were frustrated about staffing on the units and gave several examples of care not being completed for their residents. Examples included toileting not being done every two hours or according to individual needs, oral care not being done daily, and baths not completed weekly or more often if requested, and call lights not being answered. The family indicated that all they were asking for was "basic care". They also indicated there was a lack of supervision of the Hum Service Technicians and the pool staff were short and abrupt. The families reported that follow-up to their concerns is slow. A family member indicated that the administrator indicated concerns about not enough help on the unit to assist with toileting needs at mealtimes should be referred to the nurse. The family member indicated that talking to the nurse was not improving the care. The family reported that they often had to be the one to assist with toileting.

The family members stated that problems related to care issues have not been resolved and that there were conce short staffing. The families reported that when staffing concerns are raised they hear about future plans as soluti solutions are not being implemented to correct the issue in the meantime.

The Minnesota Veterans' Home Family Council minutes from April 3, 2005 indicated families were concerned a "Mandatory overtime, second shift. Members expressed concern that their loved one would be shortchanged by staff working 16 hours in a row. The current growth of this practice appeared to be worrisome. " The March mi indicated that a concern was brought up that some of the residents are not getting baths and were "falling throug

During the "Minnesota Veterans Home-Minneapolis Resident Council/Administration Meeting" June 1, 2005 th brought up concerns about nursing regarding staff following care plans. No specifics were included in the minu reflected that the Director of Nursing found the information "disturbing." The July 6, 2005 minutes repor ' tha issues about the number of staff on weekends.

D.) Administrative staff when interviewed on 7/28/05 at 1:00 PM indicated that some of the empty shifts were w from the supplemental nursing service agencies (pools) and that mandated overtime and in-house volunteers. Th

administrator indicated that they were aware the current staffing model wasn't working and they were trying the model to increase HST hours.

E.) throughout the course of the survey the surveyors observed resident needs were not being met. Fifteen out of in the sample (#2, #5, #6, #7, #9, #10, #11, #12 , #13 , #15, #17, #18, #20, 33 & 36) and 5 out 5 in the expandec 51, 52, 53, & 54) did not receive services in accordance with their plan of care. Services not performed include:

- Residents in restraints were not released and given opportunity for motion and exercise every two hours
- Residents did not receive timely services with incontinent cares and one resident did not receive those services in a dignified manner.
- Residents did not receive assistance with shaving.
- Residents did not receive oral cares.
- Residents did not receive assistance with nail care.
- Residents who were unable to change their own position did not receive assistance with repositioning.
- The facility did not ensure that residents with a history of dehydration were receiving adequate hydration.
- Residents did not receive assistance with eating in a manner that enhanced their dignity.
- Residents who were incontinent did not receive timely assistance with toileting and incontinence cares.

TO COMPLY: A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements.

SUGGESTED METHOD OF CORRECTION: The Administrator and the Director of Nursing could review the current staffing pattern and resident needs, revise the number of staff to meet the resident needs and instruct all appropriate personnel in the revisions. The Administrator could designate a staff person to do ongoing monitoring to ensure compliance with meeting resident's personal needs.

TIME PERIOD FOR CORRECTION: Fourteen (14) days.

10. N Rule 4658.0520 Subp. 2. A.

Based on observation, interview, and record review, the facility failed to provide adequate and kind and considerate treatment at all times for 1 out of 27 residents in the sample (#33) during repositioning and in continence cares. Findings include:

Evening cares were observed for resident #33 on 7/26/05 at approximately 7:06 PM, the resident was observed to be dangling over a trash can while attached to a manual Sara-type standing lift with no shirt on and his pants down around his ankles (mostly naked). The fleece sling was located directly underneath the resident's armpits and the resident was not holding onto the lift bar. The resident was not bearing any weight on the lift stand that left the resident unsupported in the air (no safety belt was noted). The human service technician (HST) was standing behind the resident and removed the incontinence pad and dropped it into the trashcan located underneath the resident. The HST then cleansed the resident's peri-area as the resident had been incontinent of bowel and bladder, the resident continued to dangle during the process. The resident's face was reddened, eyes open and his expression was a frowning type scowl. An interview with the HST when the evening cares had been completed to follow up on what the usual practice was the resident for repositioning and toileting to find that usually the HST would have a second HST to assist but the HST stated my partner was on break and the resident needed to be changed.

An additional observation of resident #33during evening cares on 7/28/05 at 4:20 PM revealed a similar picture as the evening before; the resident was again hanging over the trash can while attached to the manual Sara lift as the HST was changing the incontinence pad over the trash can. The resident was able to hold onto the lift bar with his left hand and was able to partially bear weight on his feet. The resident was awake and stated to the HST, "what in the hell do you think you're doing?" and the HST replied, "just cleaning y up".

A review of the HST assignment sheet last updated as of 7/22/05 indicated that the resident was non-ambulatory, needed assistance of 1-2 staff, was dependent in all cares, was incontinent of urine – needs help to toilet, check, toilet or change, mechanical lift used for transfers as needed. A review of the resident's current plan of care as of 11/3/04 indicated: "Provide for safety"; "12/29/04, May use mechanical lift as needed due to residents inability to stand". An interview with a second HST on 7/28/05 at 10:30 AM, that had cared for the resident on both the day and evening shifts in the past, as to how resident #33 was transferred revealed that the electric Sara or hand (manual) lift could be used. The HST preferred to use the electric Sara as it had a safety belt. The resident required assistance of 1-2 staff depending on mood, behavior or sleepiness. If the resident was antsy then two staff was needed to assist the resident with transfers and incontinence care. The HST stated the resident was able to sometimes sit on the toilet depending on the level of agitation and that two staff to toilet the resident was a good idea. The manual (hand) Sara was totally unsafe for the resident and if used would definitely need another staff to assist. The HST indicated that the resident was never changed over the trash.

A review of the facility policy and procedure related to use a Sara lift transfer, dated 9/1993, indicated; "The Sara lift is used for residents who can bear weight through one or both lower extremities but require moderate to maximal assistance of 1-2 persons to stand and /or pivot. Resident transfers in which a Sara l... is used will require the assistance of one person unless otherwise indicated on the resident's care plan." A picture with instructions on how to apply the sling was also included in the procedure and indicated, "Lower the support arms and place the sling around the resident's back so that it lies 1" of so horizontally above the waist line. If possible, the resident should now hold onto the padded frame with one or both hands. Be

careful not to raise the resident too high or this could cause pressure under the arms. Release brakes and move resident and Sara lift to desired location; commode, toilet, wheelchair, bed, etc." The procedure went onto to state, " Residents who have had a stroke and can only hold with one hand, or who cannot hold on at all, may still be lifted by Sara but a second staff person should support the arm(s) or hold the resident's arms in front of the body during the lift. The Sara is designed for quick easy transfers from one sitting position to another and to elevate a resident for toileting, repositioning, changing of incontinence pads, wound dressings, etc. It is not intended for long periods of suspension or transportation.

TO COMPLY: The criteria for determining adequate and proper care include: Evidence of adequate care and kind and considerate treatment at all times. Privacy must be respected and safeguarded.

SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review the policies and procedures for all areas of treatment with resident care, revise as needed and instruct all appropriate personnel. The Director of Nursing could designate a staff person to do ongoing monitoring to ensure compliance of considerate and adequate resident personal needs.

TIME PERIOD FOR CORRECTION: Fourteen (14) days.

11. MN Rule 4658.0520 Subp. 2. D.

Based on observation, interview, and record review, the facility failed to provide assistance with or supervision of shaving of 9 residents (#6, #9, #50, #5, #51, #52, #53, #2, #54) observed randomly in building 6 as necessary to keep them clean and well groomed. Findings include:

Observations during the initial tour of building 6 on 7/26/05 from approximately 11:30 AM until 1:43 PM revealed 7 male residents (#50, #5, #51, #52, #53, #2, #54) who had not been shaved. Observations during the evening shift on 7/26/05 revealed that resident #6 and resident #9 were not shaved. A review of current plans of care for resident #6 (1/10/05) and resident #9 (8/11/04) indicated that both were dependent with grooming and required assistance to shave. An interview with a human service technician (HST) to follow up on ability of residents (#52, #5, #50, #51, #53 and #2)) to shave on 7/29/05 at 9:45 AM revealed that all of the residents identified needed assistance to shave. A review of the standards of practice for the nursing department related to quality resident care, which was received from the administrator on 7/28/05, indicated, "Shaving daily and as needed".

TO COMPLY: The criteria for determining adequate and proper care include: D. Assistance with or supervision of shaving of all residents as necessary to keep them clean and well groomed.

SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review the current policies and procedures for resident care needs, revise as needed and instruct the appropriate personnel. The Director of Nursing could designate a staff person to do ongoing monitoring of residents personal needs to ensure compliance.

TIME PERIOD FOR CORRECTION: Fourteen (14) days.

12. MN Rule 4658.0520 Supb. 2. E.

Based on observation, interview and record review the facility failed to ensure that 5 out of 27 residents in the sample (#s: 12, 15, 18, 19, & 20) received assistance with oral care. Findings include:

Resident #12 and #15's teeth were not brushed.

Resident #12 had diagnoses that included Alzheimer's disease. According to the care plan dated 7/8/05, the resident's teeth were to be brushed. On 7/26/05 at approximately 7 PM, bedtime cares were observed. The Human Services Technician (HST) used a pink swab to cleanse the oral cavity. Upon interview with the HST immediately following the cares she reported the resident had a full set of teeth, but she did not brush the teeth anymore because she swallowed the toothpaste.

Resident #15 had diagnoses that included dementia, and esophageal reflux. The nursing assistant assignment sheet indicated the resident was total care for grooming. During observations of bedtime cares on 7/26/05 at approximately 7:30 PM, the resident's teeth were not brushed. Upon interview with the HST immediately following cares she reported the resident did have natural teeth. The HST reported she used glycerine swabs for oral care, instead of brushing her teeth.

Upon interview with the nurse manager on 7/28/05 at approximately 9 AM, she reported she would expect resident's teeth brushed, if they have them. Review of the facility's oral care polic dated 4/16/04 directed natural teeth to be brushed at least twice daily.

Oral cares were not done for residents #18, #19, and #20 resulting in plaque build up and reddened gums.

Per record review, resident #18 was admitted to the facility on 6/10/03 diagnosed with senile delusions, history of myocardial infarction and strokes. According to the resident's care plan the staff was to brush teeth after each meal. Resident #18 saw the dentist on 3/22/05 and recommended tooth brushing each morning and evening. Brush teeth and gums for 2 minutes using soft brush and fluoride toothpaste. Be sure that teeth are brushed 2 times a day. The nursing assistant care sheets stated: electric toothbrush use after meals.

Resident #18 was observed during evening cares on 7/26/05 from 7:00 PM through 7:25 PM. During observation, the nursing assistant toileted the resident, put a night gown on, placed a call light in reach and placed the appropriate alarms on. At no time was the resident given oral cares. At 7:25 PM on 7/26/05 the nursing assistant who gave resident #18 evening cares was interviewed. The nursing assistant confirmed that he did not give the resident any oral care since he started his shift at 3 PM. The surveyor asked the nursing assistant to glove and check the resident's mouth. The nursing assistant gloved and checked the resident's mouth. The nursing assistant confirmed that the resident had a large amount of plaque build up and that the resident's gums both top and bottom were very reddened. The nursing assistant stated, he w... sorry for not doing the oral cares and would do it right now.

Resident #18 was observed on 7/27/05 at approximately 12:45 PM to 1:05 PM in the dining room. At 1:05 PM when the nurse manager pushed the resident to her room and positioned the broda chair with the

resident by the resident 's bed and left.. At 1:13 PM the nursing assistant went into the resident's room and put the resident to bed at 1:20 PM. When asked about oral cares the nursing assistant stated that he had not done any oral cares on the resident. The surveyor asked the nursing assistant if he would show the surveyor the resident's toothbrush. The nursing assistant looked in the resident's drawer and found a regular toothbrush. The surveyor then asked if the resident had an electric toothbrush and the nursing assistant did not know. The nursing assistant looked in the resident's top drawer in the bedside stand and found the electric toothbrush in the back of the drawer. This surveyor requested the nursing assistant to put on gloves and check the resident's mouth. The nursing assistant confirmed that there was a large build up of plague and the gums were very red. The nursing assistant then stated "I'm too busy, I did not do her oral cares today. The nursing assistant stated he wasn't aware that he was to do oral cares after each meal.

Resident #19 was transferred to this facility on 10/19/04 due to increased needs for continued skilled nursing care. The resident had been diagnosed with the dementia and paraplegia. Per the resident's care plan 11/3/04; the resident was totally dependent on staff for all grooming/hygiene needs. The nurse manager was interviewed on 7/28/05 at approximately 10:15 AM concerning resident #19's oral care. The nurse manager checked the resident's mouth after donning gloves and agreed that the resident had a large build up of plague. The resident screamed "ouch" as the nurse manager was looking into the resident's mouth. The nurse manager was questioned about the resident's oral care and confirmed by the appearance of the resident' s mouth that the resident had not been receiving oral cares.

Resident #20 was admitted to the facility on 5/22/00 Huntington's chorea, failure to thrive, dysphasia, and dementia without behaviors.

Resident #20's sister was interviewed on 7/28/05 at approximately 6:45 PM. Per the resident's sister, she stated that she visited every day and indicated that she was concerned staff did not give her brother oral care. She stated that she did not think it was being done because he does not like staff getting close to his face and mouth and can become agitated.

During record review it was noted that neither the nursing assistant care sheet stated nor care plan listed oral cares as a need. The nursing assistant on 7/28/05 at approximately 8:45 AM was interviewed. The nursing assistant stated that she did not do the resident's oral care this AM. This surveyor asked the nursing assistant to check the resident's mouth. The nursing assistant gloved and checked the resident's mouth by parting his lips. During this observation of the resident's mouth a large buildup of plague on all teeth was noted. The nursing assistant replied that she would do his oral cares. At 9:00 AM the nursing assistant reported back to the surveyor that she had completed the resident's oral care and got most of the build up food off the gums and teeth.

TO COMPLY: The criteria for determining adequate and proper care include: E. Assistance as needed with oral hygiene.

SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review the current policies and procedures for providing oral care to residents, revise as needed and instruct the appropriate personnel. The Director of Nursing could designate a staff person to do ongoing monitoring.

TIME PERIOD FOR CORRECTION: Fourteen (14) days.

13. MN Rule 4658.0520 Subp. 2 F.

Based on observation, interview, and record review, the facility failed to provide nail care for 3 out 27 residents in the sample (#6, #33, #55)). Findings include:

During random observations on Tuesday 7/26/05 at approximately 1:40 PM a male resident wearing a green plaid shirt, located in the dining room by the nursing station on unit 6-2, was noted to have long, jagged fingernails. Observations of the evening meal in the north dining room on unit 6-1 at approximately 5:31 PM revealed that residents (#55, #33 , #6) had long, jagged fingernails. A review of the bath schedule for resident #55 indicated, "Monday PM"; resident #33 "Wednesday PM"; and resident #6 "Tuesday PM". The facility-nursing standard of practice related to quality resident care indicated that nail care was completed weekly and as needed (clean and trim). The current plan of care for resident #33 as of 11/3/04 indicated, "nail care after bath"; the current plan of care for resident #6 as of 1/10/05 indicated, "nail care after bath". Observations of resident #6 on 7/28/05 at 4:25 PM revealed that the resident's fingernails continued to be approximately one and a quarter inch long and jagged.

TO COMPLY: The criteria for determining adequate and proper care include: F. Fingernails must be kept clean and trimmed.

SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review the current policies and procedures for resident hand/foot care, revise as needed and instruct the appropriate personnel. The Director of Nursing could designate a staff person to do ongoing monitoring of resident hand/foot care to ensure compliance.

TIME PERIOD FOR CORRECTION: Fourteen (14) days.

14. MN Rule 4658.0525 Subp. 4.

Based on observation, interview, and record review, the facility failed to provide a change of position at least every two hours for 6 out of 24 residents in the sample (#6, #7, #11, #12, # 13, and #18) who were unable to change their own position without assist. Findings include:

Resident #6, #7, #11, #12, #13 and #18 were not repositioned as directed by their care plans.

A review of the current plan of care for resident #6 as of 1/10/05 indicated that the resident was to be repositioned every two hours when in the Broda chair. The current plan of care for resident #7 as of 12/7/04 indicated that the resident was to be repositioned every two hours and as needed. A review of the facility standard of nursing practice related to quality resident care stated, "Turning and repositioning is done every 2 hours".

During evening observations on 7/26/05 from approximately 4:40 PM until 7:55 PM resident #6 and #7 were both observed continuously to be seated in Broda-type wheelchairs. No observations were made of

staff repositioning the residents in or out of their chairs during this period. An interview with the human service technician (HST) responsible for the residents at approximately 7:55 PM revealed that neither resident had any position changes since gotten up from their naps before dinner at approximately 4:30 PM

Resident #11 had diagnoses that included anoxic brain injury and history of falls. The resident had physician orders dated 5/29/05 for a locked Posey belt when in the bed or wheelchair. Physician orders directed the restraint to be released for repositioning every 2 hours. According to the care plan dated 5/12/05, the resident was to be repositioned every 2 hours. The RAP (resident assessment profile) dated 5/12/05 described the resident as at risk for skin breakdown, with a stage 1 pressure sore on his left outer ankle. Resident #11 was continuously observed on 7/26/05 from 4:30 PM until 7:50 PM without being released or repositioned, for a total of 3 hours, 20 minutes. At 7:30 PM the surveyor informed the Human Services Technician (HST), who then assisted the resident to bed at 7:50 PM.

Resident #12 had diagnoses that included dementia, and Alzheimer's disease. The RAP dated 7/7/05 described the resident as being severely cognitively impaired. The RAP identified the resident's skin as being at risk for breakdown, with an intervention of assisting with repositioning every 2 hours while in the wheelchair. Physician orders dated 6/10/03 directed staff to monitor the coccyx daily for signs of irritation.

On 7/26/05 at 4:30 PM, resident #12 was observed visiting with her husband in her room until 6 PM and then was escorted to the dining room. Upon interview with the husband at 6 PM he reported he had arrived at 2:45 PM and reported staff had not changed the resident's position since his arrival. At approximately 7:15 PM the surveyor questioned when resident #12 was last repositioned, and was told it was about 3:45 PM. The surveyor informed the HST the husband reported he had arrived at 2:45 PM and resident #12 had not been repositioned. The HST acknowledged resident #12 was past due for repositioning and assisted the resident to bed.

Resident #13 had diagnoses that included Parkinson's disease and arthritis. The resident was identified on 7/14/05 as having a stage 2-pressure ulcer (a partial thickness loss of skin layers that presents as an abrasion, blister, or crater) on his coccyx. According to the care plan dated 5/20/05 the resident was to be repositioned while in the wheelchair every 2 hours. The care plan identified the resident as having fragile skin and at risk for breakdown. On 7/26/05 resident #13 was observed from 4:30 PM until 7:15 PM (2 hours, 45 minutes) without being repositioned. The surveyor ended the observation at 7:15 PM. to follow-up on another resident.

Resident #18 was observed from 5:10 PM through 7:40 PM. Throughout the observation the resident was not repositioned. Per record review, resident #18 was admitted to the facility on 6/10/03 and diagnosed with senile delusions, history of myocardial infarction and strokes, incontinence of bowel and bladder, and history of pressure ulcers. The nursing assistant work sheet stated: assist with all activities of daily living. Lay down the resident three times a day due to pressure area. The resident's care plan states to check seat belt when in wheelchair every half hour and release, reposition resident every two hours.

Resident #18 was observed on 7/26/05 at approximately 5:10 PM sitting in the dining room at her assigned table with her seat belt on in a broda chair leaning to the right side. She remained in the chair leaning off center to the right 7:00 PM a nursing assistant woke up and took the resident to her room. When transferred

to toilet . The resident's buttock was observed and was reddened. The incontinent product the resident had been wearing before she was toileted was soaked with urine and a strong urine odor was present.

The nursing assistant was interviewed on 7/26/05 at 7:25 PM and confirmed that he did not know when th resident had last been toileted or repositioned. The nursing assistant stated that he started his shift at 3 PM and this was the first time he toileted the resident and repositioned her.

Resident #18 was observed again on 7/27/05 at 12:45 PM sleeping at the resident's assigned dining room table in her broda chair with her chin on her chest. At 1:07 PM the nurse manager went over to the resident and said, "it's time for your nap" and wheeled the resident to her room in the broda chair. At 1:13 PM the nursing assistant went into the resident's room, woke the resident up, and gloved before starting cares. The incontinent pad that was removed by the nursing assistant was soaked with urine. After cares were completed the nursing assistant was interviewed at 1:20 PM on 7/27/05. The nursing assistant confirmed that the resident's incontinent pad was soaked and also additional cares such as oral cares, repositioning had not been done for this resident. The nursing assistant stated, I'm just too busy to get all the cares done. I have 12 residents that I am giving care to today by myself.

TO COMPLY: Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours,

SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review the current policies and procedures on resident positioning/repositioning, revise as needed and instruct appropri personnel. The Director of Nursing could designate a staff person to do ongoing monitoring to ensure compliance of residents positioning needs.

TIME PERIOD FOR CORRECTION: Fourteen (14) days.

15. MN Rule 4658.0525 Subp. 9.

Based on record review and interview the facility failed implement a system to ensure that 3 out of 3 residents in the sample with a history of dehydration (#19, #20 & 34) were receiving adequate hydration. Findings include:

The facility failed to document intake of fluids for 3 out 3 residents in the sample (#19, #20, & #34) at high risk dehydration.

Resident #34 had been hospitalized on 5/9/05, review of the hospital intake records dated 5/9/05 reveal he had decreased oral intake at the nursing home and was dehydrated with a high potassium level and low blood pressu facility medical record progress note reveal the resident returned to the facility, 5/13/05 with a feeding tu whi accidentally pulled out by the resident, and was again hospitalized from 5/1/5/05 until 6/28/05. Review ot ...e re since 6/28/05 revealed the resident's intake was not being monitored and recorded by the staff at the facility, alt the output was recorded. The resident had a weight loss of nine pounds in less than a month, and was having an ongoing assessment of his ability to swallow. His caloric and fluid intake was not recorded in the medical record

Resident #20 was admitted to the facility on 5/22/00 and diagnosed with Huntington's chorea and failure to thrive, dysphasia, and dementia. The resident was admitted into the hospital on 2/16/05 for failure to thrive with concerns of malnutrition and dehydration. The Nurse Practitioner's note dated 3/22/2005 documented that the resident's sister's goal was not to have her brother die of dehydration. Per the Nurse Practioner's note on 3/17/05 the resident's sister wants to "Just keep pushing fluids." Care conference notes, dated 4/14/05 documented that even after the resident came out of the hospital for IV hydration that the resident was not maintaining his hydration status and in fact was still dehydrated.

Resident #20's sister was interviewed on 7/27/05 at approximately 6:45 PM stating that she was concerned that when she was not in the facility the staff was not offering fluids to the resident. The resident's sister stated that while she visited she did not see staff come in and offering fluids.

Per record review the nursing assistant sheet stated, "document fluids on the form in resident's room." Honey thickened water to be given whenever staff was with resident for cares. Per physician's orders on 2/28/05 and carried forward to present stated honey thick water 200 milliliters 4 times a day and as needed and to encourage fluids

Resident #20 was observed on 7/26/05 at approximately 6:10 PM in the dining room at the table sitting in a wheelchair eating, fed by a nursing assistant. The resident had sunken eyes and was very thin. The nursing assistant taking care of the resident on 7/28/05 was interviewed at approximately 8:45 AM in the resident's room. There were no fluids in the room to offer the resident. The nursing assistant stated she only documented the output at the end of the shift but did not document fluids taken. Shortly after the interview at 9:00 AM, the Licensed Social Worker from the floor was seen hanging up a sheet in the resident's room to track the resident's fluid intake. The health unit coordinator was interviewed on 7/28/05 at approximately 9:10 AM and confirmed that there were no oral intake records in the resident 's chart, only the output sheets were in the chart.

Per resident #20's care plan, the resident was to be weighted according to the physician's order. The MAR dated 7/05 documented that the resident's weight was to be done first Tuesday every month. Resident's weight on 7/19/05 was 95.3 pounds, 7/13/05 was 108.4 pounds, and 7/5/05 was 100 pounds. The weight recorded on 12/14/04 was 116.4 pounds. The weight for the resident was documented as 928 pounds on 3/22/05 without a reweigh.

Resident #19 was transferred to this facility on 10/19/04 due to an increased need for skilled nursing care. The resident was diagnosed with the following: diabetes type II with neuropathy, dementia with behavior, paraplegia, and renal failure. Cognition level per the quarterly MDS on 7/11/05 was a 3, which indicated severe cognition deficit. Per hospital discharge summary, 4/4/05, the resident was initially admitted with hypotension and received aggressive fluid resuscitation. At discharge from the hospital his blood pressure was normal. On 4/12/05 the resident had a diet change to honey thick secondary to progression of dysphagia. Assessment – possible dehydration and urinary tract infection . Per the resident's care plan, 11/3/04; the resident needed staff assist of one with set up of the meal tray, pouring liquids, cutting meat, applying condiments, and buttering bread. Resident #19 was observed on 7/26/05 at approximately 5:45 PM in the dining room. The resident's skin and mucus membranes appeared dry.

The Nurse Practioner's care plan dated 2/10/05 stated: will increase scheduled free water to 250 cc 4 times a day times 3 days. On 2/19/05 the plan by the nurse practitioner indicated staff were to continue scheduled free water. Per record review, resident #19's nursing assistant sheet documented the resident had a Foley catheter and output every shift was to be done. On 4/13/05, the nurse practitioner spoke with family abou resident's likely hood of becoming dehydrated because of his poor fluid intake of thickened water. The family wished for the resident to receive thin free water and thin coffee at meals for quality of life.

Per interview with the nurse manager of the unit on 7/27/05 at approximately 5:30 PM it was confirmed that the resident should be on fluid intake in order to assess the resident's intake. The nurse manager agreed that the resident has a history of dehydration, frequent urinary tract infections, and should be on fluid intake not just output.

On the general environment tour, on 7/27/05 at 10:00 AM, the staffs of building six, third floor were observed filling replaceable insert and placing them inside of water pitchers at bedside without cups or glasses. During interview with the Assistant Administrator and Assistant Director of Nurses (ADON), on 7/29/05 at 9:00 AM, in the ADON's office related to the use of water pitcher at the residents beside the assistant administrator indicated that staff would need to access the kitchenette or get cups from the medication carts in the halls to assist the resident with hydration.

TO COMPLY: Residents must be offered and receive adequate water and other fluids to maintain proper hydration and health, unless fluids are restricted.

SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review the resident hydration policies and procedures to ensure residents are receiving adequate hydration, revise as needed and instruct the appropriate personnel. The Director of Nursing could designate a staff person to do ongoing monitoring to ensure resident hydration compliance.

TIME PERIOD FOR CORRECTION: One (1) day.

16. MN Rule 4658.0530 Subp. 1.

Based on observations and interview, the facility failed to assist 2 out of 27 residents (#10, #56) in the sample with assistance to eat in a manner that was unhurried and that enhanced their dignity. Findings include:

During observations of an evening meal on unit 6-1 in the north dining room on 7/26/05 at approximately 6:00 PM it was noted that a human service technician (HST) had been standing to assist resident #10 to eat. The HST then walked over to resident #56 to continue to assist with beverages as another resident. HST had left the dining room to assist another resident that had wandered out. After approximately one minut the other HST returned to sit down and assist resident #56 while the HST returned to assist resident #10 a... remained standing. An interview with the HST while offering a chair to sit in revealed that the HST was more comfortable standing to feed resident #10 related to the height of the resident's wheelchair. A review of the nursing standard of practice for the facility related to quality of care indicated that nursing care and services are performed in such a manner as to provide for and maintain resident dignity.

Review of the care plan dated 5/4/05 direct staff to assist resident #36 by setting up the tray, opening packages ar eat. Observation of resident #36 on 7/26/05 at 8:30 AM the resident was in the dining room waiting for his breal was seated in a chair against the wall with an over bed table in front on him. At 8:40 AM the trays had been serv and resident #36 had his breakfast, there was no staff near him to assist with eating. His milk and juice had not been opened. Resident #36 was observed to lift his empty fork to his mouth and then put it down. At 9:0 the resident had eaten just two bites of food on his own and had been unable to open his beverage containers. Af minutes this surveyor asked staff to assist the resident. His beverages were opened and he was encouraged to eat AM a staff member sat next to the resident and assisted to feed the resident, no offer was made to heat up the foo charge nurse was interviewed 7/27/05 at 10:00 AM and stated that this resident should have received assistance v set up of his meal and had his beverages opened

TO COMPLY: Residents needing help in eating must be promptly assisted upon receipt of the meals and the assistance must be unhurried and in a manner that maintains or enhances each resident's dignity and respect.

SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review the resident dining policies and procedures, revise as needed and instruct appropriate personnel. The Director of Nursing could designate a staff person to do ongoing monitoring of resident meal assistance to ensure compliance.

TIME PERIOD FOR CORRECTION: Seven (7) days.

17. MN Rule 4658.0530 Subp. 3.

Based on observation, interview, and record review, the facility failed to monitor to prevent the risk of choking for resident #9 who required thickened liquids. Findings include:

Resident #9 who required thickened liquids was given unthickened juice.
A review of the current physician's orders for resident #9 as of 7/7/05 indicated, "Diet: Pureed with nectar thick liquids, ok for regular bananas, French toast, and pancakes." The plan of care dated 10/24/04 indicated the resident should have a pureed diet with nectar thick liquids.

During observations of a medication pass on 7/27/05 at 11:25 AM a licensed practical nurse (LPN) was noted to give resident #9 regular thin cranberry juice with two regular strength Tylenol. The resident proceeded to choke and cough and spit. Earlier observations of the resident receiving an evening meal on 7/26/05 revealed that the resident was to receive nectar thickened liquids. The LPN stated after having given the thin juice to the resident that, "My fault, he should have thickened liquids.

TO COMPLY: A resident identified in the comprehensive resident assessment, and as addressed in the comprehensive plan of care, as being at risk of choking on food must be continuously monitored by nursing personnel when the resident is eating so that timely emergency intervention can occur if necessary.

SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review the current policies and procedures for dispensing of thickened liquids, revise as needed and instruct appropriate

personnel. The Director of Nursing could designate a staff person to do ongoing monitoring to ensure compliance for resident's fluid needs.

TIME PERIOD FOR CORRECTION: Seven (7) days.

18. MN Rule 4658.0610 Subp. 7.

Based on observation and interview, the facility failed to maintain sanitary conditions at all times in the kitchen. The findings include:

During the initial kitchen tour on 7/26/05 at 12:30PM 3 garbage containers were noted in the food prep area without lids. Food waste was evident by inspection. The dietary manager confirmed these findings. On the subsequent kitchen inspection on 7/27/05 at 1:15 PM the garbage containers were once again noted to be coverless. The dietary manager stated that covers had been ordered.

During the initial kitchen tour on 7/26/05 at 12:30PM the hand scoop was stored inside the sugar bin.

TO COMPLY: Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times.

SUGGESTED METHOD OF CORRECTION: The Dietician could review the current sanitation polic and procedures, revise as needed and instruct appropriate personnel. The Dietician could designate a staff person to do ongoing monitoring to ensue sanitization compliance.

TIME PERIOD FOR CORRECTION: One (1) day.

19. MN Rule 4658.0670 Subp. 2

Based on observation and interview the facility failed to thoroughly clean equipment used in the serving of food. Findings include:

During the kitchen inspection on 7/27/05 at 1:30 PM three steam tables were observed to have built up grease and food residue on the underside of the shelf that was directly over the steam table pans from which food was served. The dietary manager agreed with these findings and requested staff to clean the steam tables immediately.

TO COMPLY: All equipment must be thoroughly cleaned and must be given sanitization treatment and must be stored in such a manner as to be protected from contamination.

SUGGESTED METHOD OF CORRECTION: The Dietician could review the current sanitation policies and procedures, revise as needed and instruct appropriate personnel. The Dietician could designate a staff person to do ongoing monitoring to ensue sanitization compliance.

TIME PERIOD FOR CORRECTION: One (1) day.

20. MN Rule 4658.0675 Subp. 7.

Based on observation and interview, the facility failed to air-dry pans after sanitizing and prior to storing them in cupboards. Findings include:

During the kitchen inspection on 7/27/05 at 1:30 PM 5 small baking pans and 7 medium baking pans were observed to be stored wet in the cupboard. The dietary manager agreed that the pans should be dry and removed the pans to be rewashed. On a subsequent visit to the kitchen on 7/28/05 at 7:30 AM 2 large pans were observed to be stored wet in the same cupboard.

TO COMPLY: All dishes and utensils must be air-dried before being stored or must be stored in a self-draining position.

SUGGESTED METHOD OF CORRECTION: The Dietician could review the equipment cleaning/sanitization policies and procedure, revise as needed and instruct appropriate personnel. The Dietician could designate a staff person to do ongoing monitoring to ensure compliance.

TIME PERIOD FOR CORRECTION: Seven (7) days.

21. MN Rule 4658.0720 Subp. 1 B.

Based on observation, interview and record review the facility failed to ensure that 5 out of 27 residents in the sample (#s: 12, 15, 18, 19, & 20) received assistance with oral care. Findings include:

See #14. MN Rule 4658.0520 Supb. 2. E

TO COMPLY: A nursing home must provide a resident with the supplies and assistance necessary to carry out the resident's daily oral care plan.

SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review the current policies and procedures for providing oral care to residents, revise as needed and instruct the appropriate personnel. The Director of Nursing could designate a staff person to do ongoing monitoring.

TIME PERIOD FOR CORRECTION: Fourteen (14) days.

22. MN Rule 4658. 0725 Subp. 1

Based on observation, interview and record review the facility failed to ensure that 1 out 27 residents in the sample #19 received routine dental care. Findings include:

Resident #19 was transferred to this facility on 10/19/04 due to increased needs for continued skilled nursing care. The resident had been diagnosed with the dementia and paraplegia. Per the resident's care plan 11/3/04; the resident was totally dependent on staff for all grooming/hygiene needs. The nurse manager was interviewed on 7/28/05 at approximately 10:15 AM concerning resident #19's oral care. Tl nurse manager checked the resident's mouth after donning gloves and agreed that the resident had a large build up of plague. The resident screamed "ouch" as the nurse manager was looking into the resident's mouth. The nurse manager was questioned about the resident's oral care and confirmed by the appearance of the resident' s mouth that the resident had not been receiving oral cares.

The record did not contain any reports of dental visits. The nurse manager also confirmed that the resident did not have a scheduled dental appointment.

TO COMPLY: A. A nursing home must provide, or obtain from outside resource, routine dental services to meet the needs of each resident.

SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review the current resident dental policies and procedures, revise as needed and instruct appropriate personnel. The Director of Nursing could designate a staff person to do ongoing monitoring to ensure compliance.

TIME PERIOD FOR CORRECTION: Thirty (30) days.

23. MN Rule 4658.0800 Subp. 3.

Based on observation, interview, and record review, the facility failed to provide adequate infection control for 5 out of 27 residents in the sample (#8, 11, 15, 18 & 33) . Findings include:

Gloves were not changed when going from a contaminated area to clean area, and a wet incontinent pad was placed on the floor.

Resident #15 had diagnoses that included dementia. The resident had a Foley catheter in place, with a leg bag on during the day, and a drainage bag during night hours. On 7/27/05 at approximately 7:30 PM personal cares were observed. The Human Services Technician (HST) assisted with changing an incontinent pad, which was soiled with stool. The HST applied gloves and washed the buttocks with disposable cleansing pads, which were then tossed into garbage. Without changing gloves, a new cleansing pad was retrieved from the container and used to clean the resident, a clean incontinent pad was then placed on the resident, the leg bag tubing was disconnected from the catheter and the drainage bag connection tubing wiped with alcohol and hooked to the catheter.

Upon review of the facilities Employee Exposure Control Plan, dated 4/01 it directed staff to change glov between each site being cared for, on an individual resident.

Resident #11 had diagnoses that included anoxic brain injury, and history of MRSA (methicillin resistant staphylococcus aureus). During observations of personal cares on 7/27/05 at approximately 7:45 PM the HST assisted with incontinent care. The resident's incontinent pad was removed, which was wet, and

placed on the floor. Upon review of the care plan dated 7/12/05 it stated the resident had MRSA in the urine, and to utilize precautions for MRSA. Upon interview with the HST immediately following cares she reported she usually placed soiled incontinent pads in the garbage.

Observations were made of resident #33 during evening cares on 7/26/05 at approximately 7:06 PM. The human service technician (HST) was changing the resident's incontinence pad after episodes of bowel and bladder incontinence.. The HST had gloves on as the process was started and finished but did not change the gloves after cleaning up the resident's soiled peri-area before proceeding with the rest of the resident cares. While wearing the same gloves the HST lowered the resident back into his chair and touching all areas of the Sara lift during the process, placed a clean hospital type gown on the resident and removing the resident's clothes. The HST then removed the gloves to adjust the resident in the wheelchair. The HST re-gloved, no hand washing had been observed and preceded to remove the soiled linen and incontinence product from the trashcan to place into separate garbage bags. The HST touched the handle of the door to leave the room with the gloved hand that had touched the soiled linen and incontinence pad. The HST then went down the hall to the soiled bins and disposed of the soiled items and then removed the gloves; again no hand washing had been observed.

Observations of toileting cares for resident #8 on 7/27/05 at approximately 8:45 AM revealed that the resident had placed himself on the toilet and an incontinent bowel movement all over the toilet seat and on his socks. The HST was assisting the resident with peri-care to clean up the mess wearing gloves. Wearing the same gloves the HST replaced the incontinence pad with a clean one, pulled up the resident's protective hip pads and resident's pants. The HST then proceeded to clean off the toilet seat with a disposable type washcloth and then dried the seat with a paper towel. The HST then removed the gloves, no hand washing observed, and reapplied clean gloves. An interview with the HST after the toileting cares the HST stated he would normally change gloves after cleansing the soiled peri-area, complete hand washing and reapply clean gloves to clean the toilet.

Resident #18's had blood on finger and nail bed and her hands were not washed before she was served her meal tray

Per record, resident #18 was admitted to the facility on 6/10/03 diagnosed with senile delusions, history of myocardial infarction and strokes, basal cell carcinoma of the face, incontinence of bowel and bladder, and Methicillin resistant organisms in the urine on 10/13/04. Per the resident's care plan, the resident needed assistance for all activities of daily living.

Resident #18 was observed in the dining room on 7/26/05 at approximately 5:10 PM sitting at her assigned table. The resident had dried red blood on her right pointer finger and under her nail bed. The resident had a dark black scab on the tip of her nose. At 5:40 PM the resident was served her evening meal on a tray. A RN set up the dining tray for the resident but did not wash the resident's hands.
At 5:50 PM on 7/26/05 the surveyor asked the RN about the finger. The RN confirmed that she was not aware that the resident had blood on her finger nor had she looked at the resident's hands.

A review of the standards of nursing practice for the facility related to quality of resident care indicated that, "Personal protective equipment to be worn during toileting. Wash hands after toileting/changing resident". A review of the policy related to personal protective equipment as of 4/01 indicated, "Gloves should be

changed (and hands washed) between each resident contact and between each site being cared for on an individual resident.". A review of the hand washing policy as of 4/01 indicated when to wash hands: "before and after procedures, before and after gloving, before and after direct resident contact, before and after handling equipment/supplies/laundry".

TO COMPLY: Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program.

SUGGESTED METHOD OF CORRECTION: The Infection Control nurse could review the current policies and procedures for standard infection control during resident cares, revise as needed and instruct appropriate personnel. The Infection Control nurse could designate a staff person to do ongoing monitoring to ensure infection control compliance.

24. MN Rule 4658.1340

Based on surveyor observation and staff interview, the facility failed to assure medications were secured in one out of three buildings surveyed, Building #17. Findings include

During observations, on 7/28/05 at 8:55 AM, of the medication carts on second floor of building seventeen, the two south and two north carts, were observed to be unlocked and unattended. The unit staff failed to locate the nurse assigned to the two-north cart that was located in the hallway unattended until 9:05 AM when the nurse returned from break. The two-north medication cart contained medications for 15 residents, topical diabetic supplies, and stock medications. The two south unit medication cart was parked at the nurses station 9:08 AM were it remained unattended and unlocked until 9:13 AM when the assigned nurse returned. The two-south medication cart contained medications for 15 residents.

TO COMPLY: A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys.

Subp. 2. **Storage of Schedule II drugs.** A nursing home must provide separately locked compartments, permanently affixed to the physical plant or medication cart for storage of controlled drugs listed in Minnesota Statutes, section 152.02, subdivision 3.

SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review the current medication storage policies and procedures, revise as needed and instruct appropriate personnel. The Director of Nursing could designate a staff person to do ongoing monitoring to ensure medication storage compliance.

TIME PERIOD FOR CORRECTION: One (1) day.

25. MN Rule 4658.1345

Orders to MN Veterans Home Minneapolis

Based on surveyor observation and staff interview, the facility failed to assure medications labeled. Findings include:

An open unlabeled multi-dose bottle of lidocaine was located in the two south medication cart. During observations, on 7/28/05 at 8:55 AM, of the medication carts on second floor of building seventeen were reviewed. The second floor staff provided the documentation in the resident's medication administration record that the lidocaine was ordered to dilute the Rocephin (an injectable antibiotic) as ordered by the physician.

During the interview with the facility pharmacist, on 7/29/05 at 9:30 AM, indicated that the pharmacy usually labels the lidocane, and that the bottle may have been used from the facility's E-Kit that isn't labeled. The facility's policy requires multi-dose bottles to be labeled with expiration date and the date opened.

TO COMPLY: Drugs used in the nursing home must be labeled in accordance with part 6800.6300.

SUGGESTED METHOD OF CORRECTION: The Consultant Pharmacist and the Director of Nursing could review the current medication labeling policies and procedures, revise as needed and instruct appropriate personnel. The Director of Nursing could designate a staff person to do ongoing monitoring to ensure compliance of medication labels.

TIME PERIOD FOR CORRECTION: Fourteen (14) days.

26. MN Rule 4658.1415 Subp. 2

During the environment tour, on 7/27/05 at 9:00 AM, with the assistant administrator and the director of physical maintenance department observation of the following areas of concerns were noted.

Building six

Male and female bathrooms next to the activity room (G13) were open to the corridor, the door hardware included a locking mechanism. Observation of both bathrooms with the assistant administrator verified no call light system was installed.

Through out the ground floor corridor the areas near doorways and corners had a build up of dust, debris and wax.

The smoke room (G24) had streaked areas of brown tar stains on walls and windows. The floor, chairs and tabletops had multiple areas of cigarette burns and the ceiling tiles and air supply ducts were covered with brown tar stains. The area had an internal air filter system that the director of physical maintenance stated had filters that were changed on a 1-2 month rotation.

The dining rooms (332 and 312) had multiple chairs observed to be soiled and stained with unidentified substance, the executive housekeeper indicated that the chairs where cleaned on a monthly schedule but many were stained and no longer cleanable.

Window frames in the dining room (332) had areas of dents and chips exposing the metal corner bead. When interviewed the director of physical maintenance stated that painting and wall repair was not part of the preventive maintenance program and that the staff identified areas of need using the facilities computer program.

Tub rooms on third and second floors contained tubs that had the rubber bumpers repaired with tape, the tape was coming loose in many areas leaving a sticky residue that collected water, soap and other unidentified substances. The second floor tub had gray flaked substance covering the horizontal surface of the seat and the bottom near, director of physical maintenance explained that it was a nursing duty to clean the tubs after use.

The kitchenette on second floor had areas of damage on the walls and corners.

Resident room (213) had the thermostat pushed through the dry wall, bed #2's closet had areas to both sides of the door frame damaged exposing the metal corner beading.

Building 17

The tub rooms on all floors have accumulations of dust and debris under the whirlpool tubs. Tub room floors have collection of white and brown substances in the corners under sinks and behind the stool. The three south tub room had broken tiles in the shower area. In the second south tub room baseboard area tiles had come off the wall exposing the drywall and a dark gray substance along the floor.

The floor surface of building 17 are vinyl sheet that was curled up around the walls forming a baseboard, per the director of physical maintenance this was a poor instillation currently the plan was to fix areas that became loose by reattaching and screwing the vinyl to the walls. Areas of detached vinyl observed during the tour: hall areas near rooms # 439, 247, and 286 and the bathroom of room 247.

The smoking area of building 17 had areas of tar staining on walls, windows, and ceilings. The executive housekeeper indicated the room was cleaned twice on days and once evenings. Furnishings in the smoke room have areas if cigarette burns, when approached, the director of physical maintenance stated in the last 16 months he has not identified a need to replace furnishings in the smoke room. The facility's plan with damaged or unsafe furnishings would be for staff to take it out of service and notify physical maintenance through a work order.

Resident Room 367 had damage to the walls by the windows exposing metal beading. Resident Room 288 had a strong urine odor noted throughout the room and into the hall both on initial tour 7/26/05 and during the environment tour on 7/27/05.

Main dining area of building seventeen had four suspended ceiling tiles in the center of the room over a resident tables had areas of brown stains. The director of physical maintenance stated the stains could have been caused by condensation on overhead pipes.

TO COMPLY: A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible.

SUGGESTED METHOD OF CORRECTION: The Environmental Director could review the current cleaning/maintenance policies and procedures, revise as needed and instruct appropriate personnel. The Environmental Director could designate a staff person to do ongoing monitoring to ensure compliance.

TIME PERIOD FOR CORRECTION: Thirty (30) days.

27. MN Statute § 144A.04 Subd. 11

Based on observation, interview, and record review, the facility failed to residents every two hours with incontinence care for 5 of 27 residents in the sample (#6, #7, #10, #11, #18). Findings include:

During evening observations on 7/26/05 from approximately 4:40 PM until 7:55 PM resident #6 and resident #7 were not observed to be toileted, checked or changed. An interview with the human service technician (HST) at approximately 7:55 PM revealed that the two residents had not been toileted, checked or changed since before dinner at approximately 4:30 PM. The HST assignment sheet last updated as of 7/22/05 indicated that both residents are incontinent of bowel and bladder and are to be toileted, checked and changed every two hours. A review of the current plan of care for resident #6 as of 1/10/05 indicated, "Resident incontinent of bowel and bladder. Wears incontinence pad at all times. Toilet/change q (every) 2hrs and prn (as needed).". A review of the current plan of care of resident #7 as of 12/7/04 indicated, "Toilet/change q 2hrs and prn".

Evening observations of resident #10 on 7/26/05 from approximately 4:40 PM until 7:45 PM revealed that the resident had not been toileted or checked and changed. An interview with the HST at 7:45 PM revealed that the last time the resident had been checked and changed was at approximately 3:30 PM. Morning observations of resident #10 on 7/27/05 from approximately 7:30 AM until 10:25 AM revealed that the resident was not observed to be checked and changed. An interview with the HST at 10:25 AM revealed that the last time the resident was checked and changed was at approximately 7:30 AM before breakfast. A review of the HST assignment sheet updated as of 7/22/05 indicated that the resident was incontinent of bowel and bladder and was to be toileted, checked and changed every two hours. A review of the current plan of care for resident #10 as of 12/30/04 indicated, "Toilet/change q 2hrs and prn".

A review of the standards of nursing practice for the facility related to quality of resident care indicated, " Promptly assist resident on and off toilet as needed. Offer toileting a minimum of every two hours to resident requiring assistance. Incontinent residents to use disposable garment at all times with disposable padding under the resident while in bed (check care plan for proper garment size). Change wet/soiled garment, wash peri-rectal area with periwash and disposable wash cloth; and replace disposable garment. Follow this procedure every 2 hours. Provide privacy throughout procedure."

The facility failed to ensure resident #11 was toileted as directed on the care plan.

Resident #11 had diagnoses that included anoxic brain damage, and history of falls.
Physician orders dated 5/29/05 included a locked Posey belt when in the wheelchair to enhance safety. According to the care plan, dated May 12 2005 the resident was described as requiring total assistance with toileting. The minimum data set (MDS) dated 5/12/05 described the resident as having inadequate control of the bladder, with multiple daily episodes of incontinence. The care plan directed staff to assist with toileting every 2 hours, and to check for incontinence every 2 hours. Resident #11 was observed on 7/26/05 from 4:30 PM until 7:50 PM without being toileted (3 hours, 20 minutes). The surveyor alerted staff at 7:30 PM, and at 7:50 PM the resident was assisted to bed. The resident's incontinent pad was changed, and was noted to be wet.

The facility failed to toilet resident #18 according to needs.

Resident #18 was observed on 7/26/05 at approximately 5:10 PM sitting in the dining room at her assigned table with her seat belt on in a broda chair leaning to the right side. She remained in the chair leaning to the right until shortly after 7:00 PM when a nursing assistant took the resident to the her room. The restraint was released at 7:40 when she was transferred. The resident's buttock was reddened. The incontinent product the resident had been wearing before she was toileted was soaked with urine and a strong urine odor was present. The nursing assistant was interviewed on 7/26/05 at 7:25 PM and confirmed that he did not know when the resident had last been toileted or repositioned. The nursing assistant stated that he started his shift at 3 PM and this was the first time he toileted the resident and repositioned her. The nursing assistant confirmed that the incontinent pad he removed was very wet.

Resident #18 was observed on 7/27/05 at 12:45 PM sleeping at her assigned dining room table in her broda chair with her chin on her chest. At 1:07 PM the nurse manager went over to the resident and said, "it's time for your nap" and wheeled the resident to he room in the broda chair. At 1:13 PM the nursing assistant went into the resident's room, woke the resident up and started cares. The incontinent pad that was removed by the nursing assistant was soaked with urine.

After cares were completed the nursing assistant was interviewed at 1:20 PM on 7/27/05. The nursing assistant c the resident's incontinent pad was soaked. The nursing assistant stated, I'm just too busy to get all the cares done residents that I am giving care to today by myself.

TO COMPLY: An incontinent resident must be checked according to a specific time interval written in the resident's care plan. The resident's attending physician must authorize in writing any interval longer than two hours unless the resident, if competent, or a family member of legally appointed conservator, guardian, or health care agent of a resident who is no competent , agrees in writing to waive physician involvement determining this interval.

SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review the policies and procedures for all areas of treatment with resident care, revise as needed and instruct all appropriate

personnel. The Director of Nursing could designate a staff person to do ongoing monitoring to ensure compliance of considerate and adequate resident personal needs.

TIME PERIOD FOR CORRECTION: Fourteen (14) days.

28. MN Statute §144.651 Subd. 5.

Based on observation, interview, and record review, the facility failed to treat residents with courtesy and respect for their individual differences. Findings include:

During random observations during the initial tour on 7/26/05 multiple call lights in resident rooms in building 6 were noted to be out of reach, hanging behind the bed, hanging over a recliner, hanging on a nightstand towel bar, and wrapped around the call light unit on the wall. An interview with the HST on unit 6-1 on 7/29/05 at 8:40 AM related to call lights observed that morning in resident #57 and #58 rooms that were not in reach revealed that resident #58 will use the call light and the resident #57 the HST was not sure if the resident could use the call light or not. Another interview with and HST from unit 6-2 on 7/29/05 at 9:30 AM related to a call light that was not in reach for resident #59 that morning revealed that the resident was able to use the call light. A review of the policy and procedures for resident safety indicated, "Always make sure call light is positioned within resident reach.". A review of the standards of nursing practice for the facility related to quality resident care indicated, " Call lights are accessible to residents".

Observations of incontinence care for resident #33 on 7/26/05 at 7:06 PM revealed that resident #33 was dangling from a manual Sara-type lift stand with only the fleece sling under his arms holding the weight of his body, while the human service technician (HST) changed the soiled incontinence pad and gave the resident peri- care over the trash can. An interview with a licensed practical nurse (LPN) on 7/28/05 at 10:10 AM related to the above mentioned observation of the resident dangling, the LPN stated that the HST should not have used the Sara lift if the resident could not hold on and should not have done this over a trash can. A review of the standards of practice for nursing related to quality resident care indicated, "Provide for and maintain resident dignity". A review of the policy and procedure related to use of the Sara lift as of 9/1993 indicated, "The Sara is designed for quick easy transfers from one sitting position to another and to elevate a resident for toileting, repositioning, changing of incontinence pads, wound dressings, etc. It is not intended for long periods of suspension or transportation". Resident #17 did not have his catheter bag emptied as needed. Per record review, resident #17 was admitted to the facility on 08/26/03 with diagnoses that included neurogenic bladder, and diabetes. According to the residents care plan, the staff was to empty and record Foley catheter output every shift and complete catheter care per physician order. The nursing assistant sheet instructed the nursing assistant to empty Foley every shift and report and to "check bag often – fills quickly."

Resident #17 was observed on 7/27/05 at 7:45 AM while lying in bed in his room. The resident had a leg bag on for urine collection that was full. The resident's sweat pants were soaked in the groin area. Resident #17 was interviewed at 7/27/05 at 7:45 AM and stated "cares are not very good, you have to wait a long time to get help." The staff does not empty my urine bag when they should so it overflowed. The spillage

happens so often that I don't feel real good about it. The night staff went home today without emptying my bag and now I am all wet.

The nursing assistant came into the resident's room on 7/27/05 at approximately 7:47 AM and started AM cares. The resident said to the nursing assistant as she tried to remove the residents wet sweat pants, "why don't you empty my bag first?" The nursing assistant replied to the resident, "I was going to get these wet pants off you first. The nursing assistant emptied the leg bag of 500 milliliters of urine. The maximum capacity of the leg bag was 500 milliliters.

The nursing assistant was interviewed after cares at approximately 8:00 AM and confirmed that resident #17's urine leg bag had not been emptied by the night staff.

TO COMPLY: Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility

SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review the current policies and procedures for courteous/respectful resident treatment, revise as needed and instruct the appropriate personnel. The Director of Nursing could designate a staff person to do ongoing resident treatment to ensure compliance.

TIME PERIOD FOR CORRECTION: Fourteen (14) days.

cc: Original - Facility
Licensing and Certification File
Records and Information
Ellie Laumark, Unit Supervisor
Minnesota Department of Human Services
Hennepin County Social Services
Mr. Frank Budd, MD, President Governing Body

"Attachment B"

STATE OF MINNESOTA

Office of Governor Tim Pawlenty

130 State Capitol ♦ 75 Rev. Dr. Martin Luther King Jr. Boulevard ♦ Saint Paul, MN 55155

September 20, 2005

Dr. Frank Budd, Chair
Minnesota Veterans Home Board
Veterans Service Building
20 W. 12th Street, Room 122
St. Paul, MN 55155

Dear Dr. Budd:

I know we share a deep belief in serving all of Minnesota's veterans, particularly those at Veterans Home Board facilities who require professional and dignified care. That is why the deficiencies of the Minneapolis Veterans Home outlined in the recent Department of Health inspection are so troubling. Our veterans deserve better.

Along with the immediate steps taken by the Board at the Minneapolis facility, I believe a broader review of all our veterans' facilities is appropriate.

For this reason, I am directing the Veterans Home Board to conduct a comprehensive review of the quality of care at all Minnesota's Veterans Homes. A system-wide analysis of Minnesota's veterans home program should include patient care, staffing, financing, governance, quality assurance, and other issues identified by the Board. I would like a report on the results of the review, modifications taken to ensure ongoing quality of care, and recommendations for further changes by January 15, 2006.

We need to make certain that the Veterans Home Board is well positioned to give Minnesota's veterans the compassionate care they so well deserve. Thank you for your prompt attention to this important matter.

Sincerely,

Tim Pawlenty
Governor

c: Stephen J. Musser, Executive Director

Voice: (651) 296-3391 or (800) 657-3717 Fax: (651) 296-2089 TDD: (651) 296-0075 or (800) 657-3598
Web site: http://www.governor.state.mn.us An Equal Opportunity Employer

Printed on recycled paper containing 15% post consumer material

"Attachment C"

STATE OF MINNESOTA
VETERANS HOMES BOARD
MINNESOTA VETERANS HOME – MINNEAPOLIS
5101 MINNEHAHA AVENUE SOUTH
MINNEAPOLIS, MINNESOTA 55417-1699
(612) 721-0600

September 7, 2005

Ms. Ellie Laumark, Unit Supervisor
Minnesota Department of Health
Health Policy, Information and Compliance Monitoring Division
Licensing and Certification Program
1645 Energy Park Drive, Suite 300
St. Paul, MN 55108-2970

RE: Minneapolis Veterans Home – Plan of Correction

Dear Ms. Laumark,

Attached is the plan of correction for the Minnesota Department of Health survey that was conducted on July 26 – 29th, 2005 at the Minnesota Veterans Home – Minneapolis. As the result of the survey, the Minnesota Board of Director's responded with an action plan that was deliberate and decisive to respond to the citations and make significant changes in key personnel at the facility. The Administrator was replaced by Stephen Musser, Executive Director and the Director of Nursing replaced by Diane Vaughn, RN. In addition, one Assistance Administrator and the quality manager were removed.

We believe that the actions taken in the plan of correction demonstrate a thoughtful and comprehensive approach to correcting those items that require immediate attention and a longer range plan for ensuring that there are systems in place to proper monitoring and compliance with Health Department standards.

We look forward to your return visit so we can demonstrate that we have corrected the citations and installed procedures to ensure that ongoing compliance is met.

Sincerely,

Stephen J. Musser
Executive Director/Administrator

MN Veterans Home – Minneapolis
MDH Survey Plan of Correction
July 25-29, 2005

Abbreviation legend:
RNM: Registered Nurse Manager
IDT: Interdisciplinary Team
PCN: Position Control Number
RTF: Request to Fill form

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
1. 4658.0110 INCIDENT AND ACCIDENT REPORTING. All persons providing services in a nursing home must report any accident or injury to a resident, and the nursing home must immediately complete a detailed incident report of the accident or injury and the action taken after learning of the accident or injury. IR not completed on #34.	The incident report has been completed on resident #34. The RNM has received a review of the expectations of Incident reporting procedures. To improve monitoring of incident reports, an electronic incident report is being initiated through the clinical software program. This allows for "real time" monitoring of incident reports. Incident reports will be continued to be tracked and trended on an on-going basis.	8/8/05 Electronic IR initiated 9/1/05 9/1/05	RNM 2N Assistant Administrator of Resident Life Services Director of Nursing	See attachments: 1a (Incident Report) 1b (Incident Report procedure) 1c (Sample of electronic incident report tracking list)

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
2. 4658.0300 USE OF RESTRAINTS **Subp. 4. Decision to apply restraint.** The decision to apply a restraint must be based on the comprehensive resident assessment. The least restrictive restraint must be used and incorporated into the comprehensive plan of care. The comprehensive plan of care must allow for progressive removal or the progressive use of less restrictive means. A nursing home must obtain an informed consent for a resident placed in a physical or chemical restraint. A physician's order must be obtained for a physical or chemical restraint which specifies the duration and circumstances under which the restraint is to be used, including the monitoring interval. Nothing in this part requires a resident to be awakened during the resident's normal sleeping hours strictly for the purpose of releasing restraints. Lap Buddies without doctor's orders - residents #'s 4,9,30, 31, 18, 19 No assessment of least restrictive device 14 days	Those residents noted in the survey requiring documentation, reassessment, and/or a plan for reduction were brought to the individual resident's clinical rounds (IDT) team for reassessment. The social workers and behavioral analysts performed a complete house audit of all devices to assure that required documentation is present. The audits were reviewed by the Clinical Rounds (Interdisciplinary Team - IDT). Reviews and reassessments were completed as indicated. To continue a restraint reduction process the Resident Safety Workgroup will add restraint rounds to its process to ensure reduction is occurring throughout the facility. Resident Safety processes were reviewed and updated. On-going education re: "restraint proper environments" will be developed through this rounds team. An educational event is scheduled for 9/14 and 15/05.	9/2/05 8/25-30/05 8/31/05 to 9/2/05 9/2/05 9/14 & 15/05	Director of Nursing	See attachments: #2a (Team instructions) #2b (Device audit) #2c (Team instructions for reassessment)

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
3. 4658.0300 USE OF RESTRAINTS **Subp. 5 C. Physical restraints.** At a minimum, for a resident placed in a physical restraint, a nursing home must also: C. provide an opportunity for motion, exercise, and elimination for not less than ten minutes during each two-hour period in which a restraint is employed; and Repositioning - residents not repositioned for greater than 3 hours #4, 11, 9, 18 14 days	Unit by unit education was given to ensure the expectation that all residents are provided an opportunity for motion, exercise, and elimination for not less than ten minutes during each two-hour period in which a restraint is employed. Monitors (Internal surveyors) are in place to observe this occurs and intervene to eliminate the barriers when this is challenged.	9/2/05	Director of Nursing	See also Licensing violation # 10-2

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
4. 4658.0400 Subp 2I Dental Subp. 2. **Information gathered.** The comprehensive resident assessment must include at least the following information: I. dental condition; **14 days**	We respectfully disagree with this citation as the existing system does meet the regulatory requirements. The residents in the survey sample had an initial oral exam by Appletree Dental. An excel file exists that tracks resident dental visits. To continuously improve service, the existing policy was modified.	9/2/05	Director of Health Information Management	See attachments #4 a and #4b (oral exam forms) #4c (scheduling procedures - changes circled) #4d (existing Dental Services Protocol) #4e Dental Director Program

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
5. 4658.0405 Subp 1 Failure to develop care plans **Subpart 1. Assessment.** A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care as defined in part 4658.0405. No smoking assessment #35 General lack of assessment #20, 27 20 days	Individual resident assessments have been completed. Met with the IDT department managers and reviewed the documentation policy - which remains compliant with the regulations. IDT departments are reviewing the expectation with their staff. On-going surveillance for timeliness of assessment and for re-assessments is instituted.	9/8/05	Director of Nursing and Assistant Administrator of Resident Life Services Quality Manager	See attachment #5a (meeting minutes) #5b (related policies)

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
6. 4658.0405 COMPREHENSIVE PLAN OF CARE. **Subp. 3. Use.** A comprehensive plan of care must be used by all personnel involved in the care of the resident. Toileting Repositioning Oral care I&O Residents: 20, 17,. 11, 13, 12, 7, 10, 6 14 days	The plan of care and HST worksheets were reviewed for completeness on the noted residents. Educational review and enforcement with HST's and staff nurses HST sheets are care plan based On-going surveillance for timeliness of assessment and for re-assessments is instituted.	9/2/05	Director of Nursing Quality Manager	

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
7. 4658.0405 COMPREHENSIVE PLAN OF CARE. **Subp. 4. Revision.** A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. Not revised resident #34 (thickened liquid diet change -) **14 days**	IDT review of individual resident case. Review and enforcement of IDT responsibilities to update care plan as orders are obtained.	9/2/05	Director of Nursing Assistant Administrator of Resident Life Service	See attachments # 5b (documentation policy)

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
8. 4658.0470 Subp 2 **4658.0470 RETENTION, STORAGE, AND RETRIEVAL.** Subp. 2. **Storage.** Space must be provided for the safe and confidential storage of residents' clinical records. Records of current residents must be stored on site. 7 days	The charts racks at building 6 nursing stations have been relocated to the charting room which has a locked door. IDT members will have key access.	8/26/05	Director of Health Information Management	Completed

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
9.4658.0505 Subp 1 Comprehensive care plan carried out **14 days**	Unit by unit on all shift education was given to review the basic methods of care plan implementation involving HST duties. The daily HST sheets are care plan based. RNMs reviewed them for completeness.	9/2/05	Director of Nursing	Completed

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
10. 4658.0510 sp 1: Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. **14 days** Staffing Needs: through interviews and observations, staff were unable to meet resident needs; toileting, repositioning, shaving, nail care and nourishments not being passed.	Major administrative changes were made. The administrator, assistant administrator of resident clinical services, Director of Nursing, and Quality Manager have separated employment. An interim administrator and interim DON are in place. Initially 4 HST shifts were added to building 6; On 8/26/05 14 shifts of HST's per 24 hours was added within the nursing home care units. Meeting was held with temporary agency vendors to improve availability and continuity of care givers on 8/31/05. Priority of replacing shift vacancies is: volunteers for extra hours, temporary agency, and as a last resort - mandation. The system of RTF's and PCN was reviewed and the process improved to decrease the time a vacancy is open. Absenteeism policies are being enforced. We are continuing to refine staffing patterns / distribution of staff	8/30/05 8/29 and 30/05 8/26/05 8/31/05 8/22/05 9/2/05 On-going On-going	Administrator ,Director of Nursing, and Director of Human Resources	

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
10-2. 4658.0520 ADEQUATE AND PROPER NURSING CARE. **Subp. 2.A. Criteria for determining adequate and proper care.** The criteria for determining adequate and proper care include: A. Evidence of adequate care and kind and considerate treatment at all times. Privacy must be respected and safeguarded. 14 days Toileting, mechanical lift transfers, oral hygiene, repositioning, and clean clothing.	Nursing care standards were reviewed. Unit by unit - all shift inservicing was done to review expectations of care and resident treatment. A care audit was designed and is used on every shift to ensure cares are being delivered. Intermittent monitors are scheduled to assure cares are being delivered properly and with respect. A comprehensive inservice is being designed by social services for use in additional HST training and to replace current general orientation education on resident dignity and respectful treatment. HST orientation competency processes are being revised. Current HST's will go through re-competency testing over the next two quarters. Leadership training for licensed nurses will be presented within the next 2 quarters.	9/2/05 9/2/05 Started 8/30/05 10/1/05 10/1/05 1/1/06 1/1/06	Director of Nursing	See attachments 10-2a (standards) 10-2b (audit) 10-2c (monitor packet)

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
11. 4658.0520 ADEQUATE AND PROPER NURSING CARE. Subp 2 D D. Assistance with or supervision of shaving of all residents as necessary to keep them clean and well-groomed. 14 days	See #10-2 above	9/2/05	Director of Nursing	
12. 4658.0520 ADEQUATE AND PROPER NURSING CARE. Subp 2 E E. Assistance as needed with oral hygiene to keep the mouth, teeth, or dentures clean. Measures must be used to prevent dry, cracked lips. **14 days**	See #10-2 above	9/2/05	Director of Nursing	
13. 4658.0520 ADEQUATE AND PROPER NURSING CARE. Subp 2F F. Proper care and attention to hands and feet. Fingernails and toenails must be kept clean and trimmed. **14 days**	See #10-2 above	9/2/05	Director of Nursing	

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
14. 4658.0525 REHABILITATION NURSING CARE. **Subp. 4. Positioning.** Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval. 14 days Residents # 6, 7, 12, 18	See #10-2 above The individual residents noted in the survey sample have been reviewed by the nurse manager.	9/2/05	Director of Nursing	

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
15. 4658.0525 REHABILITATION NURSING CARE. **Subp. 9. Hydration.** Residents must be offered and receive adequate water and other fluids to maintain proper hydration and health, unless fluids are restricted. No I & O No cups provided with water pitchers Residents # 34, 20, 19 1 day	The individual residents noted in the survey were reviewed by the RNM. These situations are remedied. An interdisciplinary team including Speech Therapy Nursing, Medical Director, and Dietitians met to review the hydration procedures. The following decisions were made: The current water passing procedure will be continued and the RNM and OD's are accountable to enforce that it is followed. See also # 17	8/24/05	Director of Nursing	

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
16. 4658.0530 ASSISTANCE WITH EATING. **Subpart 1. Nursing personnel.** Nursing personnel must determine that residents are served diets as prescribed. Residents needing help in eating must be promptly assisted upon receipt of the meals and the assistance must be unhurried and in a manner that maintains or enhances each resident's dignity and respect. Adaptive self-help devices must be provided to contribute to the resident's independence in eating. Food and fluid intake of residents must be observed and deviations from normal reported to the nurse responsible for the resident's care during the work period the observation of a deviation was made. Persistent unresolved problems must be reported to the attending physician. 7 days Staff standing while feeding residents Staff not assisting with feeding residents Resident # 10 , 36	See also #10-2 A Meal Assistance Program was developed to increase the assistance available to the residents. A paging system was developed to page for additional assistance if an individual units mealtime is challenged. It was reviewed with staff regarding proper feeding assistance (e.g. do not stand while assisting a resident with feeding.) Long-term Plans: Tray-line meal service is being changed to buffet style dining after the dining rooms are renovated. There are funds encumbered for the required construction required. When completed, this will allow greater flexibility in schedule meals and setting up unit routines as compared to the tray line system.	8/26/05 9/9/05 Summer 2006	Director of Nursing Director of Dietary Administrator	

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
17. Subpart 3. Risk of Choking A resident identified in the comprehensive resident assessment, and as addressed in the comprehensive plan of care, as being at risk of choking on food must be continuously monitored by nursing personnel when the resident is eating so that timely emergency intervention can occur if necessary. #9 given regular juice when an order for thickened liquid was in place 7 days	An interdisciplinary team including Speech Therapy Nursing, Medical Director, and Dietitians met to review the hydration procedures. An improved system for identification of residents who require thickened liquids was designed. The Resident Dining and Nutrition Committee will be revitalized to address on-going issues related to nutrition and hydration. Residents with thickened liquids will have this noted on the individual resident guide in the MAR in additional to the existing diet order locations.	8/26/05 and 8/31/05 Designed 8/31/05, to be implemented by 10/1/05 8/31/05 9/9/05	Director of Nursing, Director of Rehab and Director of Dietary	See attachment 17-a (Thickened Liquids procedure)

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
18. MN 4658.0610 Subp 7 **Sanitary conditions.** Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. **1 day** Based on observations and interview, the facility failed to maintain sanitary conditions at all times in the kitchen. The findings include: 3 garbage containers without lids. Also, a hand scoop was stored inside a sugar bin.	**Immediate Correction:** Garbage can lids were ordered, please see attached invoice. An in-service was given on 8-4-05 and 8-10-05. Please see attachments. **Long term correction:** A sanitation rounds checklist was developed and will be completed monthly by a dietitian. Immediate correction will follow for any areas of concern. Please see the attached checklist.	8/20/05	Director of Dietary	

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
19. 4658.0670 Subp 2 **Sanitization; storage.** All utensils and equipment must be thoroughly cleaned, and food-contact surfaces of utensils and equipment must be given sanitization treatment and must be stored in such a manner as to be protected from contamination. Cleaned and sanitized equipment and utensils must be handled in a way that protects them from contamination. Based on observations and interview the facility failed to thoroughly clean equipment used in the serving of food. Findings include: the under part of the shelves over the steam tables and prep area was found to be soiled with food debris. **1 day**	**Tag #4658.0670 Subp. 2** **Immediate correction:** A staff member was ordered to clean the area and was checked by the Dietary Director and found to be cleaned. An in-service was given on 8-4-05 to discuss this procedure. Please see attachment. **Long term correction:** A sanitation rounds checklist was developed and will be completed monthly by a dietitian. Immediate correction will follow for any areas of concern. Please see the attached checklist.	8/20/05	Director of Dietary	

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
20. 4658.0675 Subp 7 **4658.0675 MECHANICAL CLEANING AND SANITIZING. Subpart 7 Air drying.** Dishes and utensils must be air dried before being stored or must be stored in a self-draining position. Properly racked sanitized dishes and utensils may complete air drying in proper storage places, if available. Based on observations and interview, the facility failed to air-dry pans after sanitizing and prior to storing them in the cupboard. Findings include: baking pans were observed to be stored wet in the cupboard. **7 days**	**Tag #4658.0675 Subp. 7** **Immediate correction:** All wet pans were removed, sent through the dishmachine and properly air-dried before putting away. An in-service was given on 8-4-05 and 8-10-05. Please see attachments. **Long term correction:** A sanitation rounds checklist was developed and will be completed monthly by a dietitian. Immediate correction will follow for any areas of concern. Please see the attached checklist.	8/26/05	Director of Dietary	

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
21. 4658.0720 PROVIDING DAILY ORAL CARE. Subpart 1. **Daily oral care plan.** A nursing home must establish a daily oral care plan for each resident consistent with the results of the comprehensive resident assessment. B. A nursing home must provide a resident with the supplies and assistance necessary to carry out the resident's daily oral care plan. The supplies must include at a minimum: toothbrushes, fluoride toothpaste, mouth rinses, dental floss, denture cups, denture brushes, denture cleaning products, and denture adhesive products. Not provided for resident # 19, 20, 18, 12, 15 14 days	The individual residents noted in the survey have been reviewed and supplied are provided. See also #10-2	9/2/05	Director of Nursing	
22. 4658.0725 PROVIDING ROUTINE AND EMERGENCY ORAL HEALTH SERVICES. Subpart 1. **Routine dental services.** A nursing home must provide, or obtain from an outside resource, routine dental services to meet the needs of each resident. Routine dental services include dental examinations and cleanings, fillings and crowns, root canals, periodontal care, oral surgery, bridges and removable dentures, orthodontic procedures, and adjunctive services that are provided for similar dental patients in the community at large, as limited by third party reimbursement policies. Not done on all residents **30 days**	We respectfully disagree with this citation as the existing system does meet the regulation requirements. We apologize that the survey team was not made aware of the existing system and tracking. The residents in the survey sample had an initial oral exam by Appletree Dental. An excel file exists that tracks resident dental visits. To continuously improve service, the existing policy was modified.	9/2/05	Director of Health Information Management and Director of Nursing	See attachments #4 a and #4b (oral exam forms) #4c (scheduling procedures - changes circled) #4d (existing Dental Services Protocol) #4e Dental Director Program

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
23. 4658.0800 INFECTION CONTROL. Subp. 3. **Staff assistance with infection control.** Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. No timeframe listed # 15 gloves not changed from dirty to clean # 11 incontinent pad on floor	A handout was designed to review proper glove use and included in the education noted in #10-2.	9/2/05	Director of Nursing	See attachments 10-2a (standards), 10-2b (audit) and #23a (Glove use handout)

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
24. 4658.1340 MEDICINE CABINET AND PREPARATION AREA. **Subpart 1. Storage of drugs.** A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. Subp. 2. **Storage of Schedule II drugs.** A nursing home must provide separately locked compartments, permanently affixed to the physical plant or medication cart for storage of controlled drugs listed in Minnesota Statutes, section 152.02, subdivision 3. **1 day** Unlocked med carts bldg 17, 2nd and 3rd	Current policy requires the securing of the medication carts including the double locking of narcotics. To enforce the policy and monitor medication / treatment cart compliance, a routine audit will be done by the pharmacy. Random audits will be done by the Quality Manager, Officers of the Day, and RNM's.	8/24/05	Director of Nursing Director of Pharmacy	See attachment #24a (audit)
25. 4658.1345 LABELING OF DRUGS. Drugs used in the nursing home must be labeled in accordance with part 6800.6300. **14 days** Unlabeled meds 2nd fl bldg 17	All vials for individual residents will be labeled individually versus labeling only the larger container of the vials.	9/2/05	Director of Pharmacy	

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
26. 4658.1415 Subp 2 **4658.1415 PLANT HOUSEKEEPING, OPERATION, AND MAINTENANCE.** Subp. 2. **Physical plant.** The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. 30 days	See individual items listed below: Daily rounds are being conducted.	See individual items below	Physical Plant Manager	
BUILDING 6 **4658.1415**				
G-13 bathrooms	No call light system. 1. Get quotes from vendor & install	9/17	Maint Sup	9/2/ Quote to arrive Can be installed 10 days after aproval.
Bsmt. Corridor & area near doorways	Build up of dust, debris and wax. 1. Clean corridor	8/26	Hskp	Done
Smoke RM G24	Brown stains on walls, windows, ceiling tiles & air ducts. Burns on floor, chairs and tabletops. * See overall plan for both lounges.	10/7	Chief Eng	Contracts for work being obligated and work on both smoking lounge Bldg 9 & 17
Dining RMS 332 & 312 *(include all dining rooms and overflow areas)*	Stained & soiled chairs. 1. Clean chairs 2. Redistribute good chairs. 3. Recover or replace? Minncor	8/26	Hskp Hskp Project Mgr	Done Recover seats/backs
Dining RM 332	Dents & chips in window frames exposing metal corner bead.	9/30	Maint Sup	Contact obligated

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
2nd & 3rd FL tub rooms	Tubs had rubber bumpers repaired with tape that was loose leaving residue. 1. Repair bumpers w/ adhesive	9/27	Maint Sup	In progress
2nd FL Kitchenette	Damaged walls and corners on laminate. 1. Repair sheetrock & paint. 2. Repair or replace laminate.	9/27	Maint Sup	In progress
Resident RM 213	Damaged door frame w/exposed metal corner beading 1. Repair sheetrock 2. Paint 3. Install corner protectors.	9/27	Maint Sup	In progress
BUILDING 17				
Tub Rooms all floors	Dust & debris under tubs. 1. Clean all tub rooms	8/30	Hskp.	*Status: 4th floor done 3rd floor done 1 on 2nd floor done.
3-North Tub Room	Repair all broken, crack & chipped wall tiles in shower & toilet rm.	9/17	Maint Sup	In progress
3-South Tub Room	Repair broken tiles in shower.	9/17	Maint Sup	In progress
2-North Tub Room	Repair crack corner on wall/base.	9/1	Maint Sup	Done
2-South Tub Room	Replace tile baseboard.	8/30	Maint Sup	
Hall areas near RMS 439,247,286 & bathroom of RM 247	Detached vinyl that has curled up around the walls forming a baseboard.	9/17	Project Mgr	In progress
Smoking area	Tar stains on walls, windows & ceilings. Damaged/unsafe furniture. * See overall plan for correction	9/17	Chief Eng	In progress

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
Resident RM 367	Damaged walls by windows exposed metal beading.	9/17	Maint Sup	**9/1 Ready for painting**
Resident RM 288	Strong urine odor throughout room into hall.	9/17	Hskp	**In progress**
Main dining RM	Brown stains on suspended ceiling tiles.	8/31	Maint Sup	Completed 8/31/05
4655.4110 Safety issue	Lack of non-slip strips on floor in shower Review all showers in DOMS, THP for loose or no strips - Replace immediately Incorporate this into Environmental and Nursing Rounds	9/27	Maint Sup Nursing and Environ-mental Services	**Work In-process** Replace all loose and missing strips immediately or after regrouting has occurred
MSFC 703.1 **Repair damage or seal opening to fire-resistive construction with approved materials and methods.**	Bldg 6,9: Repair wall penetrations from wires and pipes throughout the buildings 1. Seal penetrations 2. Policy to manage construct projects	8/31/05	Chief Eng Maint Sup Plant Mgr	Repairs 100% complete Mgt Action: P/P draft completed for construction mgt.
MSFC 304.1 **Remove combustible material from dryers and vent pipes.**	Remove all lint and combustibles from behind the dryers and clean vent piping from dryers in building 17. 1. Clean ducting 2. Install new access panel for future inspections & cleaning 3. Write a PM to Archibus.	8/31/05	Chief Eng Chief Eng Chief Eng	Mgt Action: New inspection access to be installed & *PM written in Archibus*

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
MSFC 1010.5 **Emergency lighting shall be provided installed and maintain operational in the following areas where two or more means of egress are required. This includes the following areas: 1. interior corridors passageways aisles and spaces, 2) exit stairways, 3) windowless areas having student occupancy, an d4) shops and laboratories.**	Provide emergency lighting for all buildings. Emergency lighting shall provide at least one foot candle power at the floor throughout all means of egress. At this time, the emergency generator comes on-line only if the public utility power supply is interrupted. If the electrical power is interrupted to a single building or section or a building, no emergency power is provided for the effected building or section.	Project included in FY07 Bonding request to State legislature	Plant Mgr& & Project Mgr	Study in progress to construct time extension. Meeting with state architect office has been set-up. Major project - will need extension Cost $800K for fix $1.2 mil. To do it right. Bond request
MSFC 3006.4 **Medical gas (liquid oxygen) shall comply with NFPA 99 Bldg. 16 Because it is occupied and MVH is the owner**	Building 6,9,16, 17: Liquid oxygen is transferred in resident rooms. Fire Marshal omitted B16 for orders.	This project is in progress and will be funded once a design work complete - in progress	Project Mgr Asst Admin	Project design in progress for asset preservation resources for Bldg. 6
MSFC 903.2 **Provide an approved automatic fire sprinkler system. Such system shall be installed in accordance with NFPA standards 13, 13-R, and 13-D, as appropriate**	Building 17, 17 are not fully sprinklered. Provide automatic sprinkler coverage in walk-in type coolers and freezers. Building 17 Electrical/Telephone Room is not sprinklered. 1. Get bids for contractor to repair	9/29	Plant Mgr & Project Mgr Chief Eng	Work to begin week of 9/12/05.

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
27. MN Statute 144A.04 Subd 4 (reissued at Subd 11) Subd. 11. **Incontinent residents.** Notwithstanding Minnesota Rules, part 4658.0520, an incontinent resident must be checked according to a specific time interval written in the resident's care plan. The resident's attending physician must authorize in writing any interval longer than two hours unless the resident, if competent, or a family member or legally appointed conservator, guardian, or health care agent of a resident who is not competent, agrees in writing to waive physician involvement in determining this interval, and this waiver is documented in the resident's care plan. 14 days	See # 10-2 Individual residents were reviewed by the RNM. The nurse practitioners, interim director of nursing, and OT developed a urinary incontinence management process to be implemented for residents with UI over the next 6 months as their individual quarterly assessments or significant change assessments come due.	9/2/05 9/2/05 2/23/06	RNM Director of Nursing	See attachment # 27a (UI Management procedures - draft 2)
28. MN Statute 144.651 Subd 5 courtesy Subd. 5. **Courteous treatment.** Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. 14 days	A comprehensive inservice is being designed by social services for use in additional HST training and to replace current general orientation education on resident dignity and respectful treatment. See also #10-2	10/1/05	Director of Social Services Administrator	

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
Boarding Care Rules:				
1. 4655.4700 Physical Exams **Subpart 1** Subpart 1. **Physical examination at admission.** Each patient or resident shall have an admission medical history and complete physical examination performed and recorded by a physician within five days prior to or within 72 hours after admission. The medical record shall include: the report of the admission history and physical examination; the admitting diagnosis and report of subsequent physical examinations; a report of a standard Mantoux tuberculin test or, if the Mantoux test is positive or contraindicated, a chest X ray within three months in advance of admission and as indicated thereafter; reports of appropriate laboratory examinations; general medical condition including disabilities and limitations; instructions relative to the patient's or resident's total program of care; written orders for all medications with stop dates, treatments, special diets, and for extent or restriction of activity; physician's orders and progress notes; and condition on discharge or transfer, or cause of death. **14 days**	A procedural review was performed by the DON and DOM's NP. The HIM will audit all admissions by day 2 of admission to ensure the MD has signed the H&P.	9/2/05	Medical Director HIM Director	

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
2. 4655.4000 Subp. 2. **Types of information reported.** The care record for each resident shall contain the resident's weight at the time of admission and at least once each month thereafter and a summary completed at least monthly by the person in charge indicating the resident's general condition, actions, attitude, changes in sleeping habits or appetite, and any complaints. A detailed incident report of any accident or injury and the action taken shall be recorded immediately. All dates and times of visits by physicians or podiatrists and visits to clinics, dentists, or hospitals shall be recorded. No monthly progress notes for 1 of 6 residents 14 days	The individual residents review was completed. A full house audit was done to determine that all residents monthly reviews are being done. The RNM will monitor this through the electronic medical record to ensure that all are completed timely.	9/2/05	RNM Director of Nursing	

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
3.4655.7000 Resident Rooms **Subpart j** J. All furnishings and equipment shall be maintained in a usable, safe, and sanitary condition. All rooms and beds shall be numbered. All beds shall be identified with the name of the patient or resident. Beds not marked with resident names 27 days	All beds have been marked with resident names.	8/1/05	Physical Plant Director	
4. 4655.9000 Environment Subpart 1. **General requirements.** The entire facility, including walls, floors, ceilings, registers, fixtures, equipment, and furnishings shall be maintained in a clean, sanitary, and orderly condition throughout and shall be kept free from offensive odors, dust, rubbish, and safety hazards. Accumulation of combustible material or waste in unassigned areas is prohibited.	See individual items listed below Daily rounds will be conducted	See individual items below	Physical Plant Director	
Urine smell MMS 311 & 307	Resident relocated	Complete	Housekeeping Supervisor	
RM 114 bath/ shower rm.	Black on floor & Walls, tub dingy 1. Remove old caulking & clean. 2. Regrout shower & caulk tub. 3. Clean return grill & vent.	8/26 9/1	Housekeeping Supervisor Maintenance Supervisor	1. Done 9/1/05 2. Done 9/1/05
RM 214 bath/ shower rm.	One loose tile. Tub black areas, metal disc on ceiling rusted. 1. Remove old caulking & clean. 2. Regrout shower & caulk tub. 3. Preplace cover. 4. Clean return grill & vent.	8/26	Housekeeping Supervisor Maintenance Supervisor	

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
RM 314 bath/ shower rm.	Black in grout, tub dingy, black grout under sink. Rust on radiator cover. Dust in vent by shower. Non-slip missing. 1. Remove old caulking & clean. 2. Regrout shower & caulk tub. Preplace cover. 3. Clean return grill & vent. 4. Paint radiator cover	9/27	Housekeeping Supervisor Maintenance Supervisor	*Vent cleaned. Need help of Howard behind vent grid. Work order sent for radiator needs repainting.
3rd Floor lounge.	Soiled carpet, couch & pillow. 1. Clean carpet. 2. Remove exiting furniture.	8/25 8/26	Housekeeping Supervisor Maintenance Supervisor	Replace carpet? Pictures taken.
3rd Floor phone	Plaster peeling around window	9/27	Maintenance Supervisor	Ready for paint 9/1/05
2nd Floor alcove	Plaster peeling around window	9/27	Maintenance Supervisor	Ready for final coat.
1std Floor alcove	Plaster peeling around window	9/27	Maintenance Supervisor	Ready for final coat
1st dayspace	Plaster peeling around window	9/27	Maintenance Supervisor	Ready for final coat
Paint chipped	In lobby & dayroom.	9/27	Maintenance Supervisor	In progress
RM 315 lounges	Soiled carpet 1. Clean carpet	8/25	Housekeeping Supervisor	Replace carpet

Licensing Violation	Plan of Correction	Comp Date	Person(s) Responsible	Follow-up
OVERALL PHYSICAL PLANT CORRECTION ACTIVITIES				
Tub Rooms	1. Repair chemical pumps to all tubs 2. Repair all tile walls/floors 3. Deep clean floors 4. Replace all rusty metal objects 5. Replace any worn curtains. 6. Replace worn soap/towel dispensors. 7. Replace old vents.		Maint Sup Maint Sup Hskp Hskp Hskp Hskp Chief Eng	Mgt Action: Training for hskp recognition of needed repairs. New construction project planned for tub room in B17.
Plaster work (Bldg 9) **Painting**	Repair walls & paint 1. Develop daily tracking log. Update daily 2. Weekly access workload. 1. Develop plan a. Door frame & Handrails (B17) b. Lower B17 corridor walls. c. Door & Frames in B6 & B9. d. Follow plastering e. Day spaces f. Main Dining Room g. Resident rooms		Maint Sup Maint Sup/Plant Mgr	Create a wall chart to track daily work. Work possible till midnight and on weekends. Mgt Action: Develop plan to address needs of facility B-17 4th floor door frames done.
Hallways (all)			Maint Sup	
BLD 6 Mudding			Maint Sup	
Housekeeping	Assess all areas. Attention to baseboards and corners, Condition of furniture. Clean all tubs.		Hskp	Document daily rounds. Use Susan T-C as additional auditor.
Smoke Rooms	1. Replace ceilings & grid. 2. Order new metal furniture. 3. Paint with Epoxy. 4. Install 2nd cleaner in both. 5. Remove vinyl in B6. 6. Install new fan in B6 7. Create monthly GI cleaning day. Coordination –Safety Mgr		Chief Eng	Use contractor to do work. Copy Env. Secretary with all POs for contracted work. Mgt Action: Create monthly deep cleaning day. Shutdown lounge for up to 8 hours.
Flooring Issues	StP Linoleum to repair? - B17 hallways? - Resident rooms - B6 Nurses sta. - B6 dayrooms. - B9 vending areas/VCT		Project Eng	8/29 – StP Linoleum due in.

Minnesota Veterans Home - Minneapolis
Resident Incident/Variance Report

Attachment 1a

Employee's Description of Variance/Incident

Date/Time of report 5/7/05 7p Date/Time of Variance (if different) 5/15/05 7p

Resident's name [redacted] Bldg/Rm # 711 MR# 12863 DOB 12-25-1932

Name/title of witness(es) —

Type of Variance:

Non-Falls: (check only one)

___ Behavioral altercation ___ Biting ___ Superficial Soft Tissue Injury unrelated to a fall

___ Burn ___ Choking ___ Unsafe Smoking ___ Restraint incident

___ ETOH/Chemical Use ___ Elopement X Other

Falls: ___ unwitnessed fall or found on floor ___ witnessed fall

Location of Variance (check only one)

X Bedroom ___ Bathroom ___ Other Resident's Room ___ Unit Hallway

___ Elevator: ____ ___ Other Unit ___ Outdoors ___ Main Dining Room 17

___ Unit Dining Room ___ Unit Day Room ___ Smoking lounge ___ Chapel of Peace

___ Tub/Shower Room ___ Other: ____

Situational Information

___ From bed ___ From toilet ___ Mechanical Lift involved

___ From chair or (w/c) ___ Other: ____ ___ Tub/shower equipment involved

Description of Event: (facts, no opinions)
Resident wheeled self to window and pulled fdg peg out. Sent to VAMC per transportation and admitted to 3F

Was eting and/or incontinence a factor? No If so, last time resident toileted: ____

at time did resident last eat? TF and have fluids? TF

Was resident standing ____ walking ____ reaching up ____ reaching down ____?

Any environmental issues? (i.e. poor lighting, wet floor, etc.) No

Immediate Triage: Head to Toe exam:

Did resident hit head? (No) / Yes If yes, initial neuro exam: ____

Temperature: 100.5 Pulse: 76 Respiration: 20 B/P: 120/70 (Usual B/P: WNL)

Describe any injury: Bleeding from Peg Site was controlled c pressure. Clotting occurred. Area was cleansed. et drsg applied

Action Taken: None ____ First Aid X Emergency room ____ Hospitalized X

Comments: ____

Physician notified: Person notified/Date/time Call log MD aware Dr. L Fang

Family notified: Date/time 5/15/05 7p Name/relationship: Wife present when incident occur

C/P updated or temporary CP started? admitted to hosp Nurses' Note made: (Yes) / No

Nurse Signature Margaret Shrake LPN Date/Time 5/15/05 22:41

24 Hour review of incident/variance reveals:

___ No Injury ___ Minor Injury ✓ Complicated Minor Injury ___ Major Injury

Describe: *Peg tube dislodgement, upon G I bleed secondary to dislodge*

Take vital signs when reproducing circumstances of a fall (e.g., at same time of day as fall or if resident fell 10 minutes after eating a large meal, take vital signs 10 minutes after the resident eats): ____________

Lying/Standing B/P: *hospitalized*

Lying:	______ / ______	Pulse	______
1 minute after standing:	______ / ______	Pulse	______
3 minutes after standing :	______ / ______	Pulse	______

Changes in resident requiring reassessment of the care plan:

hospitalized will review careplan upon readmission from VAMC to MOH

Interdisciplinary Discussion of Variance: *Mary Glaser NP, LaVonne Tiedens RN*

Signature *LaVonne Tiedens RN* Date *8/8/05* Time *10a*

Route to Nurse Manager

Review for quality improvement:

Did the care plan address potential for this type of variance? Yes / (No) If yes, was the care plan followed? Yes / No

For falls only:

Internal Factors

#___ past falls (0-180 days) ___ Isolated event ___ Cardiovascular ___ Neurological

___ Orthopedic ___ Perceptual ___ Psychological /cognitive ___ New illness / onset

___ Elimination needs ___ Pain - Does the resident have an identified pain management plan? Yes / No

Comments: ____________

External Factors

___ Medications ___ Appliances / devices ___ Environmental /situational hazards

Is resident receiving: ___ antipsychotics ___ antianxiety/hypnotics ___ antidepressants

___ cardiovascular medications ___ diuretics

Comments: ____________

For any type of variance:

Modifications to the Resident Care Plan: Yes / (No) (describe changes or why no change is made *will reassess plan of care upon readmission MVH*

Referral Necessary:

___ OT/PT/ST ___ Vision ___ Audio ___ Medical

Comment: ____________

RN Manager (when section complete) *LaVonne Tiedens RN* Date: *8/18/05*

Summary of Contributing factors: *Multiple Sclerosis*

Corrective Action: *Back from hospital - no feeding tube 6/28/05 diet dysphagia II c̄ nectar thick liquids (pureed) offer 8 oz thickened liquids 6X qd. sitting when eating or drinking*

ON Review

Vulnerable Adult Act - Is external report required? Yes ______ No ✓

Date/time/name report made to CEP: ______ / ______ / ______ Date original reporter notified: ______

Comments: ____________

Signature: *Sue Garretson RN* Date *08-08-05*

STATE OF MINNESOTA
VETERANS HOME - MINNEAPOLIS

OPERATING POLICY AND PROCEDURES

Title: (Agency) – Resident Incident Report

Number: 01-06

Approvals: Admimistrator

Date: DRAFT 8/30/05

OBJECTIVE:

- To define the role/responsibility of staff for reporting resident incidents/accidents.
- To describe the procedure for completing an electronic resident incident report.
- To establish a method that will provide direction for the assessment and appropriate medical intervention when a resident incident occurs.
- To assure that appropriate persons are notified of incidents, i.e., staff, physicians, family members, etc.
- To assess the cause of incidents and implement corrective/preventive action when indicated.

POLICY:

All resident incidents/accidents, and injuries must be reported. An incident report that details the circumstances surrounding/leading up to the accident/injury must be completed. The report shall also define the action taken after learning of the incident/accident or injury.

- A resident incident report shall be completed for any incident/accident occurring on or off the facility campus.
- The person arriving first on the scene or first to be made aware of the incident shall initiate the Observation Report. The only exception is for medication errors. Observation forms will be completed for medication errors only by pool staff, pharmacy staff and all non-nursing staff. A nurse finding a medication error will complete the Resident Incident Report.
- Licensed nurse intervention/assessment should be sought as soon as possible after the incident.
- All incident reports are to be reviewed by the Director/Assistant Director of Nursing and the Quality Manager to determine the need for further assessment, investigation, to identify possible vulnerable adult issues, and to ensure appropriate follow-up action.
- Incident reports will be retained according to the Agency Record Retention Schedule.

FORMS:

Momentum Agency Incident Report

DEFINITIONS:

Staff: Any person employed by or volunteering for the Minneapolis Veterans Home including persons providing contract services/care.

Incident: A sudden, unforeseen, and unexpected occurrence or event. Any unusual occurrence that causes harm or has the potential for causing harm to a resident. Any resident behavior which may put the resident or others at risk (i.e., physical/verbal aggression, unauthorized leave, use of non-prescribed mood altering substances, etc.). Any physical injury (with or without a known cause) noted upon examination of a resident.

PROCEDURE:

When a staff member is made aware of or witnesses an incident the following steps are to be taken:

1. Immediate intervention to ensure the safety of the resident. *NOTE*: In the case of a physical threat to safety, such as a fall or noted injury, a licensed nurse/nurse practitioner should do an assessment and initiate follow-up. In emergency situations stay with the resident while summoning a licensed nurse; provide first aid to the resident within the scope of training and ability.

2. Immediately report the incident to the unit nurse.

3. The licensed nurse will initiate the Resident Incident Report. Rehab staff will initiate a resident incident report for incidents occurring while in therapy. Recreational Therapy staff will initiate a resident incident report for incidents occurring while at an RT Program. Social Service will imitate a resident incident report for behavioral incidents

   NOTE:
   - Altercations/incidents involving two or more residents require a separate incident report for each resident.
   - Identify residents by full name and medical record number.
   - Complete Incident Report for observations from a mandated reported
   - Contact the ADON during regular business hours and the Nursing Supervisor during off-hour shifts for immediate triage for Vulnerable Adult concerns.

4. Triage the resident situation
   A. Handle any acute issues for the resident's status using emergency nursing procedures. Once the resident is determined to be in a stable situation initiate the completion of the report
   B. For non-acute incidents refer to attachment one for examples of types of incidents.?????
   C. Contact the ADON during regular business hours and the Nursing Supervisor during off-hour shifts for immediate triage for Vulnerable Adult concerns.

5. Initiate the Resident Incident Report
   A. Section A for all incidents
   B. Section B for all falls
   C. Section C for all medication/pharmacy incidents
   D. Section D for all behavioral related incidents
   E. Section E for all other incidents including mandated reporter observations Section F for all incidents

Completion and Routing Guidelines:

D. The nurse manager/designee/nursing supervisor will review the incident report on the shift of occurrence or as soon as possible and note review in the Section F comment box. The review shall include care plan adjustments to meet the needs of the resident.

E. The assistant director of nursing/designee will complete Section G – Nursing Administration review within 24 hours of occurrence. The nursing supervisor will complete Section G for nights/weekends/holiday within 24 hours of occurrence. Section G includes reviewing all incidents for CEP/DA Criteria.

F. Pharmacist will review and sign off all incident reports related to medication/pharmacy incidents on the shift of occurrence or as soon as possible..

~~G.~~ **Assistant Director of Nursing will trigger administration to review specific incidents reports via Morning meeting.** Assistant Director of Nursing will approve the electronic Incident report ~~within 24 hours of occurrence.~~

H:\DRAFT\POL-PROC\01-06 8-30-05.doc

Listing of Incidents

Attachment

Patient: <All>
Incident Category: <All>
Unit: <All>
Date Range: Sep 6, 2004 to Sep 6, 2005

Incident Category	Resident Name	Unit	Date Occured	Status
Abusive/Aggressive	[redacted]	2N	08/31/2005	Entered
Abusive/Aggressive		2N	08/31/2005	Entered
Abusive/Aggressive		3N	08/31/2005	Entered
Falls		2N	09/05/2005	Entered
alls		4N	09/01/2005	Entered
Falls		2N	09/05/2005	Entered
Falls		3S	09/05/2005	Entered
Falls		3S	09/03/2005	Entered
Falls		3N	09/05/2005	Entered
Falls		4N	09/02/2005	Entered
Falls		U2-62	09/02/2005	Entered
Falls		4N	09/02/2005	Entered
Falls		2S	09/02/2005	Entered
Falls		4N	09/05/2005	Entered
Falls		2N	09/04/2005	Entered
Falls		4N	09/02/2005	Entered
Falls		U3-63	09/03/2005	Entered
Falls		2N	09/02/2005	Entered
Falls		2N	09/02/2005	Entered
Falls		U1-61	09/05/2005	Entered
Falls		U2-62	09/05/2005	Entered
s		U2-62	09/01/2005	Entered
Falls		U3-63	09/03/2005	Entered
Falls		U2-62	09/03/2005	Entered
Falls		U2-62	09/02/2005	Entered
Falls		U2-62	09/05/2005	Entered
Falls		3S	09/02/2005	Entered
Falls		3S	09/01/2005	Entered
Medications		2N	09/05/2005	Entered
Medications		2N	09/05/2005	Entered
Medications		2N	09/02/2005	Entered
Medications		2N	09/03/2005	Entered
Medications		U3-93	09/01/2005	Entered
Misc.		3S	09/06/2005	Entered
Misc.		2N	09/01/2005	Entered
Misc.		U1-12	09/02/2005	Entered
Misc.		2N	09/05/2005	Entered
Misc.		U2-62	09/04/2005	Entered
M		3N	09/05/2005	Entered

August 25, 2005

To: Interdisciplinary Team Members (IDT)

From: Diane Vaughn

Re: Restraint Audits

Thank you for letting me alter the routine of your day in regards to survey follow-up. I appreciate your willingness to participate in this urgent process.

The goal of this audit is to:

- Inventory the actual devices each resident is using
- Ensure that proper assessment and documentation were done in the selection of this intervention
- Assess the needs for immediate reassessment of any individual resident by the IDT
- Ensure the care plan coveys required documentation
- Ensure residents have a documented plan for reassessment for least restrictiveness

The methodology is:

- Utilize the restraint audit and device listing
- Evaluate each resident on the unit as to if they are utilizing any devices
- If the resident is utilizing a device, complete the audit and update the device listing
- Note which residents require follow-up and what type (e.g. need MD order, or care plan changes, etc)

What happens then:

- The resident specific clinical rounds team will convene to reassess the items requiring follow-up
- We are assured the residents are in the least restrictive device and are aware of the risks of a device
- We regain survey compliance

Examples of devices:

- Alarms
- Siderails
- Belts
- Lap buddy's
- Chairs that prevent rising
- Other individualized devices

Restraint Audit

Documentation Requirement	Compliance	Comments for Variances	Follow-up Required
Type of Device(s)	Confirm is actual device in use		
Device is an enabler			
Device is a positioner			
Device is a restraint			
Medical Symptom of device	List Med. Symptom:		
Goal of device	List Goal:		
Pain assessment was completed prior to the initiation of a device			
Rehab was consulted	Date Rehab consulted:		
OT recommended device	Yes / No		
Least restrictive steps taken prior to initiation of device	Please list:		
Documentation exists that the medical decision maker has been informed of the **risks** of the device including serious injury and death	Date/Location of information		
Progress notes indicate the resident's tolerance to the device	Date(s) of progress note:		
CARE PLAN DOCUMENTATION			
Device is on the care plan including:			
Goal and Medical Symptom			
Time out from being in device (e.g. to walk)			
Interventions to meet toileting needs			
Interventions to meet repositioning needs			
Interventions to meet hydration / nourishment needs			
The care plan contains steps to decrease the use of the device over time			
Other comments regarding the device use:			

Resident: _____ **Unit:** _____ **Date:** _____

August 31, 2005

To: Clinical Rounds Teams

From: Diane Vaughn

RE: Restraint Audit / Review

Thank you to the social workers and behavior analysts that worked so diligently on the restraint documentation audits.

Our next step is to have an IDT review of the audits. The IDT should review for:

- Is the device identified a positioner/enabler/or restraint
- Is medical symptom present
- Is there a goal for the device
- Are there parameters set as to when to use
- Is there informed consent for devices that can cause harm – if it says, "archived" we need to re-do it
- Is there a progress note for resident tolerance to the device
- Are all of the details on the care plan:
- interventions to meet toileting, repositioning, hydration
- Do they have a restraint reduction plan

Most of this is done on the audit – where items are missing, unclear or archived, please write a IDT progress note. Here is an example:

IDT met to review the use of device). The IDT continues to find this device to be the least restrictive device (include previous attempts if relevent) , the resident is tolerating it well (examples are best). Reduction plan: We will continue this device for the next quarter at which time will reassess the device.

Oral Health Screening Form

Facility Code: VM

Screening Date: 10-26-04

Facility Staff - Please complete this section

Resident Last Name: [redacted]

First Name & MI: [redacted]

Room & Bed# [redacted] Date of Birth: 10-31-24 Gender: (M) [F]

Soc Sec #: [redacted]

Type of Screening: [M] Initial [ ] Annual [ ] Status Change

Payment Type: [ ] MA [ ] PVT [ ] PPS

Diet and Nutrition Problems: [ ] Weight Loss [ ] Nutrition Problem [ ] Feeding Tube [ ] Mechanically Altered Diet

(1) Minimum Data Set Information

a.

	Heavy Debris
	Heavy Plaque
	Heavy Calculus

b.

[/] None		
Upper	[ ] Full	[ ] Partial
Lower	[ ] Full	[ ] Partial

c.

✓	Missing Teeth w/o Replacement
	Doesn't wear Dentures or Partials
	Problems with Dentures or Partials
✓	Natural Teeth are Present

d.

	Loose Teeth
	Decayed Teeth
	Broken Teeth/Fillings
	Root Tips Present

e.

	Swollen or Bleeding Gums
	Oral Abscesses, fistulas
	Ulcerations, Denture Sores
	Soft or Hard Tissue Lesions

f. [✓] Daily Oral Care Needed

SECTION K: ORAL/ NUTRITIONAL STATUS

1.	a. Chewing Problems	a.
	b. Swallowing Problems	b.
	c. Mouth Pain	c.
	d. *NONE OF ABOVE*	d. ✓

SECTION L: ORAL/DENTAL STATUS

1.	a. Debris (soft, easily movable substances) present in mouth prior to going to bed at night	a.
	b. Has dentures and/or removable bridge	b.
	c. Some / all natural teeth lost - does not have or does not use dentures (or partial dentures)	c. ✓
	d. Broken, loose, or carious teeth	d.
	e. Inflamed gums (gingiva); swollen or bleeding gums; oral abscesses; ulcers or rashes	e.
	f. Daily cleaning of teeth/dentures or daily mouth care – by resident or staff	f. ✓
	g. *NONE OF ABOVE*	g.

(2) Daily Oral Care Plan

[ ] Resident Maintains Oral Care Independently
[✓] Resident Needs Staff Supervision
[ ] Resident Needs Direct Staff Assistance

The items checked below are recommended to maintain the oral health of this resident:

[✓] **Toothbrushing** Each morning and evening, brush teeth and gums for 2 minutes using a soft toothbrush and fluoride toothpaste.
[ ] Remove Partial(s) before brushing teeth [ ] Provide dental floss [ ] Electric toothbrush recommended
[ ] Each morning and evening, swish with 2-3 teaspoons of Fluorigard or ACT fluoride rinse for one minute, then spit out.

[ ] **Denture and Partial Denture Care** Once daily, use a toothbrush or denture brush and mild soap to brush dentures and partials –soaking alone will not remove harmful plaque. At bedtime, remove and brush dentures, then soak them in a denture cup overnight. Soak dentures in plain water, or use a cleaning product such as Efferdent or Polident, but do not let the dentures dry out.
[ ] Apply a denture adhesive, such as Fixodent or Polygrip each morning

(✓) only a few teeth - brush them as above & then swab / rinse mouth as needed.

(3) Dental Care Referral Recommendations

[ ] No Dental Referral. Resident has no need for dental referral at this time.
[✓] Routine Dental Referral. Resident has routine dental care needs.
[ ] Immediate Dental Referral. Resident has urgent dental needs.

Screening and Referral Notes: Still at lunch - will try next month. 10-26-04

Screened as above today 11-23-04

D. Olson RDH
Apple Tree Screener

Vicki Cuno (612) 721-0690
Facility Staff Responsible for Referrals

Oral Health Screening Form

Facility Code: VA

Screening Date: 11/26/02

Facility Staff - Please complete this section

Resident Last Name: [redacted]

First Name & MI: [redacted]

Room & Bed#: [redacted] Date of Birth: 12/19/53 Gender: [M] [F]

Type of Screening: [ ] Initial [X] Annual [ ] Status Change

Soc Sec #: [redacted]

Payment Type: [ ] MA [ ] PVT [ ] PPS

Diet and Nutrition Problems: [ ] Weight Loss [ ] Nutrition Problem [ ] Feeding Tube [ ] Mechanically Altered Diet

(1) Minimum Data Set Information

a.

✓	Heavy Debris
✓	Heavy Plaque
	Heavy Calculus

b.

		Dentures
✓	None	
	Upper	[ ] Full [ ] Partial
	Lower	[ ] Full [ ] Partial

c.

	Missing Teeth w/o Replacement
	Doesn't wear Dentures or Partials
	Problems with Dentures or Partials
✓	Natural Teeth are Present

d.

	Loose Teeth
	Decayed Teeth
	Broken Teeth/Fillings
	Root Tips Present

e.

✓	Swollen or Bleeding Gums
	Oral Abscesses, fistulas
	Ulcerations, Denture Sores
	Soft or Hard Tissue Lesions

f.

✓	Daily Oral Care Needed

SECTION K: ORAL/ NUTRITIONAL STATUS

1.	a. Chewing Problems	a.
	b. Swallowing Problems	b.
	c. Mouth Pain	c.
	d. *NONE OF ABOVE*	d. ✓

SECTION L: ORAL/DENTAL STATUS

1.	a. Debris (soft, easily movable substances) present in mouth prior to going to bed at night	a. ✓
	b. Has dentures and/or removable bridge	b.
	c. Some / all natural teeth lost - does not have or does not use dentures (or partial dentures)	c.
	d. Broken, loose, or carious teeth	d.
	e. Inflamed gums (gingiva); swollen or bleeding gums; oral abscesses; ulcers or rashes	e. ✓
	f. Daily cleaning of teeth/dentures or daily mouth care – by resident or staff	f.
	g. *NONE OF ABOVE*	g.

(2) Daily Oral Care Plan

[ ] Resident Maintains Oral Care Independently
[ ] Resident Needs Staff Supervision
[✓] Resident Needs Direct Staff Assistance

The items checked below are recommended to maintain the oral health of this resident:

[✓] **Toothbrushing** Each morning and evening, brush teeth and gums for 2 minutes using a soft toothbrush and fluoride toothpaste.
[ ] Remove Partial(s) before brushing teeth [ ] Provide dental floss [ ] Electric toothbrush recommended
[ ] Each morning and evening, swish with 2-3 teaspoons of Fluorigard or ACT fluoride rinse for one minute, then spit out.

[ ] **Denture and Partial Denture Care** Once daily, use a toothbrush or denture brush and mild soap to brush dentures and partials –soaking alone will not remove harmful plaque. At bedtime, remove and brush dentures, then soak them in a denture cup overnight. Soak dentures in plain water, or use a cleaning product such as Efferdent or Polident, but do not let the dentures dry out.
[ ] Apply a denture adhesive, such as Fixodent or Polygrip each morning

(3) Dental Care Referral Recommendations

[ ] No Dental Referral. Resident has no need for dental referral at this time.
[✓] Routine Dental Referral. Resident has routine dental care needs.
[ ] Immediate Dental Referral. Resident has urgent dental needs.

Screening and Referral Notes:

Heidi Dze RDH
Apple Tree Screener

Vicki Cuno (6123 721-0690
Facility Staff Responsible for Referrals

Oral Health Screening Form

Facility Code: VM

Screening Date: 7-27-04

Facility Staff - Please complete this section

Type of Screening: [ ] Initial [X] Annual [ ] Status Change

Resident Last Name: [redacted]

First Name & MI: [redacted]

Soc Sec #: [redacted]

Room & Bed: [redacted] Date of Birth: 12/19/63 Gender: [X] [F] Payment Type: [ ] MA [ ] PVT [ ] PPS

Diet and Nutrition Problems: [ ] Weight Loss [ ] Nutrition Problem [ ] Feeding Tube [ ] Mechanically Altered Diet

(1) Minimum Data Set Information

a.

	Heavy Debris
	Heavy Plaque
	Heavy Calculus

b.

[ ] None		
Upper	Dentures	[ ] Full [ ] Partial
Lower		[ ] Full [ ] Partial

c.

	Missing Teeth w/o Replacement
	Doesn't wear Dentures or Partials
	Problems with Dentures or Partials
	Natural Teeth are Present

d.

	Loose Teeth
	Decayed Teeth
	Broken Teeth/Fillings
	Root Tips Present

e.

	Swollen or Bleeding Gums
	Oral Abscesses, fistulas
	Ulcerations, Denture Sores
	Soft or Hard Tissue Lesions

f.

	Daily Oral Care Needed

SECTION K: ORAL/ NUTRITIONAL STATUS

1.	a. Chewing Problems	a.
	b. Swallowing Problems	b.
	c. Mouth Pain	c.
	d. *NONE OF ABOVE*	d.

SECTION L: ORAL/DENTAL STATUS

1.	a. Debris (soft, easily movable substances) present in mouth prior to going to bed at night	a.
	b. Has dentures and/or removable bridge	b.
	c. Some / all natural teeth lost - does not have or does not use dentures (or partial dentures)	c.
	d. Broken, loose, or carious teeth	d.
	e. Inflamed gums (gingiva); swollen or bleeding gums; oral abscesses; ulcers or rashes	e.
	f. Daily cleaning of teeth/dentures or daily mouth care – by resident or staff	f.
	g. *NONE OF ABOVE*	g.

(2) Daily Oral Care Plan

[ ] Resident Maintains Oral Care Independently
[ ] Resident Needs Staff Supervision
[ ] Resident Needs Direct Staff Assistance

The items checked below are recommended to maintain the oral health of this resident:

[ ] **Toothbrushing** Each morning and evening, brush teeth and gums for 2 minutes using a soft toothbrush and fluoride toothpaste.
[ ] Remove Partial(s) before brushing teeth [ ] Provide dental floss [ ] Electric toothbrush recommended
[ ] Each morning and evening, swish with 2-3 teaspoons of Fluorigard or ACT fluoride rinse for one minute, then spit out.

[ ] **Denture and Partial Denture Care** Once daily, use a toothbrush or denture brush and mild soap to brush dentures and partials –soaking alone will not remove harmful plaque. At bedtime, remove and brush dentures, then soak them in a denture cup overnight. Soak dentures in plain water, or use a cleaning product such as Efferdent or Polident, but do not let the dentures dry out.
[ ] Apply a denture adhesive, such as Fixodent or Polygrip each morning

(3) Dental Care Referral Recommendations

[ ] No Dental Referral. Resident has no need for dental referral at this time.
[ ] Routine Dental Referral. Resident has routine dental care needs.
[ ] Immediate Dental Referral. Resident has urgent dental needs.

Screening and Referral Notes: Would not Cooperate for screening 7-27-04

D Olson RDH
Apple Tree Screener

Vicki Cuno (612) 721-0690
Facility Staff Responsible for Referrals

Oral Health Screening Form

Facility Code: VM

Screening Date: 7-27-04
8-31-04

Facility Staff - Please complete this section

Type of Screening: [ ] Initial [X] Annual [ ] Status Change

Resident Last Name: [redacted]

First Name & MI: [redacted]

Soc Sec #: [redacted]

Room & Bed# [redacted] Date of Birth: 12/19/63 Gender: [M] [F] Payment Type: [ ] MA [ ] PVT [ ] PPS

Diet and Nutrition Problems: [ ] Weight Loss [ ] Nutrition Problem [ ] Feeding Tube [ ] Mechanically Altered Diet

(1) Minimum Data Set Information

a.

	Heavy Debris
	Heavy Plaque
	Heavy Calculus

b.

[ ] None		Dentures
	Upper	[ ] Full [ ] Partial
	Lower	[ ] Full [ ] Partial

c.

	Missing Teeth w/o Replacement
	Doesn't wear Dentures or Partials
	Problems with Dentures or Partials
	Natural Teeth are Present

d.

	Loose Teeth
	Decayed Teeth
	Broken Teeth/Fillings
	Root Tips Present

e.

	Swollen or Bleeding Gums
	Oral Abscesses, fistulas
	Ulcerations, Denture Sores
	Soft or Hard Tissue Lesions

f.

	Daily Oral Care Needed

SECTION K: ORAL/ NUTRITIONAL STATUS

1.	a. Chewing Problems	a.
	b. Swallowing Problems	b.
	c. Mouth Pain	c.
	d. *NONE OF ABOVE*	d.

SECTION L: ORAL/DENTAL STATUS

1.	a. Debris (soft, easily movable substances) present in mouth prior to going to bed at night	a.
	b. Has dentures and/or removable bridge	b.
	c. Some / all natural teeth lost - does not have or does not use dentures (or partial dentures)	c.
	d. Broken, loose, or carious teeth	d.
	e. Inflamed gums (gingiva); swollen or bleeding gums; oral abscesses; ulcers or rashes	e.
	f. Daily cleaning of teeth/dentures or daily mouth care – by resident or staff	f.
	g. *NONE OF ABOVE*	g.

(2) Daily Oral Care Plan

[ ] Resident Maintains Oral Care Independently
[ ] Resident Needs Staff Supervision
[ ] Resident Needs Direct Staff Assistance

The items checked below are recommended to maintain the oral health of this resident:

[ ] **Toothbrushing** Each morning and evening, brush teeth and gums for 2 minutes using a soft toothbrush and fluoride toothpaste.
[ ] Remove Partial(s) before brushing teeth [ ] Provide dental floss [ ] Electric toothbrush recommended
[ ] Each morning and evening, swish with 2-3 teaspoons of Fluorigard or ACT fluoride rinse for one minute, then spit out.

[ ] **Denture and Partial Denture Care** Once daily, use a toothbrush or denture brush and mild soap to brush dentures and partials –soaking alone will not remove harmful plaque. At bedtime, remove and brush dentures, then soak them in a denture cup overnight. Soak dentures in plain water, or use a cleaning product such as Efferdent or Polident, but do not let the dentures dry out.
[ ] Apply a denture adhesive, such as Fixodent or Polygrip each morning

(3) Dental Care Referral Recommendations

[ ] No Dental Referral. Resident has no need for dental referral at this time.
[ ] Routine Dental Referral. Resident has routine dental care needs.
[ ] Immediate Dental Referral. Resident has urgent dental needs.

Screening and Referral Notes: Would not Cooperate for screening 7-27-04
Will not cooperate for screening 8-31-04

RDH
Apple Tree Screener

Vicki Cuno (612) 721-0690
Facility Staff Responsible for Referrals

Oral Health Screening Form

Facility Code: VM

Screening Date: 7-27-04
8-31-04
9-28-04

Facility Staff - Please complete this section

Type of Screening [ ] Initial [X] Annual [ ] Status Change

Resident Last Name: [redacted]

First Name & MI: [redacted]

Soc Sec # [redacted]

Room & Bed# [redacted] Date of Birth: 12/19/53 Gender: [M] [F] Payment Type: [ ] MA [ ] PVT [ ] PPS

Diet and Nutrition Problems: [ ] Weight Loss [ ] Nutrition Problem [ ] Feeding Tube [ ] Mechanically Altered Diet

(1) Minimum Data Set Information

a.

	Heavy Debris
	Heavy Plaque
	Heavy Calculus

b.

[ ] None		Dentures
	Upper	[ ] Full [ ] Partial
	Lower	[ ] Full [ ] Partial

c.

	Missing Teeth w/o Replacement
	Doesn't wear Dentures or Partials
	Problems with Dentures or Partials
	Natural Teeth are Present

d.

	Loose Teeth
	Decayed Teeth
	Broken Teeth/Fillings
	Root Tips Present

e.

	Swollen or Bleeding Gums
	Oral Abscesses, fistulas
	Ulcerations, Denture Sores
	Soft or Hard Tissue Lesions

f.

	Daily Oral Care Needed

SECTION K: ORAL/ NUTRITIONAL STATUS

1.	a. Chewing Problems	a.
	b. Swallowing Problems	b.
	c. Mouth Pain	c.
	d. *NONE OF ABOVE*	d.

SECTION L: ORAL/DENTAL STATUS

1.	a. Debris (soft, easily movable substances) present in mouth prior to going to bed at night	a.
	b. Has dentures and/or removable bridge	b.
	c. Some / all natural teeth lost - does not have or does not use dentures (or partial dentures)	c.
	d. Broken, loose, or carious teeth	d.
	e. Inflamed gums (gingiva); swollen or bleeding gums; oral abscesses; ulcers or rashes	e.
	f. Daily cleaning of teeth/dentures or daily mouth care – by resident or staff	f.
	g. *NONE OF ABOVE*	g.

(2) Daily Oral Care Plan

[ ] Resident Maintains Oral Care Independently
[ ] Resident Needs Staff Supervision
[ ] Resident Needs Direct Staff Assistance

The items checked below are recommended to maintain the oral health of this resident:

[ ] **Toothbrushing** Each morning and evening, brush teeth and gums for 2 minutes using a soft toothbrush and fluoride toothpaste.
[ ] Remove Partial(s) before brushing teeth [ ] Provide dental floss [ ] Electric toothbrush recommended
[ ] Each morning and evening, swish with 2-3 teaspoons of Fluorigard or ACT fluoride rinse for one minute, then spit out.

[ ] **Denture and Partial Denture Care** Once daily, use a toothbrush or denture brush and mild soap to brush dentures and partials –soaking alone will not remove harmful plaque. At bedtime, remove and brush dentures, then soak them in a denture cup overnight. Soak dentures in plain water, or use a cleaning product such as Efferdent or Polident, but do not let the dentures dry out.
[ ] Apply a denture adhesive, such as Fixodent or Polygrip each morning

(3) Dental Care Referral Recommendations

[ ] No Dental Referral. Resident has no need for dental referral at this time.
[ ] Routine Dental Referral. Resident has routine dental care needs.
[ ] Immediate Dental Referral. Resident has urgent dental needs.

Don't try again

Screening and Referral Notes: Would not Cooperate for screening 7-27-04
Will not cooperate for screening 8-31-04
Will not allow screening 9-28-04

[redacted] RDH
Apple Tree Screener

Vicki Cuno (612) 721-0690
Facility Staff Responsible for Referrals

Oral Health Screening Form

Facility Code: VM

Screening Date: 5-8405

Facility Staff - Please complete this section

Type of Screening: [ ] Initial [X] Annual [ ] Status Change

Resident Last Name: [redacted]

First Name & MI: [redacted]

Soc Sec #: [redacted]

Room & Bed#: [redacted] Date of Birth: 12/19/53 Gender: [M] [F] Payment Type: [ ] MA [ ] PVT [ ] PPS

Diet and Nutrition Problems: [ ] Weight Loss [ ] Nutrition Problem [ ] Feeding Tube [ ] Mechanically Altered Diet

(1) Minimum Data Set Information

a.

	Heavy Debris
	Heavy Plaque
	Heavy Calculus

b.

[✓] None		
Upper	Dentures	[ ] Full [ ] Partial
Lower		[ ] Full [ ] Partial

c.

	Missing Teeth w/o Replacement
	Doesn't wear Dentures or Partials
	Problems with Dentures or Partials
✓	Natural Teeth are Present

d.

	Loose Teeth
	Decayed Teeth
	Broken Teeth/Fillings
	Root Tips Present

e.

	Swollen or Bleeding Gums
	Oral Abscesses, fistulas
	Ulcerations, Denture Sores
	Soft or Hard Tissue Lesions

f.

✓	Daily Oral Care Needed

SECTION K: ORAL/ NUTRITIONAL STATUS

1.	a. Chewing Problems	a.
	b. Swallowing Problems	b.
	c. Mouth Pain	c.
	d. *NONE OF ABOVE*	d. ✓

SECTION L: ORAL/DENTAL STATUS

1.	a. Debris (soft, easily movable substances) present in mouth prior to going to bed at night.	a.
	b. Has dentures and/or removable bridge	b.
	c. Some / all natural teeth lost - does not have or does not use dentures (or partial dentures)	c.
	d. Broken, loose, or carious teeth	d.
	e. Inflamed gums (gingiva); swollen or bleeding gums; oral abscesses; ulcers or rashes	e.
	f. Daily cleaning of teeth/dentures or daily mouth care – by resident or staff	f.
	g. *NONE OF ABOVE*	g.

(2) Daily Oral Care Plan

[-] Resident Maintains Oral Care Independently
[ ] Resident Needs Staff Supervision
[✓] Resident Needs Direct Staff Assistance

The items checked below are recommended to maintain the oral health of this resident:

[✓] **Toothbrushing** Each morning and evening, brush teeth and gums for 2 minutes using a soft toothbrush and fluoride toothpaste.
[ ] Remove Partial(s) before brushing teeth [ ] Provide dental floss [ ] Electric toothbrush recommended
[ ] Each morning and evening, swish with 2-3 teaspoons of Fluorigard or ACT fluoride rinse for one minute, then spit out.

[ ] **Denture and Partial Denture Care** Once daily, use a toothbrush or denture brush and mild soap to brush dentures and partials –soaking alone will not remove harmful plaque. At bedtime, remove and brush dentures, then soak them in a denture cup overnight. Soak dentures in plain water, or use a cleaning product such as Efferdent or Polident, but do not let the dentures dry out.
[ ] Apply a denture adhesive, such as Fixodent or Polygrip each morning

(3) Dental Care Referral Recommendations

[ ] No Dental Referral. Resident has no need for dental referral at this time.
[✓] Routine Dental Referral. Resident has routine dental care needs.
[ ] Immediate Dental Referral. Resident has urgent dental needs.

Screening and Referral Notes: Not too cooperative per screening above info was as best I could do with his level of cooperation.

D. Olson RDH
Apple Tree Screener

Vicki Cuno (612) 721-0690
Facility Staff Responsible for Referrals

State Of Minnesota Veterans Homes Board
Minnesota Veterans Home - Minneapolis
5101 Minnehaha Avenue South
Minneapolis, MN 55417
612-721-0600 Fax 612-728-1259 MN Relay: 1-800-627-3529

A-19-003-C (6/98)

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please Return Information to the Attention of: _____

TO: VAMC ADDRESS: One Veterans Drive Mpls MN 55417	Name of Resident/Patient: [redacted] Date of Birth 12/19/1953 Social Security Number [redacted] Date Admitted to MVH- 5/22/2000

This is your full and sufficient authorization to release to the Minnesota Veterans Homes Board of Directors, its agents, representatives or employees, the HOSPITAL OR MEDICAL information checked below. This authorization specifically includes records prepared prior to and after the date of this authorization. I authorize conversations between the bearer of this authorization and medical, psychiatric, psychological and social services personnel. This authorization includes the release of information concerning drug abuse, alcoholism, psychiatric/psychological information and HIV/AIDS.

Information is needed for the following dates of stay: all / Any as requested

- ☐ Discharge Summaries
- ☐ Outpatient Records, Summaries, Interdisciplinary Notes, Physician and Nurses' Notes
- ☐ Labs/X-rays
- ☐ Medical, physical, social, psychological/psychiatric histories and assessments
- ☐ Statements regarding applicant's participation in programs, including compliance with treatment plans, rules, care plan and abstinence from mood-altering substances
- ☒ Other, including the following: Dental notes from Dec 2004 - May 2006

NOTICE UNDER MN. GOVERNMENT DATA PRACTICES ACT, MN STATUTES, CHAPTER 13

A. *Information collected through use of this release will not be disclosed or disseminated to individuals, business entities or state or federal government agencies without your informed consent, except as required/permitted by law.*

B. *This release will expire one (1) year from the date of your signature.* Attention Public Facilities: Minnesota Statutes §13.05, subd. 4(d)(7) requires automatic expiration of this authorization one year from the date of its execution.

C. *Information will be used to determine your eligibility for admission and continued stay at the Minnesota Veterans Homes.*

D. *You may refuse to sign this release of information, but such refusal may result in a denial of your admission to a Minnesota Veterans Home or in the Homes inability to meet your care needs.*

I have read and understand the conditions of this release of information as stated on this form. I hereby authorize you (NAMED ABOVE) to disclose the requested information to the MN Veterans Homes Board.

[redacted] 8/26/05

Applicant/Resident Signature Date Responsible Party Signature/Relationship Date

Reason Applicant/Resident Cannot Sign: Huntington's Disease

THE MINNESOTA VETERANS HOMES BOARD IS AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER.

Note Text

TITLE: PATIENT CONTACT NOTE
DATE OF NOTE: DEC 21, 2004@15:45 ENTRY DATE: DEC 21, 2004@15:45:10
AUTHOR: OFSTEHAGE,JOHN C EXP COSIGNER:
URGENCY: STATUS: COMPLETED

Name of Veteran: [redacted]

Name/Relationship of Contact if other than Veteran:
[redacted]- pt's sister

Date & Time of Contact: Dec 21,2004@15:45

Type of Contact: Telephone

Reason for Contact: I spoke with Pt's sister [redacted] regarding dental care for [redacted].
Option?s discussed include 1. No treatment.
2. Admission to VA medical center for evaluation in the OR of dental problems and necessary tooth extractions.

[redacted] is going to meet with [redacted] Hospice team in the near future at the MVH. Following a discussion of Pt's comfort issues, risks and Benefits of Dental surgery in the OR we will determine if we should admit [redacted] for dental treatment.

Next: [redacted] will call me following her meeting with the Hospice team

/es/ JOHN C OFSTEHAGE
STAFF DENTIST
Signed: 12/21/2004 15:53
Facility: MINNEAPOLIS VAMC

Minnesota Veterans Home
Minneapolis
Dental Program
Scheduling Admission/Annual Exams

Admissions

1. An admission referral for a dental exam is completed when an admission dental packet is compiled and sent to Apple Tree Dental (ATD). An admission dental packet includes an oral health plan, dental referral form, current physician order sheet, history and physical and diagnosis list. Date the admission dental packet is sent will be tracked in the Excel Tickler Dental File
2. Upon receipt of the packet ATD will schedule the admission dental exam.
3. ADT will fax the appointment list to HIM.
4. HIM will provide nursing with the list.
5. Nursing will offer the dental appointment to the resident and involve the Social Worker, as indicated, if a responsible party is involved.
6. Nursing will return the list to Unit HIC indicating the resident acceptance/refusal of the dental appointment. Unit HIC will inform the HIM dept. of refusals. Refusals are to be documented in the Excel Tickler Dental File, Momentum progress notes and Health Maintenance Monitoring form. If the resident/representative accepts the appointment the HIC will note the appointment on the calendar.
7. ATD will be notified of the refusal and schedule the resident for another dental exam.
8. Residents will be offered three consecutive opportunities to accept a dental appointment. After the third refusal, ATD will place the resident on an inactive list and HIM will track for the next annual appointment.

Annual Exams

1. Dept. HIC will track and refer all residents due for an annual dental exam. ATD will track/schedule annual dental exam and fax the appointment list to HIM approximately one week prior to the visits. HIM distributes the list to the units.
2. Nursing will offer the dental appointment to the resident and involve the Social Worker, as indicated, if a responsible party is involved.
3. Nursing will return the list to Unit HIC indicating the resident acceptance/refusal of the dental appointment. Unit HIC will inform the HIM dept. of refusals. Refusals are to be documented in the Excel Tickler Dental File, Momentum progress notes and Health Maintenance Monitoring form. If the resident/representative accepts the appointment the HIC will note the appointment on the calendar.
4. ATD will be notified of the refusal and re-schedule the resident for another dental exam.
5. Residents will be offered three consecutive opportunities to accept a dental appointment. After the third refusal, ATD will place the resident on an inactive list and HIM will track for the next annual appointment.
6. Unit HIC will track in Excel Dental Tickler File all annual dental visits refused by residents. By the fifth working day of every month the Dept. HIC will generate a Dental Referral Exam list for residents who refused the last annual exam and residents due for an annual exam. Dental packets will be completed upon request by ATD..

MINNESOTA VETERANS HOME
Minneapolis

APPLE TREE DENTAL SERVICES PROTOCOL

I. SCHEDULING

A. Admissions

Residents will be referred for a dental examination within 90 days after admission.
*Admission Dental Packet = Oral Health Plan, Dental Referral Form, Physician Order Sheet, History and Physical and Diagnosis list
**Documentation in the progress notes to include: "Resident missed/refused dental appointment on (date). See ATD progress note". Or, "Resident seen by ATD on (date). See ATD progress note".

1. On Admission, the Unit HIC will initiate the Oral Health Plan and Dental Referral by noting the resident name, room number and medical record number on the bottom of the form. The Oral Health Plan will be sent to the Social Worker for completion. The Dental Referral will be sent to Nursing for completion.
2. MVH Social Worker will be responsible to meet with the new resident or resident's representative to complete the Oral Health Plan by or at the time of the Initial Care Conference. Social Worker will complete the Oral Health Plan indicating a determination to receive dental services from Apple Tree or other dental provider and identifying who will make treatment decisions. The Oral Health Plan will be given to the Unit HIC.
3. Nursing will complete the Dental Referral by the Initial Care Conference. The Dental Referral will be given to the Unit HIC.
4. A copy of the Oral Health Plan and Dental Referral is placed in the *admission dental packet and the originals are filed in the medical record under consultation.
5. Admission Dental Packet* is completed for the admission annual dental referral and sent to the Dept HIC who will deliver the packet to Apple Tree Dental during the next visit. Referral will be entered in Momentum by the Dept. HIC
6. Upon receipt of the packet ATD will schedule the admission dental exam.
7. ADT will fax the appointment list to HIM.
8. HIM will provide nursing with the list.
9. Nursing will offer the dental appointment to the resident and involve the Social Worker, as indicated, if a responsible party is involved.
10. Nursing will return the list to Unit HIC indicating the resident acceptance/refusal of the dental appointment. Unit HIC will inform the HIM dept. of refusals. Refusals are to be documented in the Excel Tickler Dental File, Momentum progress notes and Health Maintenance Monitoring form by the unit HIC. If the resident/representative accepts the appointment the Unit HIC will note the appointment on the calendar.
11. ATD will be notified of the refusal and schedule the resident for another dental exam.
12. Residents will be offered three consecutive opportunities to accept a dental appointment. After the third refusal, ATD will place the resident on an inactive list and HIM will track for the next annual appointment.
13. The medical record and a copy of the current medication/treatment sheet accompany the resident for admission exams.
14. Nursing will initiate the Oral Care Plan by the time of the Initial Care Conference

B. ANNUAL EXAMINATIONS

Residents will be referred for an annual dental examination every 12 months.

1. Dept. HIC will track and refer all residents due for an annual dental exam. Referral will be documented in the progress notes by the Dept. HIC.
2. ATD will track/schedule annual dental exam and fax the appointment list to HIM approximately one week prior to the visits.
3. HIM distributes the list to the units.

4. Nursing will offer the dental appointment to the resident and involve the Social Worker, as indicated, if a responsible party is involved.
5. Nursing will return the list to Unit HIC indicating the resident acceptance/refusal of the dental appointment. Unit HIC will inform the HIM dept. of refusals. Refusals are to be documented in the Excel Tickler Dental File, Momentum progress notes and Health Maintenance Monitoring form by the Unit HIC. If the resident/representative accepts the appointment the HIC will note the appointment on the calendar.
6. ATD will be notified of the refusal and re-schedule the resident for another dental exam.
7. Residents will be offered three consecutive opportunities to accept a dental appointment. After the third refusal, ATD will place the resident on an inactive list and HIM will track for the next annual appointment.
8. Unit HIC will track in Excel Dental Tickler File all annual dental visits refused by residents. By the fifth working day of every month the Dept. HIC will generate a Dental Referral Exam list for residents who refused the last annual exam and residents due for an annual exam. Dental packets will be completed upon request by ATD..

II. RETURN FROM DENTAL APPOINTMENT

A. Apple Tree Dental will complete a progress note for every resident seen that includes the name of the dentist or dental hygienist, date of service, specific dental services provided (documentation needs to reflect if this appointment included an annual exam), medications administered, medical or dental consultations, follow-up orders and follow-up appointments.
B. Nursing will review progress notes and follow-up with any orders according to policy and procedure for transcribing physician orders. (Attending physician shall verify/clarify all orders prior to implementation).
C. Dept. HIC will provide the unit HIC with the appointment list noting if the resident was seen for an annual exam. The unit HIC will document the admission/annual dental visits on the Health Maintenance Monitoring form and in the progress notes. **
D. Unit HIC will file the dental (nursing) referral and dental progress notes under the consultation tab in the medical record . Unit HIC will note dental visit in the progress notes.

III. EMERGENCY/DENTAL CONCERNS

A. Emergency/Dental Concerns will be initiated by Nursing on the Request for Dental Exam Form and given to the Unit HIC. Nursing will document request in the progress notes.
B. Unit HIC will send the request to the Dept HIC.
C. Dept. HIC will fax the request to Apple Tree Dental or call it in depending on the situation/time until the next visit.
D. Apple Tree Dental will schedule the appointment and notify the Dept. HIC via a phone call or on the next schedule.

IV. MISCELLANEOUS

A. After every examination or check-up Apple Tree Dental provides a written treatment plan to the resident or their representative. The resident or their representative signs a consent form, a tear-off section which is part of the treatment plan letter. Consent forms must be received by Apple Tree Dental before treatment is started. Treatment plans will not be sent out for emergency visits.
B. Unit HIC notifies the Department HIC of cancellations. Department HIC will notify Apple Tree Dental.
C. All missed appointments will be noted on the Health Maintenance Monitoring form and in the progress notes the Unit HIC.
D. Oral Health Plan will be updated by the Social Worker

maker changes.

E. The Dept.HIC will be the contact between MVH-Mpls and Apple Tree Dental for scheduling all dental appointments and all scheduling concerns. Clinical concerns will be directed to the DON and administrative concerns to the Director of HIM and/or the Assistant Administrator.

F. Dept. HIC will notify Apple Tree Dental of all admissions, discharges and room changes on a monthly basis.

H:\16\Dental\ATDPROTOCOL.doc MVH 3/20/00
REV 08/31/0505

MINNESOTA VETERANS HOME
Minneapolis

ORAL HEALTH PLAN – NURSING CARE UNIT

As part of your admission to the Minnesota Veterans Home, you are being offered dental services through Apple Tree Dental, a private, non-profit, contracted dental service. An Apple Tree dental hygienist will provide an initial oral health screening within the first two months after admission and an oral health screening annually. Should additional dental work be needed, a referral will be made and Apple Tree will provide you or your responsible party a detailed plan of treatment for approval before any work is initiated. At present, most dental services are at no cost to you.

***Admission and annual dental exams will be provided as services allow. You may wish to continue seeing your present dentist, especially if you are currently having dental problems which your dentist is addressing.**

To be completed by/at initial care conference.

Date of last dental exam (check-up): _____

☐ I authorize Apple Tree Dental to provide dental examinations and routine preventive and diagnostic services. Following each exam, as indicated, I understand that I will be provided with a treatment plan, and treatment will not be started without further consent.

☐ I will make arrangements with my dentist, Dr. _____, to provide oral health care and will also provide this health care facility with a written record of a dental exam provided within the last year. (Required by MN Health Department Regulations)

☐ I refuse an admission dental examination. I understand that a dental examination to include routine preventive and diagnostic services will be offered to me on an annual bases. Services will be provided by Apple Tree Dental.

_____ _____
Resident's/Resident Representative's Signature **Date**

TREATMENT DECISIONS

1. Does the resident make treatment decisions? ____ No ____ Yes
   If yes, the resident must sign below.

   _____ _____
   Resident's Signature Date

2. Does the resident's representative make treatment decisions? ___ No ___ Yes
   If yes, the resident's representative must sign below:

   _____ _____ _____
   Representative's Signature **Relationship** **Date**

   _____
   Representative's Name (PRINTED)

   _____ _____
   Address **Phone Number**

   _____
   City **State** **Zip Code**

_____ _____ _____ _____ _____
Resident Name **Bldg/Rm#** **MR#** **Social Security #** **Birth Date**

Distribution: Original- Resident Chart/ Consultation Tab
Copy – Medical Record Clerk/Apple Tree Dental

MINNESOTA VETERANS HOME
Minneapolis

ORAL HEALTH PLAN - BOARDING CARE

As part of your admission to the Minnesota Veterans Home, you are being offered dental services through Apple Tree Dental, a private, non-profit, contracted dental service.

Admission and annual dental exams will be provided as services allow. Should additional dental work be needed, Apple Tree will provide you or your responsible party a detailed plan of treatment for approval before any work is initiated. At present, most dental services are at no cost to you. You may wish to continue seeing your present dentist, especially if you are currently having dental problems which your dentist is addressing.

To be completed by/at initial care conference.

Date of last dental exam (check-up): _____

☐ I authorize Apple Tree Dental to provide dental examinations and routine preventive and diagnostic services. Following each exam, as indicated, I understand that I will be provided with a treatment plan, and treatment will not be started without further consent.

☐ I will make arrangements with my dentist, Dr. _____, to provide oral health care and will also provide this health care facility with a written record of a dental exam provided within the last year. (Required by MN Health Department Regulations)

☐ I refuse an admission dental examination. I understand that a dental examination to include routine preventive and diagnostic services will be offered to me on an annual bases. Services will be provided by Apple Tree Dental.

_____ _____
Resident's/Resident Representative's Signature **Date**

TREATMENT DECISIONS

1. Does the resident make treatment decisions? ____ No ____ Yes
   If yes, the resident must sign below.

   _____ _____
   Resident's Signature Date

2. Does the resident's representative make treatment decisions? ___ No ___ Yes
   If yes, the resident's representative must sign below:

   _____ _____ _____
   Representative's Signature **Relationship** **Date**

   _____
   Representative's Name (PRINTED)

   _____ _____
   Address **Phone Number**

   _____
   City **State** **Zip Code**

_____ _____ _____ _____ _____
Resident Name **Bldg/Rm#** **MR#** **Social Security #** **Birth Date**

Distribution: Original- Resident Chart/ Consultation Tab
Copy – Medical Record Clerk/Apple Tree Dental

MINNESOTA VETERANS HOME
Minneapolis

DENTAL REFERRAL

Resident Name:_____ Bldg/Rm#:_____ MR#:_____

Attending Physician: _____ Date of Appointment:_____

COMPLETED BY MVH STAFF

PROBLEMS TO BE EVALUATED

Reason for Appointment (√) ☐Admission Exam ☐Annual Exam ☐Other (Explain)

_____

_____

Check all that apply: (√) ☐Own Teeth ☐ Denture
☐Upper Full
☐Lower Full
☐Upper Partial
☐Lower Partial

MEDICAL ALERTS

Allergies/Sensitivities: (√)
☐No Known Allergies/Sensitivities

☐ Penicillin	☐ Codeine	☐NSAID:_____
☐Amoxicillin	☐ Aspirin	☐ Other:_____
☐Erythromycin	☐ Lidocaine	☐ Other:_____
☐Tetracycline	☐Novocaine	☐ Other:_____
☐Sulfa	☐ Latex	☐Other:_____

Other Alerts: (√)

☐Premed, heart	☐None
☐Premed, joint	☐Chemotherapy
☐Pacemaker	☐Head/Neck Radiation
☐DNR/DNI	☐Coumadin
☐Steroids	☐ Other:_____
	☐Other:_____

See Attached: Current medical history /Current medications / Current diagnosis list

Requires monitoring for wandering (√) ☐Yes ☐No (If yes, make arrangements for an escort)
Ambulatory? (√) ☐Yes ☐No Needs assistance with transfers? (√) ☐Yes ☐No
Special Needs:_____

Mental Status and Decision Making

	Normal	Slightly Impaired	Severely Impaired
Memory	☐	☐	☐
Orientation	☐	☐	☐
Judgement	☐	☐	☐

☐ This Client makes their own treatment decisions.
☐ This Client's Representative makes treatment decisions.
Representative Name:_____
Phone #:_____

Cooperation, Communication, Behavior Management

☐ Generally Cooperative
☐ Sometimes Uncooperative
☐ Usually Uncooperative
☐ Always Uncooperative

Approaches for managing behavior:
_____
_____
_____

SIGNATURE:_____ DATE:_____
(Nurse Completing Request)

Minnesota Veterans Home
Minneapolis

Health Care Maintenance Monitoring

Influenza Vaccine				Pneumococcal Vaccine		Tetanus Vaccine	
Other Immunizations							

Mantoux 1st Step							Mantoux 2nd Step			Chest X-ray			
Date Read							Date Read						
Induration (mm)							Induration (mm)						

Health Maintenance (record date of lab/test in box)											
Guaiac (date/results)											

Dental Examination											
Date of Exam	Admission										
Date of Refusal											
Date of Missed Appt											

Resident Name _____ Room # _____ MR# _____

Apple Tree Dental Phone: 763-784-7993 Fax: 763-784-5978

Dental Concern: Request For Dental Exam

Resident:	Facility: Minnesota Veterans Home 5101 Minnehaha Ave. So. Minneapolis, MN 55417 Phone #: 612-721-0690 Attention: Health Information Fax #: 612-728-1237	Bldg# Rm# MR#

Is resident currently an Apple Tree Patient? ☐ Yes ☐ No ** If no, send a copy of the following to MVH dental liaison: OHP, Physician Order Sheet, H&P, Diagnosis List

☐ **Denture Concern**

- ☐ Upper Full
- ☐ Lower Full
- ☐ Upper Partial
- ☐ Lower Partial

- ___ Broken Denture
- ___ Broken/Bent Clasp
- ___ Broken/Missing Tooth
- ___ Ill Fitting Denture
- ___ Sore/Bleeding Gums
- ___ Patient Lost Denture
- ___ Staff Lost Denture
- ___ Check-Up (12 month)
- ___ Other_____

☐ **Tooth Concern**

- ☐ Upper
- ☐ Lower
- ☐ Front
- ☐ Back
- ☐ Left
- ☐ Right

- ___ Pain
- ___ Swelling
- ___ Chipped/Broken Tooth/Teeth
- ___ Sensitive Tooth/Teeth
- ___ Loose Tooth/Teeth
- ___ Lost Filling
- ___ Lost Crown
- ___ Cleaning Needed
- ___ Other_____

Requested on Oral Health Screening Form by Apple Tree Dental Screener Date:_____

Reported By:_____ Date:_____

FOR DENTAL LIAISION USE ONLY

Date ATD contacted:_____ Contacted:_____

Date DC Faxed to ATD:_____

Attention: Sharon Pederson or Marcia Marks

Notes:_____

MVH Dental Liaison: Vicki Cuno, Health Information

***Send completed form to MVH Department Health Information Clerk**

For MVH Dental Liaison Use

Appointment Date:_____

Notes:_____

16-41F
H:\16\pc16-41F.doc

MVH 10-97/rev 05/03

Minnesota Veterans Home
Minneapolis

Dental Progress Note File

Resident Name: _____ RM.#: _____ MR#: _____

MINNESOTA VETERANS HOME – Minneapolis
DENTAL DIRECTOR PROGRAM

Apple Dental will provide a Dental Professional Screener to visit the Minnesota Veterans Home monthly to perform the oral screening section of the Minimum Data Set (MDS) and recommend daily oral care plans for every new resident of your facility.

Prior to Dental Director Visit:

- HIC will fill out the information in the top box (plus room and bed numbers) of the Oral Health Screening Form. Nursing will fill in nutritional section.
- Screenings will be completed on:
  - ✓ Anyone due for annual MDS Screening (current month and next month).
  - ✓ New Admits
  - ✓ Residents with significant status change.

When Apple Tree Dental Screener is Present for the MDS Screening Visit:

- Upon arrival to the nurses' station the HIC will present forms for those needing MDS screenings to Apple Tree Dental Screener.
- A staff member escorts the screener to the resident's room for the screening.
- When the Apple Tree Dental Screener is finished at each nurses' station, she will give the completed Screening Forms to the HIC to make copies: Copy goes to screener original form will be filed in the chart.

After Dental Director Visit:

- Nursing will review *Section 2 Daily Oral Care Plan* to see if *Daily Oral Care Plans* have changed.
- HIC will review *Section 3.*
  - ✓ If there is an immediate *Dental Referral Recommendation*, the HIC will initiate a *Dental Concern Form* and send to the HIM Department.
  - ✓ If there is a *Routine Dental Referral Recommendation* Apple Tree Dental will schedule their routine examination when it is due.
- Department HIC who is responsible for making the dental referral will sign the bottom of the *Oral Health Screening Form.*
- The original *Oral Health Screening Form* should be filed in the resident's facility chart after it has been reviewed/initialed off by nursing.

Oral Health Screening Form

Facility Code: _____

Screening Date: _____

Facility Staff - Please complete this section

Type of Screening: [ ] Initial [ ] Annual [ ] Status Change

Resident Last Name: _____ First Name & MI: _____ Soc Sec #: _____

Room & Bed#: _____ Date of Birth: _____ Gender: [M] [F] Payment Type: [ ] MA [ ] PVT [ ] PPS

Diet and Nutrition Problems: [ ] Weight Loss [ ] Nutrition Problem [ ] Feeding Tube [ ] Mechanically Altered Diet

(1) Minimum Data Set Information

a.

	Heavy Debris
	Heavy Plaque
	Heavy Calculus

b.

[ ] None	Dentures
Upper	[ ] Full [ ] Partial
Lower	[ ] Full [ ] Partial

c.

	Missing Teeth w/o Replacement
	Doesn't wear Dentures or Partials
	Problems with Dentures or Partials
	Natural Teeth are Present

d.

	Loose Teeth
	Decayed Teeth
	Broken Teeth/Fillings
	Root Tips Present

e.

	Swollen or Bleeding Gums
	Oral Abscesses, fistulas
	Ulcerations, Denture Sores
	Soft or Hard Tissue Lesions

f.

	Daily Oral Care Needed

SECTION K: ORAL/ NUTRITIONAL STATUS

1.	a. Chewing Problems	a.
	b. Swallowing Problems	b.
	c. Mouth Pain	c.
	d. *NONE OF ABOVE*	d.

SECTION L: ORAL/DENTAL STATUS

1.	a. Debris (soft, easily movable substances) present in mouth prior to going to bed at night	a.
	b. Has dentures and/or removable bridge	b.
	c. Some / all natural teeth lost - does not have or does not use dentures (or partial dentures)	c.
	d. Broken, loose, or carious teeth	d.
	e. Inflamed gums (gingiva); swollen or bleeding gums; oral abscesses; ulcers or rashes	e.
	f. Daily cleaning of teeth/dentures or daily mouth care – by resident or staff	f.
	g. *NONE OF ABOVE*	g.

(2) Daily Oral Care Plan

[ ] Resident Maintains Oral Care Independently
[ ] Resident Needs Staff Supervision
[ ] Resident Needs Direct Staff Assistance

The items checked below are recommended to maintain the oral health of this resident:

[ ] **Toothbrushing** Each morning and evening, brush teeth and gums for 2 minutes using a soft toothbrush and fluoride toothpaste.
[ ] Remove Partial(s) before brushing teeth [ ] Provide dental floss [ ] Electric toothbrush recommended
[ ] Each morning and evening, swish with 2-3 teaspoons of Fluorigard or ACT fluoride rinse for one minute, then spit out.

[ ] **Denture and Partial Denture Care** Once daily, use a toothbrush or denture brush and mild soap to brush dentures and partials –soaking alone will not remove harmful plaque. At bedtime, remove and brush dentures, then soak them in a denture cup overnight. Soak dentures in plain water, or use a cleaning product such as Efferdent or Polident, but do not let the dentures dry out.
[ ] Apply a denture adhesive, such as Fixodent or Polygrip each morning

(3) Dental Care Referral Recommendations

[ ] No Dental Referral. Resident has no need for dental referral at this time.
[ ] Routine Dental Referral. Resident has routine dental care needs.
[ ] Immediate Dental Referral. Resident has urgent dental needs.

Screening and Referral Notes: _____

_____ Apple Tree Screener

Vicki Cuno (612) 721-0690
Facility Staff Responsible for Referrals

MN Veterans Homes Mpls
Interdisciplinary Comprehensive Assessment
August 25, 2005
Minutes

The team members reviewed the current policy for comprehensive assessment / clinical rounds process and accountabilities.

No changes were made to the existing procedures. Review and enforcement of the policy/procedures is required.

It was clarified that the Social Worker will initiate the Safe Smoking Assessment upon admission, smoking incident, and PRN. The IDT will review the assessment as a team and determine if the resident requires any interventions regarding their smoking practices.

Department directors will review the policy with their staff and enforce the timely completion of assessments and related documentation.

An additional meeting will be set up to review the Clinical Rounds and Care Conference meetings to ensure all IDT members are clear on their responsibilities.

STATE OF MINNESOTA
VETERANS HOME - MINNEAPOLIS
OPERATING POLICY AND PROCEDURES

Title: Resident Assessment Instrument (RAI) Number: 01-71

Approvals: Administrator A.S. 11/01 Date: 11/01

POLICY: It is the policy of MVH-Mpls. that a comprehensive assessment, i.e. RAI, including the MDS, RAP's (Resident Assessment Protocols...in conjunction with the RAP Guidelines), be completed upon admission of a resident, quarterly, annually, and if a significant change in status occurs. The Lead MDS Coordinator/designee will track and provide a schedule for MDS completion and monitor for compliance.

PROCEDURE:

I. New Admission:

A. Nursing, Recreation Therapy, Mental Health Services (MHS), PT, and Dietary will complete a departmental assessment between day 2 and day 8 (admission day = day "one") for each newly admitted resident. Data from the departmental assessments will correspond to appropriate sections of the MDS, i.e. MHS= Sections **B**, **E**, and **F**; Dietary = **K**; PT = **G-3**, **G-4**; Recreation Therapy = **N**; Nursing = all other sections.

B. The Admission MDS, and Resident Assessment Protocols (RAP's) will be completed by the unit MDS Coordinator by day 14 of the resident's stay. By signing lines **AA-9a** and **R-2**, the MDS Coordinator is attesting to the accuracy of the submitted MDS data. By signing line **V-B1**, the MDS Coordinator is assuring completion of the RAP's. After RAP and care plan review, the staff person leading the care conference (any interdisciplinary team member, i.e. RN, Social Worker, Dietician etc.) will sign line **V-B2** to assure that appropriate problem areas as identified by the MDS are addressed within the resident's plan of care. The initial care conference will be scheduled by day 21 via Health Information Management.

II. Quarterly MDS Review:

A. Each resident will be reassessed every 84-90 days utilizing the Quarterly MDS form to monitor for changes in resident status. The MDS Coordinator will complete all sections of the Quarterly MDS via staff/resident interview, and utilizing data from the resident's

written record including, Nurses' Weekly Charting, and Quarterly Range of Motion Data Collection Form, and will sign lines **AA-9a** and **R2** attesting to the accuracy and completion of the assessment. A care conference will be scheduled via Health Information Management corresponding with the completion date of the Quarterly MDS.

III. Annual MDS Reassessment:

A. The RAI will be completed within 365 days of the resident's last comprehensive assessment, i.e. Admission MDS, Significant Change MDS, or last Annual MDS Assessment.

B. Eleven days prior to the Annual MDS due date the Lead MDS Coordinator will notify the interdisciplinary team of the seven-day observation period for completing departmental assessments. Each section of the MDS will correspond to a departmental assessment as per the Admission MDS, except Social Services (not MHS) will be responsible for sections **B**, **E**, and **F**.

C. The unit MDS Coordinator will be responsible for completing the MDS and RAP's as per the Admission section above. Health Information Management will schedule care conferences as above.

IV. Significant Change MDS:

A. If at any time during the year a resident experiences a significant change in health status, as defined in the HCFA RAI Version 2.0 Manual (located on all units) and per an interdisciplinary team dialogue, another comprehensive assessment ("Significant Change MDS") will be initiated per the above manual instructions. Subsequent care conferences and MDS's will be scheduled from the date of Significant Change MDS completion.

Minnesota Veterans Home-Minneapolis DATE:_____
Clinical Rounds Review ☐ Admission ☐ Quarterly ☐ Annual ☐ Significant Change

Quality of Life	Comments from Clinical Rounds Discussion
Vulnerabilities Reviewed ☐	
Long Term Goal	
Discharge Plan ☐ Long-term placement ☐ Plans to discharge ☐ Level of care change	
Resuscitation Code Status *Review MD Orders ☐ Full Code ☐ DNR ☐ DNI ☐ Hospice ☐ Comfort Care ☐ LTP	☐ referral to MD for "ability to make HC Decisions"
Social/Personal Support Personal / Business Management/ Psychosocial support services provided ☐ Strengths_____ ☐ Has support of family/friends _____ ☐ 1:1 counseling support_____ ☐ Financial mgt._____ ☐ Group(s)_____ ☐ End of life_____ ☐ Other_____	
Spiritual Care ☐ Worship Services ☐ Recent loss/life change Faith Concerns ☐ yes ☐ no	☐ Chaplain Visit Referral
Therapeutic Recreation Frequency groups attended_____ Program type_____ Goal Met: ☐ yes ☐ no ☐ partially_____ ☐ Goal continue ☐ Goal Change _____ ☐ work therapy program Comments	
Smoking Smoker? ☐ yes ☐ no Any unsafe incidents? ☐ yes ☐ no Any change in risk factors? ☐ yes ☐ no	
Mental Health ☐ Baseline Status ☐ Change From Baseline Status Describe:_____ ☐ Target Behavior:_____ ☐ No Psychotropics used ☐ Psychotropics used Consent in place ☐yes ☐no (circle) antidepressant antipsychotic hypnotic antianxiety ☐ Routine ☐ PRN DX:_____ Describe Problems with: ☐ Behavior: _____ ☐ Cognition: _____ ☐ Mood/thought ☐ MHS Referral for Behavior, Assessment, Therapy Services, Psychiatry Currently involved in:	☐ Referral for Decision Making Assessment

Resident Name: _____ Bldg/RM#: _____ MR#: _____

Quality of Care	Comments from Clinical Rounds Discussion
Medical Condition Baseline? ☐ yes ☐ no. Describe_____ Infection: ☐ MRSA ☐ VRE ☐ HX of TB Location: Precautions: ☐ Contact ☐ Isolation Pain: ☐ No pain ☐ Chronic pain managed Location: _____ Acute/new pain: ☐ yes ☐ no Location: _____ Pain Management Plan: Effective : ☐ yes ☐ no ☐ Routine analgesics/tx's: ☐ PRN's used Update pain management plan: ☐ yes ☐ no	Medical Referral Needed : _____ _____ Temp. Care Plan needed: ☐ yes ☐ no
Skin Skin Impaired ☐ yes ☐ no ☐Chronic Condition Treatment _____ Describe: Location:	Treatment
Nutrition Current Weight (lbs.): _____ Weight: ☐ stable ☐ loss #_____ ☐ gain #_____ Diet/texture: ☐ Hydration Plan Comments:	
Elimination Bladder Continent ☐ yes ☐ no ☐ Assisted _____ ☐ SIC ☐ Foley ☐ S/P Bowel Continent ☐ yes ☐ no ☐ Ostomy Change: _____ At Risk:	
Falls/Safety/ Mobility ☐ No falls Frequency over past quarter(#): ____ ☐ bed alarm ☐ wheelchair alarm ☐locked unit ☐ TAS unit ☐ thigh belt ☐ front closure ☐ rear closure ☐ lap tray ☐ lap buddy ☐ wedge cushion ☐ perimeter mattress ☐ floor matt ☐ Other: _____ Siderails: ☐ half ☐ full ☐ 1 or 2 Straps: ☐ foot ☐ ankle ☐ shoulder Why: Consent in place ☐ yes ☐ no	☐ PT/OT Referral Restraints Reviewed – ☐ Remains least restrictive ☐ Recommend Change
Rehab Status ☐ PT _____ Attends: ☐ OT _____ ☐ Speech _____ Dysphagia Diagnosis / Swallowing Guide in place _____ ☐ Fitness Gym:	
Clinical Rounds Attendee's Signature:	
CARE CONFERENCE REVIEW **DATE:**	
☐ **No change since clinical rounds notation** ☐ **Changes/updates since clinical rounds notation** **Describe:**	
Resident/Family Concerns or Comments:	
Care Conference Attendee's Signature (including resident and family):	

Resident Name: _____ Bldg/RM#: _____ MR#: _____

Title: Resident Focused Documentation System for MVH-Mpls Interdisciplinary Team

Number: 01-76

REV: 12/1/04

Approvals: Administrator A.S. 12-1-04

Date: 01/03

Objective: Resident focused care planning has been proven to improve outcomes for residents. Having individualized problem/issue identification completed by an interdisciplinary team will improve the resident's quality of life and quality of care.

Policy: Pre-screening to discharge is a continuous process versus a segmentation. The work of one part of the team becomes a formal part of the next steps. Interdisciplinary teaming is built in, duplication is minimized, and residents are not asked repeated questions. The framework of this process is:

- Pre-Admission documents are a permanent part of the medical record
- The RNM puts in place predictable interventions prior to admission.
- The designated Nurse further assesses the resident upon admission and adds to the document.
- The interdisciplinary team assessments begin.
- The care plan is developed.
- Interventions are implemented.
- Evaluation towards goals is performed.
- Reassessment is started.

PROCEDURE:

1. **Pre-screening:** Clinical Nurse Specialists
   - A. Determine eligibility of resident
   - B. Determine if holistic needs can be met within the MVH-Mpls Continuum of Care
   - C. Complete Pre-Screening Assessment (M02-298C.vsd)
   - D. Communicate to applicant
   - E. Communicate to Interdisciplinary Team

2. **Pre-admission:** Registered Nurse Manager (RNM)
   - A. RNM or designee begins pre-coordination of care
   - B. Coordinate plan for safety and pressure ulcer prevention so it may be implemented the day of admission
     1. Estimated Braden Score and Proactive interventions
     2. Predictable Fall Potential / Safety Issues / Proactive interventions
     3. Pre-care plan any other issues that need to be addressed for the resident upon admission

3. **Admission:** Nursing
   A. RNM or designated Nurse admits resident
      (1). Complete indicated sections of the Admission Assessment (M02-302C) and scheduled Momentus assessments.
      (2). Initiate Admission Vital Sign /Narrative Notes in Momentus
   B. Add initial resident issues to the Interdisciplinary Care Plan Templates. (MCP-002)
   C. Start communication link with family
   D. Insures all required physician orders are obtained and transcribed
   E. HIM schedules in Momentus
      1. Admission height and weight
      2. Admission vital signs q 4hrs x 24
      3. Admission narrative notes q 4hrs x 24
      4. Risk for falls assessment
      5. Skin Check Questionnaire
      6. Admission Base Care Path

4. **Assessments:** Nursing
   A. RNM or Designated Nurse implement assessment process
   B. Complete the Admission Nursing Data Collection Coordination Form (M02-300C) to assign the assessments.
      1. Assessments include:
         a. Bowel and bladder Incontinence Assessment (02-035c/02-174C)
         b. Pain Assessment (M02-282C)
         c. Risk for Falls (Momentus)
         d. Resident Functional Abilities Form (M02-299C.vsd)
         e. Skin check questionnaire (Momentus)
      2. Assign Mantoux
      3. Assign Skin Inspection
   C. Review the following vulnerable areas for resident specific vulnerabilities.
      1. Exhibiting psychotic or psychopathic behavior, manic-depressive, hallucinations, delusions, delirious, clinically depressed
      2. Combative or physically assaultive
      3. Verbally threatening, poor impulse control
      4. Chemical health drugs, alcohol
      5. Agitated, anxious
      6. Socially isolated – withdrawn, alienated from other residents or staff
      7. Unable to make decisions
      8. Persons unable to perform ADL's
      9. Impaired memory, judgement
      10. Impaired speech and communications
      11. Sensory deficits – visual, auditory
      12. Neurological impairments
      13. Self harm
      14. Suicidal ideation
      15. Persons easily exploited by other residents
      16. Sound deficits
      17. Isolation

5. **RAI Process (MDS, Triggers, RAPs)** Interdisciplianry Team Members

It is the policy of MVH-Mpls. that a comprehensive assessment, i.e. RAI, including the MDS, RAP's (Resident Assessment Protocols...in conjunction with the RAP Guidelines), be completed upon admission of a resident, quarterly, annually, and if a significant change in status occurs.

Accountabilities: The Lead MDS Coordinator/designee will track and provide a schedule for MDS completion and monitor for compliance.

A. **New Admission / Initial MDS:**

1. Nursing, Social Services, Therapeutic Recreation, Mental Health Services (MHS), Rehabilitation, Chaplaincy, and Dietary will complete interdisciplinary assessments between day 2 and day 8 (admission day = day "one") for each newly admitted resident. Data from the departmental assessments will correspond to appropriate sections of the MDS, i.e. MHS= Sections B, E, and F; Dietary = K; PT = G-3, G-4; Recreation Therapy = N; Nursing = all other sections.
2. The Admission MDS, and Resident Assessment Protocols (RAP's) will be completed by the Unit MDS Coordinator by day 14 of the resident's stay. By signing lines **AA-9a** and **R-2**, the MDS Coordinator is attesting to the accuracy of the submitted MDS data. By signing line **V-B1**, the MDS Coordinator is assuring completion of the RAP's. After RAP and care plan review, the staff person leading the care conference (any interdisciplinary team member, i.e. RN, Social Worker, Dietician etc.) will sign line **V-B2** to assure that appropriate problem areas as identified by the MDS are addressed within the resident's plan of care. The initial care conference will be scheduled by day 21 via Health Information Management and / or MDS Coordinator.

B. **Quarterly MDS Review:**

1. Each resident will be reassessed every 84-90 days utilizing the Quarterly MDS form to monitor for changes in resident status. The MDS Coordinator will complete all sections of the Quarterly MDS via staff/resident interview, and utilizing data from the resident's record including, Nurses' Weekly Charting, and Quarterly Range of Motion Data Collection Form, and will sign lines **AA-9a** and **R2** attesting to the accuracy and completion of the assessment. A care conference will be scheduled via Health Information Management corresponding with the completion date of the Quarterly MDS.

C. **Annual MDS Reassessment:**

1. The RAI will be completed within 365 days of the resident's last comprehensive assessment, i.e. Admission MDS, Significant Change MDS, or last Annual MDS Assessment.
2. Eleven days prior to the Annual MDS due date the Lead MDS Coordinator will notify the interdisciplinary team of the seven-day observation period for completing departmental assessments. Each section of the MDS will correspond to a departmental assessment as per the Admission MDS, except Social Services (not MHS) will be responsible for sections **B, E,** and **F.**
3. The unit MDS Coordinator will be responsible for completing the MDS and RAP's as per the Admission section above. Health Information Management will schedule care conferences as above.

D. **Significant Change MDS:**

1. If at any time during the year a resident experiences a significant change in health status, as defined in the CMS RAI Version 2.0 Manual (located on all units) and per an interdisciplinary team dialogue, another comprehensive assessment ("Significant Change MDS") will be initiated per the above manual instructions. Subsequent care conferences and MDS's will be scheduled from the date of Significant Change MDS completion.
2. Significant Change in Status monitoring for a NCU resident will be done at Clinical Rounds:
   a. The MDS coordinator will bring the form to Clinical Rounds
   b. The Clinical Rounds team will review residents who:
      i. have returned from the hospital
      ii. having a change in status per MDS Manual definitions
      iii. have received a new significant diagnosis or newly found terminal diagnosis
   c. The clinical rounds team will have up to 14 days to determine if there is a significant change in status. The decision will be documented on the Significant Change in Status Form M02-312C.
   d. The form is filed under the MDS section of the individual resident's medical record.

6. **Developing the Interdisciplinary Care Plan**

A. As the assessments are completed the interdisciplinary team starts to develop the initial plan of care for the resident.

(1). Each interdisciplinary team member documents - by dating and initialing each entry - indicated problems, goals, approaches required for the involved resident

a. Each member will include indicated risk factors, measurable goals as indicated, and approaches to eliminate or minimize problems, and approaches to strengthen resident's goal achievement.

b. The vulnerable areas that would place the resident at risk for abuse, including self-abuse, neglect and/or financial exploitation are noted on the care plan by an asterisk. Specific measures/approaches to be taken to minimize the risk of abuse shall be part of the care plan.

(2). The MDS Coordinators will take this information and prepare a computerized copy of the care plan and bring it to the Clinical Rounds meeting for approval/editing

(3). The templates may be thinned at the time of approval of the computerized copy of the care plan.

(4). The care plan is reviewed/revised with the resident/family at the Care Conference

(5). It is the responsibility of the Clinical Rounds Team to maintain the accuracy of the resident care plan.

7. **Progress Towards Goals:**

A. Clinical Rounds

(1). Disciplines:

- Nurse Practitioner
- RNM or designated Partnering Nurse
- MDS Coordinator
- Social Worker
- Dietician
- Rehabilitation
- Mental Health Services
- Therapeutic Recreation

- Chaplaincy
- Pharmacist
- Others as indicated

(2). Resident Selection

- Residents due for MDS and Care Conference
- Residents experiencing Significant Change
- Residents who are experiencing problems or change during the week of the Clinical Rounds (Residents with temporary care plans in place)

(3). Content

- Completion of the Clinical Rounds Review Form (MCP-001) See attached.

8. **Reassessment Processes**

A. **Weekly Charting (M02-297c)**

(1). Collection of data to determine the resident's progress towards care planned goals
(2). Noting declines and improvements
(3). Noting Acute illness

B. **Temporary Care Plans**

(1). **Temporary Care Plan Goals: (TCP01-04)**

a. To provide a high quality time efficient process to communicate temporary changes in status of residents in the NCU.
b. To enhance the care planning process so that the care plan reflects the current condition of the resident in between monthly/quarterly interdisciplinary updates.

(2). **Temporary Care Plan Definitions:**

a. *Temporary Care Plan*: A care plan that includes problems that a member(s) of the interdisciplinary team considers to be lasting < 30 days
b. *Template:* A care plan option, which contains basic standards of practice and/or policy/procedure reminders that can be individualized for each resident situation.

(3). **Temporary Care Plan Procedure**

a. When there is a change in a resident's status requiring intervention it should be documented in the nurses'/interdisciplinary Notes and on either the permanent care plan or Temporary Care Plan.
b. Determine if resident qualifies for significant change in condition per MDS criteria: The interdisciplinary team member(s) will **determine if the situation is expected to last <30 days.** If the change is <30 days, the nurse or interdisciplinary team member may:
   - Complete an individualized plan of care using the blank temporary care plan template
   - Utilize the temporary care plan template for resident illness
   - Utilize the temporary care plan template for resident injury
   - The interdisciplinary team member will determine what elements on the template are appropriate for the resident situation and add additional information to individualize it. (See instructions below)
c. **If the resident change is expected to be longer that 30 days in length,** the interdisciplinary team member should alert the MDS Coordinator and ADON to assess the resident for significant change (by MDS definition). If determined that

a significant change has occurred, the care plan will be updated through the significant change assessment process.

d. Directions for completing a Temporary Care Plan Template
- Date and initial the left hand column of the template
- As further changes are made, date and initial the changes as on any legal document. Highlighting out discontinued sections of the plan is acceptable as long as it is dated and initialed.
- Place in the MAR so on-coming nurses will see
- Insure a nurses' note or interdisciplinary note has been written on the situation
- When resolved, the template should be filed behind the permanent care plan in the individual resident's medical record.

C. Significant Change in Condition:

1. When a condition is identified that is considered by clinical judgement to be permanent and/or meets the MDS Significant Change Criteria a significant change in status assessment process is to take place (Comprehensive MDS - Refer to Assessment section above.)

D. Re-admission

(1). Pharmacy will print out the most current listing of the resident's medication on a duplicate carbonless form when the resident is admitted to the hospital. This will have holes for the chart punched in it. It will be delivered to the floor through the pharmacy delivery system.

(2). The Health Information Clerks will place the form in the front of the resident's chart

(3). Upon receipt of the readmission orders form, the GNP will review the previous and new orders. She/he will mark R,C, or D by each order – noting specifics of changes at the bottom of the form. The GNP will bring the duplicate page of the form and a copy of the readmission orders to the pharmacy

(4). The pharmacy will produce a MAR/TAR from the information and send the order listing, MAR/TAR to the station. The timeframe will be approximately 1-2 hours if received before 2:30 PM. If received after, call the pharmacy to see if MAR/TAR will be available.

a. The partnering nurse will send the following to the pharmacy:
- review the ancillary orders
- review the allergy listing
- attach a copy of the discharge summary if available
- return medications needed a label change

(5). The nurse on duty will transcribe the orders. She/he will also include reviewing the chart for **any orders or ancillary orders missed from prior to the hospitalization**

(6). If the nurse practitioner or pharmacy services are not available, the nurse will call the Medical Officer of the Day for confirmation of the orders.

Minnesota Veterans Home
Minneapolis
Procedure for Admission Documentation

Phase I: Pre-Screening / Clinical Specialist RN

A. The Clinical Specialist RN's will document information obtained on a resident through the pre-screening process on the **NURSING PRE-ADMISSION ASSESSMENT.**

B. The original **NURSING PRE-ADMISSION ASSESSMENT** will be filed in the administrative folder in Admissions Office.

C. A copy will be attached to the admission packet that goes to the RN Nurse Manager on the admitting unit.

Phase II: Pre-Admission / RN Nurse Manager (RNM)

A. The RNM will review the **NURSING PRE-ADMISSION ASSESSMENT.** He/she will then initiate the **ADMISSION CARE PLAN.** At a minimum, the resident's safety plan, pressure ulcer prevention plan, and ADL plan will be addressed.

B. The RNM will make arrangements for specialized equipment, pressure relieving mattresses, safety devices to be available prior to the admission.

C. The RNM will delegate assignments for new admission assessments on the **ADMISSION NURSING DATA COLLECTION COORDINATION** form.

Phase III: Admitting RN/LPN

A. The admitting RN/LPN will:

1. Greet the resident
2. Review the **NURSING PRE-ADMISSION ASSESSMENT**
3. Review the RNM comments
4. Review the **ADMISSION CARE PLAN**

B. Update with additional information:
1. Communication
2. Behavioral concerns initially noted
3. ADL's
4. Nutrition/Hydration
5. Elimination
6. Mobility

7. Safety Plan
8. Pain Management plan
9. Sleep pattern concerns
10. Acute diagnosis concerns
11. Pressure Ulcer Prevention Plan
12. Complete the **ADMISSION ASSESSMENT** including
13. Skin inspection
14. Height / weight
15. Last bowel movement
16. Neurological baseline
17. Vital signs every 4 hours times 24 hours (record in Momentus).
18. Pain rating with vital signs
19. Lying and standing blood pressure baseline
20. Noting special personal devices: dentures, hearing aids, pacemaker check boxes, glasses, etc.
21. ***Write an incidental status entry in the Nurses' Notes every 4 hours times 24 hours in Momentus.***

C. Interdisciplinary Team Assessments:

1. Range of motion
2. Cognition assessment
3. Dietary
4. Therapeutic recreation
5. Social Service
6. Spirituality
7. Rehabilitation as indicated
8. Others as indicated by resident need

Minnesota Veterans Home
Minneapolis
Guide for Completing "Clinical Rounds / Care Conference Form"

This form is meant not only as a way to more fully capture the interdisciplinary discussion of residents at clinical rounds who are scheduled for upcoming care conferences, but as a guide and documentation tool for the care conference itself. In the future, some version of this form (and attached informational letter) could also be used as a routine communication tool for families.

What follows is a step-by-step guide for the interdisciplinary (ID) team members attending Clinical Rounds (page 1) and those attending the Care Conferences (side 2) for completing the form.

1. Each Clinical Rounds group is to designate a **recorder.** The recorder is to complete the **"Clinical Rounds / Care Conference Form"** and also document indicated aspects of the clinical discussion in the individual resident's medical record.
   A. Here are options for selecting a recorder:
      1. Each ID member selects one of the residents on the schedule
      2. A fixed rotation of one designated recorder
      3. Selecting a volunteer
      4. * Note: For the sake of experience it is more beneficial to rotate this role, i.e. not having the same person be designated as the recorder each week.
2. The residents reviewed at Clinical Rounds are scheduled for the next week's care conferences. This will include residents up for **annual, quarterly, admission** and **significant change** review. Non-scheduled residents with concerns, multiple falls, or other acute health or safety issues are also to be brought up at this time (discussion of non-scheduled residents should be documented in a progress note versus the Clinical Rounds form).

3. The date of the Clinical Rounds discussion and review type should be recorded at the top of the page 1.

4. The Long-Term Goal should be written in the space provided. The resident's current long-term goal can be found on the cover sheet at the beginning of the care plans. If the team finds the goal has been met or is outdated, a recommendation can be made to review/rewrite the goal at the care conference.

5. Designate with a "✓" the current Discharge Plan (located on the care plan cover sheet). If changes to the plan are to be made, check the appropriate option. Follow-up documentation will be recorded at the care conference.

6. Medical Condition can be answered with the GNP's and unit nurse's input.

7. Indicate the Resuscitation Code Status. The current order can be found on the Physician's Order form in the Physician Order portion of the chart.

8. Information regarding Restraints and non-restraining (NR) devices can also be found on the Physician's Order form. The GNP, partnering nurse, RNM, or OT staff can help provide accurate information.

9. Any ID member can help provide input regarding Mood / Behavior / Cognition, and if referrals should be made to MHS, VA psychiatry, or Chaplaincy. A nurse or GNP can help indicate if psychotropics are used and if an accompanying diagnosis is listed.

10. Spiritual Care information and needs should be indicated, or if there are "no concerns at this time". Referrals to Chaplaincy may be indicated here.

11. Data regarding Therapeutic Recreation should be indicated by the TR staff.

12. Skin status can be indicated with input from the partnering nurse, RNM, or GNP.

13. The dietician will have information regarding Nutrition, including current weight.

14. Data regarding Falls can be found on the Falls Flow Sheet (in the Flow Sheet portion of the chart).

15. Representatives from PT and OT can help the recorder complete the Rehab Status section of the form. Resident communication or swallowing issues/concerns indicating a need for Speech Therapy services can be documented here (referrals need an MD order).

16. Clinical Rounds Attendee's Signatures to be recorded. ** Prior to the care conference, each discipline should review their resident goals, document this review by highlighting the last review date (next to the goal on the care plan), write in the next date of review, initial next to this date, and indicate the discipline responsible.**

17. Upon completion of page 1, the form should be filed in the Care Plan portion of the chart, after the resident's care plan and before the MDSs.

18. Those staff attending the Care Conference can review the Clinical Rounds documentation on page 1 with the resident and family at the care conference. On page two, designate with a "✓" if the information on page 1 remains current and correct. If changes have occurred, "✓" the appropriate space and provide an explanation in the Comments section. Resident goal review and care plan updates may be documented here as well as resident and family comments.

19. After the care conference, Page 2 should be signed by those attending including the resident and family and dated. Both pages should have the resident's name, room #, and medical records # documented at the spaces provided at the bottom.

MN Veterans Home – Minneapolis
MDS Significant Change Determination

Reason for Significant Change Discussion: A Decline / Improvement is noted that: (Check all that apply)

☐ Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, is not self-limiting.	☐ Impacts more than one area of the resident's health status; and Requires interdisciplinary review and/or revision of the care plan.

Improvement in two of more of the following	**Decline in two or more of the following or Primary Discipline Requests a Significant Change in Status Assessment be done**	
☐ Any improvement in an ADL physical functioning area where a resident is newly coded as 0,1, or 2 when previously scored as 3,4, or 8 G1A	☐ Resident's decision-making change from 0 or 1 to 2 or 3 for item B4	☐ Unplanned weight loss problem (5% in 30 days or 10% in 180 days) K3a
☐ Decrease in the number of areas where Behavioral Symptoms or Sand or Anxious Mood are coded as "not easily altered" E2 and E4B	☐ Emergence of sad or anxious mood pattern as a problem that is not easily altered (Item E2)	☐ New pressure ulcer at Stage II or higher, when no pressure ulcers were previously present at Stage II or higher M2a
☐ Resident's decision-making changes from 2 or 3 to 0 or 1: B4	☐ Increase in the number of areas where Behavioral Symptoms are coded as "not easily altered"	☐ Resident begins to use trunk restraint or a chair that prevents rising when it was not used before P4c and e
☐ Resident's incontinence pattern changes from 2,3, or 4 to 0 or 1 H1a or b	☐ Any decline in an ADL physical functioning area where a resident is newly coded as 3,4, or 8 for G1A	☐ Overall deterioration of resident's condition; resident receives more support Q2=2
☐ Overall improvement of resident's condition; resident receives fewer supports Q2=1	☐ Resident's incontinence pattern changes from 0or 1 to 2,3,or 4 (H1a or b) or there was placement of an indwelling catheter (Item H3d);	

☐ Does not meet significant change criteria: (must include rationale)

_____
_____
_____
_____

☐ Does meet significant change criteria:

_____
_____
_____
_____

Assessment Reference Date:	Date MDS Due:
HIM Notified on:	Date Care Conference Scheduled:

Date / Interdisciplinary Team Signatures:

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

Resident: _____ Med. Rec. #_____ / Room # _____

"Serving Those Who Have Served"

MN Veterans Homes – Minneapolis
Quality of Care Standards – Nursing Care Units

Nursing care and services are performed to:

- maximize the residents' current abilities
- preserve and/or restore functional status
- support residents' freedom of choice
- provide for resident privacy and ensure a safe environment.
- follow the residents' plan of care
- provide for and maintain resident dignity and right to confidentiality
- perform tasks within the scope of the employee's training and ability
- administer care which promotes dignity and respect.
- communicate significant resident information to appropriate care team members
- comply with MVH policies/procedures
- comply with MDH and VA regulations

Promote a resident-centered environment:

- primary focus is physical, mental and emotional well-being of each resident
- supports an environment of trust dignity and caring.
- maximize the comfort level of the residents through pain management. Pain assessment is the 5th vital sign.

Comprehensive Resident Assessment and Care Planning:

- all residents receive a comprehensive assessment through the RAI/MDS process.
- RAPS are completed
- items of concern are communicated on the resident focused care plan
- goal attainment is measured during the quarterly process and when a significant change in status is identified
- all nursing staff are aware of the contents of individual residents in their care.

ersonal Cares :

- Bathing:
  1. Each resident receives a bathe or shower a minimum of one time per week and as needed and as desired.
  2. Provide for resident privacy throughout the procedure including to and from the tub room
  3. The safety belt is applied to and worn by all residents in the tub throughout the bath.
  4. Observe and report skin conditions to licensed staff

  Note: NCU residents are not to be unsupervised in tub/shower rooms.

- Dressing:
  1. Clothing is changed daily and as needed
  2. Residents are dressed appropriately for weather, activity level, social acceptability and to maintain privacy / dignity.
  3. Clothing protectors are applied as needed while dining and are removed before the resident leaves the dining area.
  4. Footwear is appropriate to the resident mobility status.
  5. Privacy and dignity are maintained throughout the process of dressing.
  6. Clothing items are labeled with the resident's name.

- Grooming

  Monitor, encourage participation, assist and/or perform resident grooming which includes:

  1. Shaving: daily and as needed
  2. Deodorant: daily
  3. Nail Care: weekly and as needed (clean and trim)
  4. Hair care: Combed daily, washed weekly and as needed
  5. Oral Care: Twice a day and as needed

"Serving Those Who Have Served"

Nutrition and Dining:

- Nursing staff will assist resident's in completing hand hygiene prior to each meal and follow infection control policies through out the meal
- Trays are picked up and served promptly within 5-10 minutes of arrival.
- Trays are served to all residents at each dining room table before assisting individuals.
- Staff is present throughout the meal. Licensed staff is available on the unit.
- Resident focused atmosphere and conversation are maintained throughout the dining experience
- Residents receive the required (including care planned items) assistance through out the meal.
- Staff are seated while assisting residents with their meal
- Nutritional supplements are provided in the type, amount and time indicated
- Documentation of nutritional supplement consumption is completed promptly
- Fluids are offered to the residents frequently throughout the day.
- Intake report and/or record is monitored/documented as indicated.
- Fresh water {at the proper consistency} will be supplied every shift.

Positioning:

- Residents are positioned in a manner to promote comfort and allow for maximum freedom of movement.
- Turning and repositioning is done every 2 hours or as care planned through individual assessments.
- Positioners, enablers, and restrictive devices all are <u>least</u> restrictive, have a physician / NP order including medical symptom, and a plan for re-evaluation of tolerance and effectiveness.

Resident mobility:

It is the goal of the nursing department to assist the resident to maintain their highest level of functioning. All residents will be assessed and care planned for their individualized mobility plan containing:

- Transfer technique
- Plan for ambulating as assessed
- AROM / PROM as assessed
- Bed mobility

Resident / Staff Safety:

- Suspected abuse or neglect is reported immediately to the nursing supervisor, nurse manager, director of nursing or social worker
- Mechanical lifts will be used as assessed specific to type. This will be noted on the care plan
- The use of transfer belts is <u>required</u> on all physically assisted transfers.
- Nursing and housekeeping staff promptly resolves spills and wet spots on the floor.
- Equipment that is in disrepair, inoperable or unsafe is reported to the maintenance department and removed from the patient care area.

Customer Service:

- Call lights will be answered within 3-5 minutes and tub room/bathroom call lights are responded to immediately.
- Each resident will be addressed by the name they prefer and in a respectful way.
- All nursing staff are responsible for answering call lights in a timely and courteous manner.
- The call light cord is accessible for the resident's use.

ction Control policies and guidelines will be followed and include:

- Hand hygiene
- Use of Personal Protective Equipment
- Providing nursing services in a way that minimizes the transfer of pathogens.

"Serving Those Who Have Served"

Resident and staff safety:

- Residents are monitored a minimum of every two hours and more frequently as indicated.
- Resident environment is maintained free of hazards and obstacles
- Egress paths are consistently clear of obstacles.
- Rooms and beds are labeled with resident names.
- Wrist bands are legible and on all residents.

Resident Dignity and Privacy

- Knock before entering rooms
- Always ensure privacy for conversation and cares
- Use respectful tones
- Resident medical records are not left unattended in the public view
- MAR's are closed or covered when away from the cart
- Queries into resident status by others are referred to the nurse

Minnesota Veterans Home-Minneapolis
Resident Care Audit

Date / Shift of Audit: _____ / _____ Unit: _____
Auditor: _____
Instructions: Record resident's name, complete the audit with yes or no answers. If the answer is no, contact RNM before leaving the unit. Return completed audit form to RNM..

Standard / Resident	Name	Name	Name	Name	Name	Name	Name	Name
Resident appears well groomed.								
*Oral hygiene has been done								
Fingernail are clean and trimmed								
Facial hair is absent (except for beards/mustaches)								
Hair is neatly combed								
*Repositioning {every 2 hours} of residents have occurred and documented on HST assignment list.								
*The incontinent resident is dry and odor free								
*Treatment plan has been followed regarding incontinent residents. Check and changed q 2 hours.								
*Resident has been offered fluids within the past 2 hours. Note: res that require thickened liquids								
Hearing Aids are in and on								
Glasses are clean and worn								
*Splints / therapeutic appliances are on as ordered								
Residents clothes are clean and worn in a dignified manner								
Proper foot attire is being worn.								
Ward Order								
Bed has been made. Room is neat, no personal belongings on floor.								
Fresh Water and **cup** is at bedside. (n/a on 6-3) **NOTE: Exception those that require thickened liquids**								
*Gloves are readily available and worn according to MVH policy								
*No Incontinent pads on the floor								
*No linen on the floor								
*No food containers or incontinent pads in the waste basket in the room								
When assisting with meals staff is sitting with resident. {Not standing}								

Use back of form to document actions taken.

- NOCs

MN Veterans Homes Minneapolis
Internal Monitor
August / September 2005

Thank you for agreeing to be the shift monitor.

The purpose of the monitor is to validate that care standards are being met and if the care standards are not being met, what was the obstacle to having the care standards met.

Here is the procedure I would like you to follow:

1. Introduce yourself to the units and let them know your purpose.
2. Select 2 or more residents per NCU unit that are dependent on staff for cares such as toileting, repositioning, restraint release, oral cares, hydration, etc.
3. Don't share who the residents are initially.
4. You may note the time and positioning of a resident, or if the resident does not object, mark the incontinent pad with a time.
5. Come back after two hours have passed and see if the cares have been provided.
6. If the cares have not been provided, gather the nurse and the HST assigned to the resident. Ask them:
   A. What were the obstacles or barriers that kept you from providing the required care - ask them to be as specific as possible?
   B. What would help remove those barriers?
   C. Let them know that we are "friendly fire" looking for solutions from versus criticism of staff.
7. Also, select random room ensuring the water pitcher liner date is today's date, denture cups are dated within the month, oxygen tubing is no older than 1 week, toiletries are not in shared bathrooms.
8. Do a spot check of oral care being performed.
9. Also, monitor glove use.
10. Check that med / tx carts are locked and confidential information is not left open.
11. Check that in between med passes the juices / applesauces are dated, covered, and placed in the refrigerator.
12. Ensure charts are not left unattended on the floor.

It's a big job, but it is necessary now as we rebuild the structure of the nursing department and restore quality care as we "Serve Those Who Have Served".

Please leave your findings in the nursing supervisor office with at note, "for Diane Vaughn".

Thank you!

Minnesota Veterans Home-Minneapolis
Resident Care Audit

Date / Shift of Audit: _____ / _____ Unit: _____
Auditor: _____
Instructions: Record resident's name, complete the audit with yes or no answers. If the answer is no, contact RNM before leaving the unit. Return completed audit form to RNM..

Standard / Resident	Name	Name	Name	Name	Name	Name	Name	Name
Resident appears well groomed.								
*Oral hygiene has been done								
Fingernail are clean and trimmed								
Facial hair is absent (except for beards/mustaches)								
Hair is neatly combed								
*Repositioning {every 2 hours} of residents have occurred and documented on HST assignment list.								
*The incontinent resident is dry and odor free								
*Treatment plan has been followed regarding incontinent residents. Check and changed q 2 hours.								
*Resident has been offered fluids within the past 2 hours. Note: res that require thickened liquids								
Hearing Aids are in and on								
Glasses are clean and worn								
*Splints / therapeutic appliances are on as ordered								
Residents clothes are clean and worn in a dignified manner								
Proper foot attire is being worn.								
Ward Order								
Bed has been made. Room is neat, no personal belongings on floor.								
Fresh Water and **cup** is at bedside. (n/a on 6-3) **NOTE: Exception those that require thickened liquids**								
*Gloves are readily available and worn according to MVH policy								
*No Incontinent pads on the floor								
*No linen on the floor								
*No food containers or incontinent pads in the waste basket in the room								
When assisting with meals staff is sitting with resident. {Not standing}								

Use back of form to document actions taken.

- NOCs

Minnesota Veterans Home - Mpls
Resident Care Worksheet

Date: ____________________ Unit/Team _____/_____

Resident	Oral Care		Circle Hour Resident Repositioned / Toileted																								Comments
Repositioned (R) / Toileted (T)	AM	PM																									
			R	23	24	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	
			T	23	24	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	
			R	23	24	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	
			T	23	24	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	
			R	23	24	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	
			T	23	24	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	
			R	23	24	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	
			T	23	24	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	
			R	23	24	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	
			T	23	24	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	
			R	23	24	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	
			T	23	24	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	
			R	23	24	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	
			T	23	24	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	
			R	23	24	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	
			T	23	24	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	
			R	23	24	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	
			T	23	24	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	
			R	23	24	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	
			T	23	24	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	
			R	23	24	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	
			T	23	24	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	

1. Circle the time you complete positioning and toileting on each resident
2. Initial when oral cares are completed
3. Return this document to the staff nurse at the end of your shift

Night shift: HST: ____________________ Nurse Review: ____________________

Day shift: HST: ____________________ Nurse Review: ____________________

Evening Shift: HST: ____________________ Nurse Review: ____________________

RNM: ____________________

Thank you for "Serving Those Who Have Served."

Minnesota Veterans Home- Minneapolis -DRAFT#1

GUIDELINES FOR GLOVE USE

Health care workers wear gloves to:

- Reduce the risk of acquiring infections
- Prevent health care worker flora from being transmitted to residents
- Reduce the transmission of flora from resident to resident via the health care worker.
- Prevent the transmission of hepatitis B, hepatitis C and HIV.

Did you know?

Gloves do not provide complete protection against hand contamination.
Wearing gloves does not provide complete protection against acquisition of infections caused by hepatitis B virus and herpes simplex.
Failure to change gloves between residents may contribute to the transmission of organisms.
Weather the wearing of rings results in greater transmission of pathogens remains unknown, further research is indicated.

Gloves are worn when:

- Personal care is provided to residents.
- There is a possibility of having contact with blood or body fluids.
- Contact with mucous membranes or non-intact skin.
- Personal protection is indicated.

Change gloves during resident care if moving from a contaminated body site to a clean body site.
Hands must be washed immediately after gloves are removed.

Source: Guideline for Hand Hygiene in Health-Care Settings: MMWR. October 25, 2003/51{RR16}:1-44

"Serving Those Who Have Served"

MN Veterans Homes – Minneapolis
Quality of Care Standards – Nursing Care Units

Nursing care and services are performed to:

- maximize the residents' current abilities
- preserve and/or restore functional status
- support residents' freedom of choice
- provide for resident privacy and ensure a safe environment.
- follow the residents' plan of care
- provide for and maintain resident dignity and right to confidentiality
- perform tasks within the scope of the employee's training and ability
- administer care which promotes dignity and respect.
- communicate significant resident information to appropriate care team members
- comply with MVH policies/procedures
- comply with MDH and VA regulations

Promote a resident-centered environment:

- primary focus is physical, mental and emotional well-being of each resident
- supports an environment of trust dignity and caring.
- maximize the comfort level of the residents through pain management. Pain assessment is the 5th vital sign.

Comprehensive Resident Assessment and Care Planning:

- all residents receive a comprehensive assessment through the RAI/MDS process.
- RAPS are completed
- items of concern are communicated on the resident focused care plan
- goal attainment is measured during the quarterly process and when a significant change in status is identified
- all nursing staff are aware of the contents of individual residents in their care.

Personal Cares :

- Bathing:
  1. Each resident receives a bathe or shower a minimum of one time per week and as needed and as desired.
  2. Provide for resident privacy throughout the procedure including to and from the tub room
  3. The safety belt is applied to and worn by all residents in the tub throughout the bath.
  4. Observe and report skin conditions to licensed staff

  Note: NCU residents are not to be unsupervised in tub/shower rooms.

- Dressing:
  1. Clothing is changed daily and as needed
  2. Residents are dressed appropriately for weather, activity level, social acceptability and to maintain privacy / dignity.
  3. Clothing protectors are applied as needed while dining and are removed before the resident leaves the dining area.
  4. Footwear is appropriate to the resident mobility status.
  5. Privacy and dignity are maintained throughout the process of dressing.
  6. Clothing items are labeled with the resident's name.

- Grooming

  Monitor, encourage participation, assist and/or perform resident grooming which includes:

  1. Shaving: daily and as needed
  2. Deodorant: daily
  3. Nail Care: weekly and as needed (clean and trim)
  4. Hair care: Combed daily, washed weekly and as needed
  5. Oral Care: Twice a day and as needed

"Serving Those Who Have Served"

Nutrition and Dining:

- Nursing staff will assist resident's in completing hand hygiene prior to each meal and follow infection control policies through out the meal
- Trays are picked up and served promptly within 5-10 minutes of arrival.
- Trays are served to all residents at each dining room table before assisting individuals.
- Staff is present throughout the meal. Licensed staff is available on the unit.
- Resident focused atmosphere and conversation are maintained throughout the dining experience
- Residents receive the required (including care planned items) assistance through out the meal.
- Staff are seated while assisting residents with their meal
- Nutritional supplements are provided in the type, amount and time indicated
- Documentation of nutritional supplement consumption is completed promptly
- Fluids are offered to the residents frequently throughout the day.
- Intake report and/or record is monitored/documented as indicated.
- Fresh water {at the proper consistency} will be supplied every shift.

Positioning:

- Residents are positioned in a manner to promote comfort and allow for maximum freedom of movement.
- Turning and repositioning is done every 2 hours or as care planned through individual assessments.
- Positioners, enablers, and restrictive devices all are least restrictive, have a physician / NP order including medical symptom, and a plan for re-evaluation of tolerance and effectiveness.

Resident mobility:

It is the goal of the nursing department to assist the resident to maintain their highest level of functioning. All residents will be assessed and care planned for their individualized mobility plan containing:

- Transfer technique
- Plan for ambulating as assessed
- AROM / PROM as assessed
- Bed mobility

Resident / Staff Safety:

- Suspected abuse or neglect is reported immediately to the nursing supervisor, nurse manager, director of nursing or social worker
- Mechanical lifts will be used as assessed specific to type. This will be noted on the care plan
- The use of transfer belts is required on all physically assisted transfers.
- Nursing and housekeeping staff promptly resolves spills and wet spots on the floor.
- Equipment that is in disrepair, inoperable or unsafe is reported to the maintenance department and removed from the patient care area.

Customer Service:

- Call lights will be answered within 3-5 minutes and tub room/bathroom call lights are responded to immediately.
- Each resident will be addressed by the name they prefer and in a respectful way.
- All nursing staff are responsible for answering call lights in a timely and courteous manner.
- The call light cord is accessible for the resident's use.

Infection Control policies and guidelines will be followed and include:

- Hand hygiene
- Use of Personal Protective Equipment
- Providing nursing services in a way that minimizes the transfer of pathogens.

"Serving Those Who Have Served"

Resident and staff safety:

- Residents are monitored a minimum of every two hours and more frequently as indicated.
- Resident environment is maintained free of hazards and obstacles
- Egress paths are consistently clear of obstacles.
- Rooms and beds are labeled with resident names.
- Wrist bands are legible and on all residents.

Resident Dignity and Privacy

- Knock before entering rooms
- Always ensure privacy for conversation and cares
- Use respectful tones
- Resident medical records are not left unattended in the public view
- MAR's are closed or covered when away from the cart
- Queries into resident status by others are referred to the nurse

State of Minnesota Veterans Home – Minneapolis
NURSING POLICY AND PROCEDURES

Title: Thickened Liquids

Number: N02-151
23-26
19-043
10-057

DRAFT #2
09/02/05

Approvals: Director of Nursing
Director of Dietary
Medical Director

Date: 09/05

Page: 1 of 1

Objective: To ensure that residents at risk for aspiration receive the right consistency of liquids while attending on and off unit events.

Policy:

Procedure:

A. Following a comprehensive assessment, if a resident is found to be at risk for aspiration requiring thickened liquids, the following will occur:
   1. The speech therapist, dietitian, or nurse practitioner writing the order for non-thin liquids will notify the HIC:
      a. In person or
      b. Via the HIC Communication Board
   2. The HIC will place a blue colored insert into the identification band of the individual resident.
   3. All departments will be aware that residents with blue name band inserts may not have thin liquids being offered.
   4. Departments hosting the resident event are responsible for ensuring a current list of resident diets/consistencies are readily available and an alternative beverage at the right consistency is available.

B. At special events, staff will note name band. If blue insert, will verify fluid consistency on current listing before serving the beverage.

C. During medication passes, the resident is to receive the ordered consistency of fluid. For current products available:
   1. Water is available in all consistencies
   2. Nectar level fluids for medication passes or between meals include:
      a. health shakes
      b. pudding,
      c. applesauce,
      d. ice cream,
      e. magic cups
   3. Honey level fluids for medication passes or between meals include:
      a. pudding,
      b. applesauce,
      c. magic cups

Minnesota Veterans Home- Minneapolis [redacted]
GUIDELINES FOR GLOVE USE

Health care workers wear gloves to:

- Reduce the risk of acquiring infections
- Prevent health care worker flora from being transmitted to residents
- Reduce the transmission of flora from resident to resident via the health care worker.
- Prevent the transmission of hepatitis B, hepatitis C and HIV.

Did you know?

Gloves do not provide complete protection against hand contamination.
Wearing gloves does not provide complete protection against acquisition of infections caused by hepatitis B virus and herpes simplex.
Failure to change gloves between residents may contribute to the transmission of organisms.
Weather the wearing of rings results in greater transmission of pathogens remains unknown, further research is indicated.

Gloves are worn when:

- Personal care is provided to residents.
- There is a possibility of having contact with blood or body fluids.
- Contact with mucous membranes or non-intact skin.
- Personal protection is indicated.

Change gloves during resident care if moving from a contaminated body site to a clean body site.
Hands must be washed immediately after gloves are removed.

Source: Guideline for Hand Hygiene in Health-Care Settings: MMWR. October 25; 2003/51{RR16}:1-44

Cart Number	Locked	Unlocked	Nurse Present	Meds out on Cart	MAR Confidential
Med Cart 1					
Med Cart 2					
Med Cart 3					
Tx 1					
Tx 2					
Tx 3					
Comments:					

Unit ID:

Tech/RPh ID:

Date:

Time:

State of Minnesota Veterans Home – Minneapolis
NURSING POLICY AND PROCEDURES

Title: Urinary Incontinence Management DRAFT #1 9-2-05 Number: N02-150

Approvals: DON/Medical Director Date: 09/05

Objective: To identify the type of urinary incontinence as resident has, so appropriate interventions may be initiated.

Policy:

Procedure:

A. Upon admission and PRN, resident that are incontinent of urine will be assessed as follows:
   1. A 3 day voiding assessment will be completed by the nursing unit during the initial MDS assessment period.
   2. The nurse practitioner/physician will order a bladder scan to determine the post void residual (PVR).
   3. The results of the MMSE, BRADEN Scale, Functional Abilities, PVR, and 3 day voiding assessment will be reviewed by the nurse practitioner or physician. (See Momentus form).
   4. The nurse practitioner or physician will determine the type/types of urinary incontinence the resident has.
   5. Based on the type of UI identified, appropriate interventions will be ordered and care planned. (See house protocol in policy appendix).
   6. Upon new incidence of UI, this process may be initiated at anytime. (i.e., significant change in status).

Appendix (draft-needs further review)
Toileting Programs

Bladder Retraining

A. Individualized Bladder Retraining

This is for a resident who is able to learn and retain new information and has the physical ability and desire to retrain the bladder to treat incontinence. Each program will be individually set up based on the resident's needs and etiology of incontinence.

B. Prompted Voiding

   1. From an individualized schedule determined by the resident's 3 day voiding assessment or
   2. From the facility schedule:
      a. Upon rising from bed.
      b. Before laying down in bed.
      c. Before leaving the floor for meals.
      d. Upon return to the floor from meals.

*"Upon" is defined as within 30-60 minutes.

Scheduled Toileting

Residents who are unable to identify or communicate to staff regarding toileting needs. They will be toileted with hands on assistance from staff:

A. Based on an individualized schedule determined by the resident's 3 day voiding assessment or
B. From the facility schedule:
    1. Upon rising from bed.
    2. Before laying down in bed.
    3. Before leaving the floor for meals.
    4. Upon return to the floor from meals.

*"Upon" is defined as within 30-60 minutes.

Check and Change

Residents who are either physically unable to be toileted comfortably or who are extremely agitated by the toileting process. These residents will be checked for wetness, changed and cleaned if wet on the following schedule:

A. Based on an individualized schedule determined by the resident's 3 day voiding assessment or
B. From the facility schedule:
    a. Upon rising from bed.
    b. Before laying down in bed.
    c. Before leaving the floor for meals.
    d. Upon return to the floor from meals.

*"Upon" is defined as within 30-60 minutes.

Some residents may be on scheduled toileting during the day and on check and change at night, based on individual resident assessment.

MN Veterans Home – Minneapolis
Urinary Incontinence Assessment

Goal: To define the type of urinary incontinence a resident has and individualized interventions.

Relevant Data:

Assessment Type / Date	Outcome	Comment
MMSE		
BRADEN		
Functional Status review or Case Mix Score		
Post Void Residual		
3 – Day Voiding Assessment		

Type(s) of Incontinence and Interventions

Check Type(s)	AHRQ Incontinence Types	Select Interventions
	Transient Acute	❑ Further medical evaluation – see physician order section ❑ Individualized bladder retraining to be evaluated / treated by occupational therapy ❑
	Chronic Urge	❑ The resident may be toileted at intervals consistent with their assessed voiding pattern utilizing the facility toileting protocols ❑ ❑ ❑
	Chronic Stress	❑ The resident may be toileted at intervals consistent with their assessed voiding pattern utilizing the facility toileting protocols ❑ Toileting intervals may be up to three hours ❑ ❑
	Chronic Overflow	❑ The resident may be toileted at intervals consistent with their assessed voiding pattern utilizing the facility toileting protocols ❑ Toileting intervals may be up to three hours ❑ ❑
	Chronic Functional	❑ Prompted voiding ❑ Scheduled toileting ❑ Check and Change Program ❑ Toileting intervals may be up to three hours ❑
	Intractable	❑ Prompted voiding ❑ Scheduled toileting ❑ Check and Change Program ❑ Toileting intervals may be up to three hours ❑

Date: _____ MD/NP Signature: _____

Resident: _____ Medical Record #_____ Unit: _____

MN Veterans Home – Minneapolis
3 Day Voiding Assessment

Check resident every hour and mark the appropriate column(s)

Day 1 Date: _____ Time	Dry	Wet	BM	Self Toilet	Staff Assisted	Type of Assist
7 AM						
8 AM						
9 AM						
10 AM						
11 AM						
12 Noon						
1 PM						
2 PM						
3 PM						
4 PM						
5 PM						
6 PM						
7 PM						
8 PM						
9 PM						
10 PM						
11 PM						
12 Midnight						
1 AM						
2 AM						
3 AM						
4 AM						
5 AM						
6 AM						

Resident: _____ Medical Record # _____ Room# _____

M03-332C
G:\MDH Response\M03-332C.DOC

MN Veterans Home – Minneapolis
3 Day Voiding Assessment

Check resident every hour and mark the appropriate column(s)

Day 2 Date: _____ Time	Dry	Wet	Self Toilet	Staff Assisted	Type of Assist
7 AM					
8 AM					
9 AM					
10 AM					
11 AM					
12 Noon					
1 PM					
2 PM					
3 PM					
4 PM					
5 PM					
6 PM					
7 PM					
8 PM					
9 PM					
10 PM					
11 PM					
12 Midnight					
1 AM					
2 AM					
3 AM					
4 AM					
5 AM					
6 AM					

Resident: _____ Medical Record # _____ Room# _____

MN Veterans Home – Minneapolis
3 Day Voiding Assessment

Check resident every hour and mark the appropriate column(s)

Day 3 Date: _____ Time	Dry	Wet	Self Toilet	Staff Assisted	Type of Assist
7 AM					
8 AM					
9 AM					
10 AM					
11 AM					
12 Noon					
1 PM					
2 PM					
3 PM					
4 PM					
5 PM					
6 PM					
7 PM					
8 PM					
9 PM					
10 PM					
11 PM					
12 Midnight					
1 AM					
2 AM					
3 AM					
4 AM					
5 AM					
6 AM					

Resident: _____ Medical Record # _____ Room# _____

Questions – Senator Vickerman

1. Staffing Issues

A. How many staff left the Minneapolis Veterans Home in the past year?

There were 462 positions at Minneapolis and 70 employees left during this period. Of the 70, 23 nursing assistants and 3 LPN's were non-certified during their probationary period.

B. Do you conduct employee exit interviews, and if so, are you able to determine why staff are leaving?

It is my understanding that exit interviews stopped a few years ago. One of our initiatives will be to begin to have formal exit interviews at all of our facilities.

C. How does the state turnover rate compare to other Veterans Homes?

Data is not available to compare ourselves against other Veterans Homes Nationally. Within the State, the figures are below:

Turnover Rates FY05 (July 04 – June 05)

Turnover Rates						
	RN	LPN	HST	GMW	FSW	Facility
Fergus Falls	12%	24%	21%	0%	4.36%	12.39%
Hastings	1%	1%	0%	1%	0%	1%
Luverne	17%	18%	6%	0%	20%	4%
Minneapolis	8%	21%	26%	18%	29%	17%
Silver Bay	18%	8%	33%	1%	36%	21%
MHHA May 2005	*31.6%*	*34.3%*	*50.4%*	*n/a*	*41.4%*	*n/a*

D. Does the Minneapolis Veterans Home pay a salary level that is competitive with other nursing homes in the metro area?

According to 2005 HHRAM Wage and Salary Survey

RN	Range	Ave
Mpls	18.62 – 29.61	27.50
State	19.56 – 27.27	25.96
LPN		
LPN 2 (+ 2 yrs)	14.51 – 19.56	18.59
State	13.66 – 18.72	17.03
HST		
Mpls	11.00 – 17.55	13.87
State	9.82 – 14.30	11.96
Note: Before 2/2% increase		

E. What would be the budgetary impact of adding staff, rather than using temporary help and mandating overtime?

We have added a number of shifts at Mpls and we are in the process of determining how we can better stagger schedules between shift changes. We have enlisted a number if nursing assistants to help with this effort. The final fiscal impact at Mpls is yet to be determined. If we do a good job a filling our vacancies, our pool use should decrease as well as our use of overtime.

We are also matching staffing levels on each unit with resident acuity level to ensure that as our resident population changes, we can adjust staffing levels.

Other factors include absenteeism or staff with attendance problems(Mpls 7%) and an excess of special schedules (78 at Mpls) which makes scheduling difficult.

Senator Berglin Questions:

1. How many positions were open at the time of the MDH?

To put this in perspective, there were 242 full time equivalents in nursing on the rolls during the past pay period.

At the time of the survey, there were 33 open positions.

- Seven of those positions were RN's;
- 12 were LPN's, and
- 14 were HST's;

Of the 33, 11 were posted for recruitment, 4 offers were made, and 18 were open with no recruitment efforts.

While these were positions that were not filled, these vacancies were filled through employees agreeing to an additional overtime shift, the use of contract help or pools, and mandating overtime.

2. How long have the vacant positions been open?

Five positions were open since January; 8 more positions were open since March, one additional position was open in April; one in May; and the biggest group of 18 was open in July. During this time, a number of positions were being recruited for and filled.

Our process for managing FTE within the agency is that every recruitment effort must be reviewed and approved at the Board office. We have a record of this activity and while we wanted to ensure that there was sufficient control of positions within the agency, all positions requested to be filled at the Minneapolis facility were approved on a timely basis.

a. Were advertisements placed to notify the public of the openings?

- During this time, Human Resource staff attended 13 job fairs.

- On 2/13/05 an advertisement in the Star Tribune for RN's, LPN's and HST's.
- The next one was not until 7/23/05 and 8/28/05. Subsequently, there have been ads placed in a variety of papers on 9/9, 9/11, 9/18, and 9/20.

According to the HR staff, the lack of advertisements early in the year was due the large number of HST applications on file. Those applications were used to fill vacancies as they occurred. HST, RN & LPN vacancies were recruited through the job fairs.

3. Policy to mandate overtime

a. When and why was it created?

The ability to mandate overtime is included in our labor agreements and can be implemented when there is deemed to be an emergency. An emergency is created when staffing falls to a level where the basic patient services are threatened and cares cannot be completed.

Mandation had been utilized as a last resort. In other words, when there was a vacant shift to fill, we would ask employees to volunteer for overtime, agency or pool was called, and mandation would be used when there were no other options.

At Minneapolis the decision to implement mandatory overtime before calling agency staffing was at the end of January. It was changed to accomplish two things;

(1) Our own staff knows our residents best our and should be the called first to care for residents before agency (pool) staffing was called.

(2) Best use of financial resources to use our staff versus pool staff as a measure to conserve resources. Agency (pool) staffing costs double what we typically pay and we would rather pay our own staff first.

(3) There were 124 shifts daily at the facility. When mandation was implemented, on average, 1.5 shifts daily were mandated. Today, it is less than one shift per day.

b. By whom?

This was a decision made by local management according to the provision included in the labor agreements.

4. **Where any of the previously mentioned actions done for financial reasons?**

   As stated above,

   (1) It was meant to have our own staff, those who best know our residents, be the called first to care for residents before agency (pool) staffing was called.

   (2) It was also implemented as a measure to conserve resources. Agency (pool) staffing cost double what we typically pay and we would rather pay our own staff.

   The Minneapolis facility has held the same level of FTE for the past four years. We track their use of these positions, use of overtime, and use of pool staff within nursing and they have typically fund all their positions by the use of salary dollars, overtime funds or the funded nursing (pool) contracts.

5. **Were the leaving of the positions vacant and the mandated overtime policy executed to save money?**

   That is not my understanding. The positions not filled in July were to be used to modify the nursing organization and introduce a new program utilizing Trained Medication Aides and a nursing assistant preceptor program at the facility. Vacant positions were filled through voluntary overtime, mandation of overtime, and agency use.

   In the long term, this modified nursing model would increase the number of nursing assistants on the floor and decrease the number of licensed staff. Once fully implemented, it would increase the number of positions on the nursing units at a slightly lower cost.

6. What policies does the Board intend to implement to ensure closer oversight of the facility?

Earlier this year, a number of board members, board staff and I began to review our budgeting process and financial controls. As a result of these discussions,

- We are working on an expanded reporting system for board member's, which includes financial, but also clinical and other performance data. Over the past year, we have implemented a new clinical software system which provides us with better clinical monitoring and reporting. We will be reviewing this information with the board on a regular basis.
- The Board has also created three new oversight committees: Financial Management, Quality Assurance; and a Special Review Committee for situation such as occurred at Minneapolis.
- Approximately a year ago, the Board approved and funded a mock survey process which Diane Vaughn, our QA Director, has begun to implement around the State. A team of employees from various homes would meet at each of the facilities and conduct a mock survey in preparation for both VA and Department of Health reviews.
- During this period, Board members have visited the facility, touring at weekends and other times, visiting with staff, residents, and family members. Dr Budd has rounded with the Medical Director of the facility and we will discuss doing the same as we conduct board meetings throughout the year at facilities around the State.
- And finally, the Governor has asked that the Board initiate a review of all homes board facilities to ensure that all aspects of operations pass muster. This review is to be completed by January 15th, 2006.
- We have wonderful support from the Service organizations in this state, many of whom are represented here today. We thank them again for their interest and participation. The Board has also encouraged the service organizations, AL, VFW, DAV, JWV, MCL, AMVETS, VVA, Korean War Vets, Purple Heart, Ex-POW's, County Veterans Service Officer Organization and others to participate on a regular basis at board meeting and we

believe there is a commitment on the part of the organizations to do so.

7. On December 12, 2000 a resident died as the result of another resident sitting on his chest for an extended period of time. Would this type of incident indicate inadequate staffing?

   A review of this incident indicates that two residents collided while in the hallway in our Alzheimer's building 6, third floor. The incident occurred at approximately 8:00am. One resident had fallen on another with his hip and upper thigh covering his chest and lower face.

   The resident on top was removed and exhibited no apparent injury. Once on his feet, he ambulated independently and appeared to be unhurt. The resident on the floor was lifted to his bed and monitored. Shortly thereafter his heart stopped and was without respirations. The resident was a do not resususitate/do not intubate (DNR/DNI) so CPR was not initiated. The incident was reported to the common entry point and due to the unusual circumstances, the medical examiner. The medical examiner's office performed an autopsy and determined the cause of death was accidental due to "compression of the chest complicated by COPD (Chronic Obstructive Pulmonary Disease)". The facility investigation included staff interviews and chart reviews. The Medical Director also reviewed both charts and determined that all action taken was appropriate and that there did not appear to be any indication of abuse, neglect, or wrong doing on the part of staff or the home in general.

   In addition, I retrieved the staffing levels on the unit during that period and found that the planned and actual staffing included one RN, one LPN and four (4) HST's. That is the same compliment of HST's that we have today on the day shift and is appropriate for the case mix on that unit.. Based upon this review, staffing was not an issue and this resident's death was deemed to be an accident.

CERTIFIED MAIL #:

ROM: Minnesota Department of Health, Health Policy, Information and Compliance Monitoring Division
1645 Energy Park Drive, Suite 300, St. Paul, MN 55108-2970
Licensing and Certification Program

Ellie Laumark, Unit Supervisor (651) 643-2566

TO Mr. Alan C. Saatkamp **DATE** August 29, 2005

PROVIDER MN Veterans Home Minneapolis **COUNTY** Hennepin

ADDRESS 5101 Minnehaha Avenue South, Minneapolis, Minnesota 55417

On July 26, 27, 28, & 29, 2005, surveyor(s) 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 the form for your records and return the original to the above address.

Signed:_____ Date:_____

In accordance with Minnesota Stat. section 144.653, Minnesota Stat. section 144A.10, or Minnesota Stat. section 144A.45, this correction order has been issued pursuant to an inspection (survey)./an inspection (survey) including a complaint investigation./a complaint investigation. 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.

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.

1. MN Rule 4658.0110

Based on staff interview and record review the facility failed to complete a detailed incident report for 1 out of 1 Resident in the sample (#34) with a feeding tube. Findings include:

Resident #34 was treated at the hospital for dehydration and had a percutaneous endoscopic gastrostomy (PEG) feeding tube surgically implanted on 5/12/05. The resident returned to the facility 5/13/05.
On 5/15/05 the medical record progress notes documented that the resident "pulled his PEG tube out. The reside transported to the hospital, and remained at the hospital until 6/28/05. The medical record did not contain an inci the unit clerk and social worker were not able to locate an incident report. The assistant director of nursing was i 7/29/05 at 10:15 AM and was not aware of an incident report. She agreed that a report should have been filled ou able to locate a report.

TO COMPLY: All persons providing services in a nursing home must report any accident or injury to a resident, and the nursing home must immediately complete a detailed incident report of the accident or injury and the action taken after learning of the accident or injury.

SUGGESTED METHOD OF CORRECTION: The Administrator and the Director of Nursing could review the current policies and procedures for reporting accident/injuries, revise as needed and instruct all personnel in the revisions. The Administrator could designate a staff person to do ongoing monitoring to ensure compliance with accident /injury reporting.

TIME PERIOD FOR CORRECTION: Fourteen (14) days.

2. MN Rule 4658.0300 Subp. 4.

Based on observations, interviews, and record review, the facility failed to ensure that that the decision to apply restraints was based on a comprehensive assessment to ensure the restraint was the least restrictive, a plan for progressive removal, physician's order and appropriate consents for 4 out 7 residents in the sample with restraints. (#s 4, 9, 30 & 31). Findings include:

A lap buddy restraint was being used on resident #9 without a physician's order or a clear indication for its use. During evening observations on 7/26/05 from approximately 4:40 PM until 7:45 PM, resident #9 was observed to have a lap buddy type restraint on his wheelchair in addition to a re-closure type seat belt. B devices remained on the resident during the meal. The registered nurse on the unit when questioned as to the reason for the lap buddy at 6:10 PM did not know and referred the surveyor to the LPN. The LPN interviewed at approximately 6:20 PM about the lap buddy did not know why the lap buddy was on thought that it had been discontinued. A review of the resident's current physician's orders indicated that the resident had orders for a lap buddy but it had been discontinued on 7/18/05. The current plan of care still referenced the lap buddy. The human service technician (HST) assignment sheet dated 7/22/05 indicated that the lap buddy had been taken off and was no longer needed. A review of the nursing policies and procedures for the facility as of 5/1990 related to resident safety, "Restraints are used only with GNP/MD (geriatric nurse practitioner/medical doctor) orders".

Resident #4 was not assessed for the least restrictive restraint, and did not have a program of progressive removal physician's order for the restraint to be used only when the resident was attempting to ambulate. Resident # 4 wa 7/26/05 at 4:30 PM in a wheelchair with thigh straps between his legs that were fastened by a belt behind his wai PM the Human Service Technician (HST) who unfastened the clip on the belt before transferring the resident ind resident could not unfasten the belt by himself. Review of the resident's medical record contained no comprehens assessment of the need for the restraint or attempts at least restrictive alternatives. The record did not contain a pl allowed for progressive removal of the restraint. The nurse practitioner ordered on 6/2/05 a "Broda "chair at all ti padded thigh belts "only if the resident is attempting unsafe ambulation ." The care plan did not specify ed removal. During observations of the resident on 7/26/05 from 4:30 PM to 7:15 PM the resident
Slept in the chair, watched television and ate dinner with the restraint on. He made no attempt to ambulate durin At 7:15 PM the resident was taken to his room. An interview 7/27/05 at 11 AM with the registered nurse (RN) or revealed that the resident only walking a few steps in the bathroom. The RN stated that the resident should be rel the restraint every two hours.

The facility failed to ensure lap buddies for residents #30 & #31 were assessed for less restrictive devices or evaluated for progressive removal.

Resident #30 had diagnoses that included Alzheimer's disease, and history of falls. The resident had physician orders for a lap buddy dated 1/28/05, which stated, "Lap buddy when in wheelchair to prevent unsafe attempts to stand due to gait instability with dementia." The comprehensive assessment (MDS) dated 5/30/05 indicated the resident had a trunk restraint. The care plan dated 5/31/05 directed staff to apply the lap buddy when in the wheelchair to prevent unsafe attempts to stand. There was no indication in the record the resident had been assessed for the use of a less restrictive device such as a wheelchair alarm. The care plan did not contain any provision for the periodic release of the device or planned attempts at removal. Resident #30 was observed with the lap buddy on 7/26/05 (dinner), and 7/27/05 (breakfast, lunch.). Staff did not attempt to remove the restraint when the resident was supervised.

Resident #31 had diagnoses that included Parkinson's disease and history of falls. Physician orders dated 4/8/05 included the lap buddy to be on when the resident was in the wheelchair as a reminder not to lean forward. The resident's RAP (resident assessment profile) dated 7/5/05 indicated the resident could and did remove the lap buddy. However during observations on 7/26/05 at approximately 6:55 PM the resident was observed attempting to remove the lap buddy for 3-4 minutes without success. During observations on 7/26/05 at 5:40 PM the resident was assisted to the bathroom. The resident began to stand immediately after the lap buddy was removed. When the surveyor questioned how she felt about the lap buddy she replied, "I hate it". The resident's comprehensive MDS date 7/5/05 failed to identify the use of the lap buddy as a restraint and therefore failed to assess less restrictive alternatives or implement a plan for the progressive removal of the device. The lap buddy was in place on 7/26/05 at dinner, and 7/27/05 at breakfast at times when the resident was supervised and could have been released.

Review of the Resident Safety policy dated 5/10/02 identified the "lap buddy" as a restraint. The policy stated all residents who had a restraint would be reviewed on a quarterly basis to determine if they were candidates for restraint reduction, less restrictive restraining measures, or total restraint elimination. The ultimate goal was elimination of restraints or reduction to the least restrictive device. Upon interview with the nurse on 7/27/05 at approximately 9 AM she reported the lap buddies had not been assessed on a regular basis. She reported the lap buddies could probably be taken off at meal times.

TO COMPLY: The decision to apply a restraint must be based on the comprehensive resident assessment. The least restrictive restraint must be used and incorporated into the comprehensive plan of care. The comprehensive plan of care must allow for progressive removal or the progressive use of less restrictive means. A nursing home must obtain an informed consent for a resident placed in a physical or chemical restraint. A physician's order must be obtained for a physical or chemical restraint, which specifies the duration, and circumstances under which the restraint is to be used, including the monitoring interval.

SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review the current policies and procedures for assessment of resident restraints, revise as necessary and instruct the appropriate personnel in the revisions. The Director of Nursing could designate a staff person to do ongoing monitoring to ensure compliance of resident assessment with use of restraints.

TIME PERIOD FOR CORRECTION: Fourteen (14) days.

3. MN Rule 4658.0300 Subp. 5 C.

Based on observation and interview the facility failed to ensure resident an opportunity for motion, exercise and elimination every 2 hours while restrained 4 out 7 residents (#s 4, 9, 11 & 18) in the sample. Findings include:

Resident #18 was not released from the restraint every two hours.

Per record review, resident #18 was admitted to the facility on 6/10/03 and was diagnosed with senile delusions, history of myocardial infarction and strokes, incontinence of bowel and bladder, and history of pressure ulcers. The nursing assistant work sheet stated: assist with all activities of daily living. The resident was to lay down three times a day due to pressure area. The resident's care plan stated to check seat belt when in wheelchair every half hour and release and reposition resident every two hours.

Resident #18 was observed on 7/26/05 at approximately 5:10 PM sitting in the dining room at her assigned table with her seat belt on in a broda chair leaning to the right side. She remained in the chair leaning to the right until shortly after 7:00 PM when a nursing assistant took the resident to her room. The restraint was released at 7:40 when she was transferred. The resident's buttock was reddened. The incontinent product the resident had been wearing before she was toileted was soaked with urine and a strong urine odor was present. The nursing assistant was interviewed on 7/26/05 at 7:25 PM and confirmed that he did not know when the resident had last been toileted or repositioned. The nursing assistant stated that he started his shift at 3 PM and this was the first time he toileted the resident and repositioned her. The nursing assistant confirmed that the incontinent pad he removed was very wet.

Resident #18 was observed again on 7/27/05 at 12:45 PM sleeping at her assigned dining room table in her broad chair with her chin on her chest. At 1:07 PM the nurse manager went over to the resident and said, "it's time for your nap" and wheeled the resident to he room in the broda chair. At 1:13 PM the nursing assistant went into the resident's room. The incontinent pad that was removed was soaked with urine. The nursing assistant interviewed at 1:20 PM confirmed that the resident's incontinent pad was soaked and also additional cares such as oral cares, repositioning with release of seat belt had not been done for this resident today. The nursing assistant stated " I'm just too busy to get all the cares done." I have 12 residents that I am giving care to today by myself.

Resident #9 was observed the evening of 7/26/05 from approximately 4:40 PM until 7:45 PM (3 hours 5 minutes) with a lap buddy restraint on his wheelchair as well as a seat belt. The restraints were not released to provide the resident with free movement.

Resident # 4 was observed on 7/26/05 from 4:30 PM to 7:30 PM in a wheelchair with thigh straps between his legs that were fastened by a belt behind his waist. At 7:30 PM the Human Service Technician (HST) who unfastened the clip on the belt before transferring the resident indicated the resident could not unfasten the belt by himself. The restraint was not released every two hours.

Resident #11 had diagnoses that included anoxic brain damage, and history of falls. The care plans directed staff to release and reposition the resident every 2 hours. The resident had physician orders dated 5/29/05 for a locked Posey belt when in bed and wheelchair to enhance safety. The physician directed staff to monitor and release every 2 hours. Resident #11 was continuously observed on 7/26/05 from 4:30 PM until 7:50

PM without being toileted or repositioned, (3 hours, 20 minutes). The surveyor alerted staff at 7:30 PM, and at 7:50 PM the resident was assisted to bed. The resident's incontinent pad was wet.

TO COMPLY: At a minimum for a resident placed in a restraint a nursing home must also provide an opportunity for motion, exercise, and elimination for not less than ten minutes during each two-hour period in which a restraint is employed.

SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review the current policies and procedures for assessment of resident restraints, revise as necessary and instruct the appropriate personnel in the revisions. The Director of Nursing could designate a staff person to do ongoing monitoring to ensure compliance of resident assessment with use of restraints.

TIME PERIOD FOR CORRECTION: Fourteen (14) days

4. MN 4685.0400 Subp. 2 I.

Based on record review the facility failed to assess dental needs for 1 out of 27 residents in the sample (#20). Findings include:

Resident #20 was not assessed for dental needs.

Resident #20 was admitted to the facility on 5/22/00 with Huntington's chorea. Per record review the resident's dental condition had not been assessed and oral cares were not listed on the nursing assistant sheets. The resident was totally dependent on staff for all cares.

TO COMPLY: The comprehensive resident assessment must include I. Dental condition.

SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review the current resident assessment policies and procedures, revise as needed and instruct appropriate personnel. The Director of Nursing could designate a staff person to do ongoing monitoring to ensure assessment compliance.

TIME PERIOD FOR CORRECTION: Fourteen (14) days.

5. MN Rule 4658.0405 Subp. 1.

Based on interview and record review, the facility failed to develop comprehensive plans for care for 2 out of 27 residents in the sample (#s 19 & 35). The findings include:

Resident #35 did not have a care plan to address risky smoking behaviors.
Resident #35 was admitted to the facility with the diagnoses of dementia, Parkinson's disease, and stroke. An incident report dated 4/14/05 revealed that the resident was found smoking in the hallway near the nurses' station (a non smoking area) and that he attempted to light a cigarette for another resident as well.

The resident known to be a frequent smoker, and according to the care plan dated 6/05 he "leaves the me... early to seek cigs." Some behaviors documented on the care plan include wandering, resistance to care, refusal of assistance, and both short term and long term memory loss. A notation was made on the resident's care plan dated 4/14/05 "incident of unsafe smoking." No specifics were detailed. One approach was listed; "enc. to not take cig out till off the floor." The specific smoking care plan form used by the facility was not evident in the chart.

On 7/28/05 at approximately 10:30AM the RN covering for the nurse manager stated that she would expect to see the smoking assessment form and the specific smoking care plan in the chart. When asked if this information was available in the computer she stated that it was not. Resident #19 had a history of dehydration to include be hospitalized dehydration. Staff was not monitoring and recording fluid intake.

The facility did not develop a care plan to monitor fluid intake for resident #19 with a recent history of dehydration.

Resident #19 was transferred to this facility in 10/04 due to increased need for skilled care. The resident was observed during the meal on 7/26/05 at 5:45 PM. The resident's skin and mucus membranes appeared dry The Nurse Practitioner's note dated 2/10/05 stated: will increase scheduled free water to 250 cc 4 times day times 3 days . The assessment/plan by the nurse practitioner on 2/14/05 was urinary tract infection, continue quinolone until 2/19/05 and continue scheduled free water. On 4/5/05 the nurse practitioner assessed the resident with possible dehydration. On 4/13/05, the nurse practitioner spoke with family about resident's likely hood of becoming dehydrated because of his poor fluid intake of thickened water. The family wished for the resident to receive thin free water and thin coffee at meals for quality of life. There was no documentation that the resident was offered or took in the scheduled water.
Per interview with the nurse manager of the unit on 7/27/05 at approximately 5:30 PM it was confirmed that the resident should be on fluid tracking in order to assess the resident's intake.

TO COMPLY: A nursing home must develop a comprehensive plan of care.

SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review the current policies and procedures, revise as needed and instruct appropriate personnel. The Director of Nursing could designate a staff person to do ongoing monitoring to care plans are complete.

TIME PERIOD FOR CORRECTION: Twenty-(20) days

6. MN Rule 4658.0405 Subp. 3.

Based on observation, interview and record review 15 out of 27 residents in the sample (#2, #5, #6, #7, #9, #10, #11, #12 , #13 , #15, #17, #18, #20, 33 & 36) and 5 out 5 in the expanded sample (#50, 51, 52, 53, & 54) did not receive services in accordance with their plan of care and policies. Findings include:

Resident #17 did not have his catheter bag emptied as needed. Per record review, resident #17 was admitted to the facility on 08/26/03 with diagnoses that included neurogenic bladder, and diabetes. According to the residents care plan, the staff was to empty and record Foley catheter output every shift and complete

catheter care per physician order. The nursing assistant sheet instructed the nursing assistant to empty Foley every shift and report and to "check bag often – fills quickly."

Resident #17 was observed on 7/27/05 at 7:45 AM while lying in bed in his room. The resident had a leg bag on for urine collection that was full. The resident's sweat pants were soaked in the groin area. Resident #17 was interviewed at 7/27/05 at 7:45 AM and stated "cares are not very good, you have to wait a long time to get help." The staff does not empty my urine bag when they should so it overflowed. The spillage happens so often that I don't feel real good about it. The night staff went home today without emptying my bag and now I am all wet.

The nursing assistant came into the resident's room on 7/27/05 at approximately 7:47 AM and started AM cares. The resident said to the nursing assistant as she tried to remove the residents wet sweat pants, "why don't you empty my bag first?" The nursing assistant replied to the resident, "I was going to get these wet pants off you first. The nursing assistant emptied the leg bag of 500 milliliters of urine. The maximum capacity of the leg bag was 500 milliliters.

The nursing assistant was interviewed after cares at approximately 8:00 AM and confirmed that resident #17's urine leg bag had not been emptied by the night staff. Resident #9 who required thickened liquids was given unthickened juice.

A review of the current physician's orders for resident #9 as of 7/7/05 indicated, "Diet: Pureed with nectar thick liquids, ok for regular bananas, French toast, and pancakes." The plan of care dated 10/24/04 indicated the resident should have a pureed diet with nectar thick liquids.

During observations of a medication pass on 7/27/05 at 11:25 AM a licensed practical nurse (LPN) was noted to give resident #9 regular thin cranberry juice with two regular strength Tylenol. The resident proceeded to choke and cough and spit. Earlier observations of the resident receiving an evening meal on 7/26/05 revealed that the resident was to receive nectar thickened liquids. The LPN stated after having given the thin juice to the resident that, "My fault, he should have thickened liquids.

During observations of resident #6 and #7 on 7/26/05 from 4:40 PM until 7:55 PM, it was noted that the residents were not repositioned or toileted during that time. Both residents were totally dependent on others to reposition and toilet. According to their plans of care (#6 – 1/10/05) and (#7 – 12/7/04) staff were directed to toilet and reposition the residents every two hours. An interview with the human service technician (HST) at 7:55 PM, who had been assigned to these residents, revealed that the last time the residents had been repositioned or toileted was around 4:30 PM just before dinner.

Observations of resident #10 on 7/26/05 from 4:40 PM until 7:45 PM revealed that the resident was not toileted, checked or changed. The resident was totally dependent on others for toileting, check and change at intervals of at least every two hours and as needed related to incontinence of bowel and bladder, according to the current plan of care dated 12/30/04. An interview with the HST at 7:45 Pm revealed that the HST had not toileted, checked or changed the resident since the resident's nap at approximately 3:30 PM. (4 hours and 15 minutes).

Observations of resident #10 on 7/27/05 from approximately 7:30 Am until 10:25 AM revealed that the resident was not toileted, checked or changed. The resident did have a Broda-type wheelchair and position changes had been observed during breakfast and afterwards when the resident had been wheeled back to her room and the hospice nurse spent time with the resident. An interview with the hospice nurse, at 9:50 AM, to follow up on what was done for the resident revealed the hospice nurse adjusted the resident's position in the Broda –type wheelchair but did not toilet, check or change the resident at the time. The nurse stated that usually the resident was placed in bed after meals as a preventative measure for skin breakdown. An interview with the HST at approximately 10:25 AM revealed that the resident had not been checked or changed since before breakfast at approximately 7:30 AM

Resident #11 was not repositioned, toileted for checked for incontinence every two hours.
Resident #11 had diagnoses that included anoxic brain injury and history of falls. The resident had physician orders dated 5/29/05 for a locked Posey belt when in the bed or wheelchair. According to the care plan dated 5/12/05, the resident was to be repositioned, toileted or checked for incontinence every 2 hours. Resident #11 was observed on 7/26/05 from 4:30 PM until 7:50 PM without being released or repositioned, for a total of 3 hours, 20 minutes. At 7:30 PM the surveyor informed the Human Services Technician (HST), who then assisted the resident to bed at 7:50 PM. The resident's incontinent pad was changed, and was noted to be wet.

Resident #12 was not repositioned in a timely manner. Resident #12 had diagnoses that included dementia, and Alzheimer's disease. The RAP (resident assessment profile) identified the resident's skin as being at risk for breakdown, with an intervention of assisting with repositioning every 2 hours while in the wheelchair. According to the care plan dated 7/8/05 the resident was to be repositioned every 2 hours. On 7/26/05 at 4:30 PM, resident #12 was observed visiting with her husband in her room until 6 PM, at which point she was escorted to the dining room. Upon interview with the husband at 6 PM he reported he had arrived at 2:45 PM. Upon further discussion with the husband he reported staff had not changed the resident's position since his arrival. At approximately 7:15 PM the surveyor questioned when resident #12 was repositioned, and was told it was at 3:45 PM. The surveyor informed the HST the husband reported he had arrived at 2:45 PM and resident #12 had not been repositioned. The HST acknowledged resident #12 was past due for repositioning and assisted the resident to bed.

Resident #12 did not receive assistance with oral cares. According to the care plan dated 7/8/05, the resident's teeth were to be brushed. On 7/26/05 at approximately 7 PM, bedtime cares were observed. The Human Services Technician (HST) used a pink swab to cleanse the oral cavity. Upon interview with the HST immediately following the cares she reported the resident had a full set of teeth, but she did not brush the teeth anymore because she swallowed the toothpaste

Resident #13 with a pressure sore was not repositioned for over 2 hours. Resident #13 had diagnoses that included Parkinson's disease and arthritis. The resident was identified on 7/14/05 as having a stage 2 pressure ulcer (a partial thickness loss of skin layers that presents as an abrasion, blister, or crater) on his coccyx. According to the care plan dated 5/20/05 the resident was to be repositioned while in the wheelchair every 2 hours. The care plan identified the resident as having fragile skin and at risk for breakdown. On 7/26/05 resident #13 was observed from 4:30 PM until 7:15 PM (2 hours, 45 minutes) without being repositioned. The surveyor entered another resident's room at 7:15 PM. Resident #18 was not released from the restraint every two hours.

Per record review, resident #18 was admitted to the facility on 6/10/03 and was diagnosed with senile delusions, history of myocardial infarction and strokes, incontinence of bowel and bladder, and history of pressure ulcers. The nursing assistant work sheet stated: assist with all activities of daily living. The resident was to lay down three times a day due to pressure area. The resident's care plan stated to check seat belt when in wheelchair every half hour and release and reposition resident every two hours.

Resident #18 was observed on 7/26/05 at approximately 5:10 PM sitting in the dining room at her assigned table with her seat belt on in a broda chair leaning to the right side. She remained in the chair leaning to the right until shortly after 7:00 PM when a nursing assistant took the resident to her room. The restraint was released at 7:40 when she was transferred. The resident's buttock was reddened. The incontinent product the resident had been wearing before she was toileted was soaked with urine and a strong urine odor was present. The nursing assistant was interviewed on 7/26/05 at 7:25 PM and confirmed that he did not know when the resident had last been toileted or repositioned. The nursing assistant stated that he started his shift at 3 PM and this was the first time he toileted the resident and repositioned her. The nursing assistant confirmed that the incontinent pad he removed was very wet.

Resident #18 was observed again on 7/27/05 at 12:45 PM sleeping at her assigned dining room table in her broad chair with her chin on her chest. At 1:07 PM the nurse manager went over to the resident and said, "it's time for your nap" and wheeled the resident to he room in the broda chair. At 1:13 PM the nursing assistant went into the resident's room. The incontinent pad that was removed was soaked with urine. The nursing assistant interviewed at 1:20 PM confirmed that the resident's incontinent pad was soaked and also additional cares such as oral cares, repositioning with release of seat belt had not been done for this resident today. The nursing assistant stated, I'm just too busy to get all the cares done. I have 12 residents that I am giving care to today by myself.

The facility did not follow the comprehensive care plan for resident #20 by not documenting fluid intake on a form in resident's room and did not complete oral cares.

Resident #20 was admitted to the facility on 5/22/00 diagnosed with Huntington's chorea, failure to thrive, dysphasia, and dementia without behaviors. The resident was admitted into the hospital on 2/16/05 for failure to thrive with concerns of malnutrition and dehydration. Resident #20 was observed on 7/26/05 at approximately 6:10 PM in the dining room. The nursing assistant fed the resident. The resident had sunken eyes and was very thin.

The physician ordered on 2/28/05 honey thick water 200 milliliters 4 times a day and as needed and to encourage fluids. The resident's care plan and nursing assistant sheet stated to document fluids on the form in resident's room. Honey thickened water was to be given whenever staff was with resident.

On 7/28/05 at 8:45 AM there was no intake record posted in the resident's room and there were no fluids available to offer the resident. The nursing assistant taking care of resident #20 on 7/28/05 was interviewed at approximately 8:45 AM in the resident's room. The nursing assistant confirmed that there was no sheet in the resident's room to document fluids and there were no fluids in the room to offer the resident. The nursing assistant stated she only documented the output at the end of the shift.

The HUK was interviewed on 7/28/05 at approximately 9:10 AM and confirmed that there were no oral intake records in the resident's chart, only the output sheets were in the chart.

Resident #20's sister was interviewed on 7/27/05 at approximately 6:45 PM. The resident' s sister stated that she was concerned that when she was not in the facility the staff did not offer fluids to the resident. The resident's sister stated that when she visited her brother, staff did not come in and offer fluids. The resident's sister stated that she had talked to the nurse manager in the past about her concerns.

Resident #20's sister was interviewed on 7/27/05 at approximately 6:45 PM. Both the resident and his sister were in the resident's room. The resident's sister was concerned that the staff did not give her brother oral care and stated that she did not think it was being done because the resident did not like staff getting close to his face and mouth and had become agitated in the past during mouth cares.

During record review it was noted that neither the nursing assistant care sheet states nor care plan listed oral cares as a need. The dental consults listed that the resident was resistive to exams and the exams could not be completed. The nursing assistant on 7/28/05 at approximately 8:45 AM was interviewed. The nursing assistant stated that she did not do the residents oral care this AM. This surveyor asked the nursing assistant to check the resident's mouth. The nursing assistant gloved and checked the resident's mouth by parting lips. During this observation of the resident's mouth a large buildup of plague on all teeth was noted. The nursing assistant replied that she would do his oral cares. At 9:00 AM the nursing assistant reported back to me that she had not completed the resident's oral care.

Resident #15's teeth were not brushed. Resident #15 had diagnoses that included dementia, and esophageal reflux. The nursing assistant assignment sheet indicated the resident was total care for grooming. During observations of bedtime cares on 7/26/05 at approximately 7:30 PM, the resident's teeth were not brushed. Upon interview with the HST immediately following cares she reported the resident did have natural teeth. The HST reported she used glycerine swabs for oral care, instead of brushing her teeth.

Upon interview with the nurse manager on 7/28/05 at approximately 9 AM, she reported she would expect resident's teeth brushed, if they have them.

Review of the facilities oral care policy, dated 4/16/04 directed natural teeth to be brushed at least twice daily.

Observations during the initial tour of building 6 on 7/26/05 from approximately 11:30 AM until 1:43 PM revealed 7 male residents (#50, #5, #51, #52, #53, #2, #54) who had not been shaved. Observations during the evening shift on 7/26/05 revealed that resident #6 and resident #9 were not shaved. A review of current plans of care for resident #6 (1/10/05) and resident #9 (8/11/04) indicated that both were dependent with grooming and required assistance to shave. An interview with a human service technician (HST) to follow up on ability of residents (#52, #5, #50, #51, #53 and #2)) to shave on 7/29/05 at 9:45 AM revealed that all needed assist to shave. A review of the standards of practice for the nursing department related to quality resident care, which was received from the administrator on 7/28/05, indicated, "Shaving daily and as needed".

Resident #33 was not transferred with the mechanical lift in accordance with the plan of care.

A review of the HST assignment sheet last updated as of 7/22/05 indicated that the resident was non-ambulatory, needed assistance of 1-2 staff, was dependent in all cares, was incontinent of urine – needs help to toilet, check, toilet or change, mechanical lift used for transfers as needed. A review of the resident's current plan of care as of 11/3/04 indicated: "Provide for safety"; "12/29/04, May use mechanical lift as needed due to residents inability to stand."

Evening cares were observed for resident #33 on 7/26/05 at approximately 7:06 PM, the resident was observed to be dangling over a trash can while attached to a manual Sara-type standing lift The fleece sling was located directly underneath the resident's armpits and the resident was not holding onto the lift bar. The resident was not bearing any weight on the lift stand that left the resident unsupported in the air (no safety belt was noted). The resident's face was reddened, eyes open and his expression was a frowning type scowl.

An interview with the HST when the evening cares had been completed to follow up on what the usual practice was the resident for repositioning and toileting to find that usually the HST would have a second HST to assist but the HST stated my partner was on break and the resident needed to be changed.

An additional observation of resident #33during evening cares on 7/28/05 at 4:20 PM revealed a similar picture as the evening before; the resident was again hanging over the trash can while attached to the manual Sara lift as the HST was changing the incontinence pad over the trash can. The resident was able to hold onto the lift bar with his left hand and was able to partially bear weight on his feet. The resident was awake and stated to the HST, "what in the hell do you think you're doing?" and the HST replied, "just cleaning you up". "An interview with a second HST on 7/28/05 at 10:30 AM, that had cared for the resident on both the day and evening shifts in the past, as to how resident #33 was transferred revealed that the electric Sara or hand (manual) lift could be used. The HST preferred to use the electric Sara as it had a safety belt. The resident required assistance of 1-2 staff depending on mood, behavior or sleepiness. The manual (hand) Sara was totally unsafe for the resident and if used would definitely need another staff to assist.

Review of the care plan dated 5/4/05 direct staff to assist resident #36 by setting up the tray, opening packages ar eat. Observation of resident #36 on 7/26/05 at 8:30 AM the resident was in the dining room waiting for his breal was seated in a chair against the wall with an over bed table in front on him. At 8:40 AM the trays had been serv and resident #36 had his breakfast, there was no staff near him to assist with eating. His milk and juice had not been opened. Resident #36 was observed to lift his empty fork to his mouth and then put it down. At 9:0 the resident had eaten just two bites of food on his own and had been unable to open his beverage containers. Af minutes this surveyor asked staff to assist the resident. His beverages were opened and he was encouraged to eat AM a staff member sat next to the resident and assisted to feed the resident, no offer was made to heat up the foo charge nurse was interviewed 7/27/05 at 10:00 AM and stated that this resident should have received assistance v set up of his meal and had his beverages opened

TO COMPLY: all personnel involved in the care of the resident must use a comprehensive plan of care.

SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review the current resident care plan policies and procedures, revise as needed and instruct appropriate personnel. The Director of Nursing could designate a staff person to do ongoing monitoring to ensure compliance of resident care plans.

TIME PERIOD FOR CORRECTION: Fourteen (14) days.

7. MN Rule 4658.0405 Subp. 4.

Based on record review and staff interview the facility failed to revise the plan of care for 1 out 1 resident's in th a change of diet texture, (# 34). Findings include:

Resident #34 had been hospitalized for dehydration and removing his feeding tube. He was returned to the facili 6/28/05. Review of the record for resident #34 revealed that his plan of care that included thickened liquids and r ground foods. A swallowing guide dated 7/12/05 signed by the speech therapist recommends nectar thickened l six times a day, and remain upright 60 minutes after meals. Review of the care plan updated 7/12/05 stated modi with regular fluids contradicting the thickened liquid plan. Interview with the nurse on the unit revealed she was assigned to this resident, and was not familiar with this resident's needs.

TO COMPLY: A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff.

SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review the current resident care plan policies and procedures, revise as needed and instruct appropriate personnel. The Director of Nursing could designate a staff person to do ongoing monitoring to ensure resident care plan compliance.

TIME PERIOD FOR CORRECTION: Fourteen (14) days.

8. MN Rule 4658.0470 Subp. 2.

Based on observation and interview the facility failed to assure that the current medical records were stored to safeguard confidential information in one out of three buildings surveyed #6. Findings include:

During the initial tour of Building 6 on 7/26/05 at 1:40 PM on the second floor the nurses station was unattended any staff, all of the medical records for the 28 residents on that unit were located on a rack behind the nurse's de There was no door to the nurse's station or a lock on the cart to protect the medical records, the records ' eas accessible and in plain view. There was no staff around this area; several residents were in the area, five . .e di room and two in the hallway. A staff was located leaving room 245 at 1:53 PM. On 7/27/05 between 11 AM and 11:30 AM on the third floor of Building 6 it was observed that the staff were not available at the nurses station a medical records were not secured. A half door with a latch was on the nurse station but this was not secured whe left the desk area. The Director of medical records was interviewed 7/29/05 at 10:15 AM and stated that there w policy about leaving the medical records unsecured in the nurse stations.

TO COMPLY: Space must be provided for the safe and confidential storage of residents' clinical records.

SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review the current resident record storage procedures, revise as needed and instruct appropriate personnel. The Director of Nursing could designate a staff person to do ongoing monitoring to ensure resident record security or provide secure areas for records to be stored.

TIME PERIOD FOR CORRECTION: Seven (7) days.

9. MN Rule 4658.0505 Subp. I. Based on observation, interview and record review the Director of Nursing failed to ensure that the comprehensive plan of care was carried out for 15 out of 27 residents in the sample. (#2, #5, #6, #7, #9, #10, #11, #12 , #13 , #15, #17, #18, #20, 33 & 36) and 5 out 5 in the expanded sample (#50, 51, 52, 53, & 54). Findings include:

Resident #17 did not have his catheter bag emptied as needed. Per record review, resident #17 was admitted to the facility on 08/26/03 with diagnoses that included neurogenic bladder, and diabetes. According to the residents care plan, the staff was to empty and record Foley catheter output every shift and complete catheter care per physician order. The nursing assistant sheet instructed the nursing assistant to empty Foley every shift and report and to "check bag often – fills quickly."

Resident #17 was observed on 7/27/05 at 7:45 AM while lying in bed in his room. The resident had a leg bag on for urine collection that was full. The resident's sweat pants were soaked in the groin area. Resident #17 was interviewed at 7/27/05 at 7:45 AM and stated "cares are not very good, you have to wait a long time to get help." The staff does not empty my urine bag when they should so it overflowed. The spillage happens so often that I don't feel real good about it. The night staff went home today without emptying my bag and now I am all wet.

The nursing assistant came into the resident's room on 7/27/05 at approximately 7:47 AM and started AM cares. The resident said to the nursing assistant as she tried to remove the residents wet sweat pants, "why don't you empty my bag first?" The nursing assistant replied to the resident, "I was going to get these wet pants off you first. The nursing assistant emptied the leg bag of 500 milliliters of urine. The maximum capacity of the leg bag was 500 milliliters.

The nursing assistant was interviewed after cares at approximately 8:00 AM and confirmed that resident #17's urine leg bag had not been emptied by the night staff. Resident #9 who required thickened liquids was given unthickened juice.

A review of the current physician's orders for resident #9 as of 7/7/05 indicated, "Diet: Pureed with nectar thick liquids, ok for regular bananas, French toast, and pancakes." The plan of care dated 10/24/04 indicated the resident should have a pureed diet with nectar thick liquids.

During observations of a medication pass on 7/27/05 at 11:25 AM a licensed practical nurse (LPN) was noted to give resident #9 regular thin cranberry juice with two regular strength Tylenol. The resident proceeded to choke and cough and spit. Earlier observations of the resident receiving an evening meal on

7/26/05 revealed that the resident was to receive nectar thickened liquids. The LPN stated after having given the thin juice to the resident that, "My fault, he should have thickened liquids.

During observations of resident #6 and #7 on 7/26/05 from 4:40 PM until 7:55 PM, it was noted that the residents were not repositioned or toileted during that time. Both residents were totally dependent on others to reposition and toilet. According to their plans of care (#6 – 1/10/05) and (#7 – 12/7/04) staff were directed to toilet and reposition the residents every two hours. An interview with the human service technician (HST) at 7:55 PM, who had been assigned to these residents, revealed that the last time the residents had been repositioned or toileted was around 4:30 PM just before dinner.

Observations of resident #10 on 7/26/05 from 4:40 PM until 7:45 PM revealed that the resident was not toileted checked or changed. The resident was totally dependent on others for toileting, check and change at intervals of at least every two hours and as needed related to incontinence of bowel and bladder, according to the current plan of care dated 12/30/04. An interview with the HST at 7:45 Pm revealed that the HST had not toileted, checked or changed the resident since the resident's nap at approximately 3:30 PM. (4 hours and 15 minutes).

Observations of resident #10 on 7/27/05 from approximately 7:30 Am until 10:25 AM revealed tha resident was not toileted checked or changed. The resident did have a Broda-type wheelchair and posi changes had been observed during breakfast and afterwards when the resident had been wheeled back to her room and the hospice nurse spent time with the resident. An interview with the hospice nurse, at 9:50 AM, to follow up on what was done for the resident revealed the hospice nurse adjusted the resident's position in the Broda –type wheelchair but did not toilet, check or change the resident at the time. The nurse stated that usually the resident was placed in bed after meals as a preventative measure for skin breakdown. An interview with the HST at approximately 10:25 AM revealed that the resident had not been checked or changed since before breakfast at approximately 7:30 AM

Resident #11 was not repositioned, toileted for checked for incontinence every two hours.
Resident #11 had diagnoses that included anoxic brain injury and history of falls. The resident had physician orders dated 5/29/05 for a locked Posey belt when in the bed or wheelchair. According to the care plan dated 5/12/05, the resident was to be repositioned, toileted or checked for incontinence every 2 hours. Resident #11 was observed on 7/26/05 from 4:30 PM until 7:50 PM without being released or repositioned, for a total of 3 hours, 20 minutes. At 7:30 PM the surveyor informed the Human Services Technician (HST), who then assisted the resident to bed at 7:50 PM. The resident's incontinent pad was changed, and was noted to be wet.

Resident #12 was not repositioned in a timely manner. Resident #12 had diagnoses that included demen and Alzheimer's disease. The RAP (resident assessment profile) identified the resident's skin as being at risk for breakdown, with an intervention of assisting with repositioning every 2 hours while in the wheelchair. According to the care plan dated 7/8/05 the resident was to be repositioned every 2 hours. On 7/26/05 at 4:30 PM, resident #12 was observed visiting with her husband in her room until 6 PM, at which point she was escorted to the dining room. Upon interview with the husband at 6 PM he reported he had arrived at 2:45 PM. Upon further discussion with the husband he reported staff had not changed the resident's position since his arrival. At approximately 7:15 PM the surveyor questioned when resident #12 was repositioned, and was told it was at 3:45 PM. The surveyor informed the HST the husband reported he

had arrived at 2:45 PM and resident #12 had not been repositioned. The HST acknowledged resident #12 was past due for repositioning and assisted the resident to bed.

Resident #12 did not receive assistance with oral cares. According to the care plan dated 7/8/05, the resident's teeth were to be brushed. On 7/26/05 at approximately 7 PM, bedtime cares were observed. The Human Services Technician (HST) used a pink swab to cleanse the oral cavity. Upon interview with the HST immediately following the cares she reported the resident had a full set of teeth, but she did not brush the teeth anymore because she swallowed the toothpaste

Resident #13 with a pressure sore was not repositioned for over 2 hours. Resident #13 had diagnoses that included Parkinson's disease and arthritis. The resident was identified on 7/14/05 as having a stage 2-pressure ulcer (a partial thickness loss of skin layers that presents as an abrasion, blister, or crater) on his coccyx. According to the care plan dated 5/20/05 the resident was to be repositioned while in the wheelchair every 2 hours. The care plan identified the resident as having fragile skin and at risk for breakdown. On 7/26/05 resident #13 was observed from 4:30 PM until 7:15 PM (2 hours, 45 minutes) without being repositioned. The surveyor entered another resident's room at 7:15 PM. Resident #18 was not released from the restraint every two hours.

Per record review, resident #18 was admitted to the facility on 6/10/03 and was diagnosed with senile delusions, history of myocardial infarction and strokes, incontinence of bowel and bladder, and history of pressure ulcers. The nursing assistant work sheet stated: assist with all activities of daily living. The resident was to lay down three times a day due to pressure area. The resident's care plan stated to check seat belt when in wheelchair every half hour and release and reposition resident every two hours.

Resident #18 was observed on 7/26/05 at approximately 5:10 PM sitting in the dining room at her assigned table with her seat belt on in a broda chair leaning to the right side. She remained in the chair leaning to the right until shortly after 7:00 PM when a nursing assistant took the resident to her room. The restraint was released at 7:40 when she was transferred. The resident's buttock was reddened. The incontinent product the resident had been wearing before she was toileted was soaked with urine and a strong urine odor was present. The nursing assistant was interviewed on 7/26/05 at 7:25 PM and confirmed that he did not know when the resident had last been toileted or repositioned. The nursing assistant stated that he started his shift at 3 PM and this was the first time he toileted the resident and repositioned her. The nursing assistant confirmed that the incontinent pad he removed was very wet.

Resident #18 was observed again on 7/27/05 at 12:45 PM sleeping at her assigned dining room table in her broad chair with her chin on her chest. At 1:07 PM the nurse manager went over to the resident and said, "it's time for your nap" and wheeled the resident to he room in the broda chair. At 1:13 PM the nursing assistant went into the resident's room. The incontinent pad that was removed was soaked with urine. The nursing assistant interviewed at 1:20 PM confirmed that the resident's incontinent pad was soaked and also additional cares such as oral cares, repositioning with release of seat belt had not been done for this resident today. The nursing assistant stated, I'm just too busy to get all the cares done. I have 12 residents that I am giving care to today by myself.

The facility did not follow the comprehensive care plan for resident #20 by not documenting fluid intake on a form in resident's room and did not complete oral cares.

Resident #20 was admitted to the facility on 5/22/00 diagnosed with Huntington's chorea, failure to thrive, dysphasia, and dementia without behaviors. The resident was admitted into the hospital on 2/16/05 for failure to thrive with concerns of malnutrition and dehydration. Resident #20 was observed on 7/26/05 at approximately 6:10 PM in the dining room. The nursing assistant fed the resident. The resident had sunken eyes and was very thin.

The physician ordered on 2/28/05 honey thick water 200 milliliters 4 times a day and as needed and to encourage fluids. The resident's care plan and nursing assistant sheet stated to document fluids on the form in resident's room. Honey thickened water was to be given whenever staff was with resident.

On 7/28/05 at 8:45 AM there was no intake record posted in the resident's room and there were no fluids available to offer the resident. The nursing assistant taking care of resident #20 on 7/28/05 was interviewed at approximately 8:45 AM in the resident's room. The nursing assistant confirmed that there was no sheet in the resident's room to document fluids and there were no fluids in the room to offer the resident. The nursing assistant stated she only documented the output at the end of the shift.
The HUK was interviewed on 7/28/05 at approximately 9:10 AM and confirmed that there were no oral intake records in the resident's chart, only the output sheets were in the chart.

Resident #20's sister was interviewed on 7/27/05 at approximately 6:45 PM. The resident' s sister stated that she was concerned that when she was not in the facility the staff did not offer fluids to the resident. The resident's sister stated that when she visited her brother, staff did not come in and offer fluids. The resident's sister stated that she had talked to the nurse manager in the past about her concerns.

Resident #20's sister was interviewed on 7/27/05 at approximately 6:45 PM. Both the resident and his sister were in the resident's room. The resident's sister was concerned that the staff did not give her brother oral care and stated that she did not think it was being done because the resident did not like staff getting close to his face and mouth and had become agitated in the past during mouth cares.

During record review it was noted that neither the nursing assistant care sheet states nor care plan listed oral cares as a need. The dental consults listed that the resident was resistive to exams and the exams could not be completed. The nursing assistant on 7/28/05 at approximately 8:45 AM was interviewed. The nursing assistant stated that she did not do the residents oral care this AM. This surveyor asked the nursing assistant to check the resident's mouth. The nursing assistant gloved and checked the resident's mouth by parting his lips. During this observation of the resident's mouth a large buildup of plague on all teeth was noted. The nursing assistant replied that she would do his oral cares. At 9:00 AM the nursing assistant reported bac' me that she had not completed the resident's oral care.

Resident #15's teeth were not brushed. Resident #15 had diagnoses that included dementia, and esophageal reflux. The nursing assistant assignment sheet indicated the resident was total care for grooming. During observations of bedtime cares on 7/26/05 at approximately 7:30 PM, the resident's teeth were not brushed. Upon interview with the HST immediately following cares she reported the resident did have natural teeth. The HST reported she used glycerine swabs for oral care, instead of brushing her teeth.

Upon interview with the nurse manager on 7/28/05 at approximately 9 AM, she reported she would expect resident's teeth brushed, if they have them.

Review of the facilities oral care policy, dated 4/16/04 directed natural teeth to be brushed at least twice daily.

Observations during the initial tour of building 6 on 7/26/05 from approximately 11:30 AM until 1:43 PM revealed 7 male residents (#50, #5, #51, #52, #53, #2, #54) who had not been shaved. Observations during the evening shift on 7/26/05 revealed that resident #6 and resident #9 were not shaved. A review of current plans of care for resident #6 (1/10/05) and resident #9 (8/11/04) indicated that both were dependent with grooming and required assistance to shave. An interview with a human service technician (HST) to follow up on ability of residents (#52, #5, #50, #51, #53 and #2)) to shave on 7/29/05 at 9:45 AM revealed that all needed assist to shave. A review of the standards of practice for the nursing department related to quality resident care, which was received from the administrator on 7/28/05, indicated, "Shaving daily and as needed".

Resident #33 was not transferred with the mechanical lift in accordance with the plan of care.
A review of the HST assignment sheet last updated as of 7/22/05 indicated that the resident was non-ambulatory, needed assistance of 1-2 staff, was dependent in all cares, was incontinent of urine – needs help to toilet, check, toilet or change, mechanical lift used for transfers as needed. A review of the resident's current plan of care as of 11/3/04 indicated: "Provide for safety"; "12/29/04, May use mechanical lift as needed due to residents inability to stand."

Evening cares were observed for resident #33 on 7/26/05 at approximately 7:06 PM, the resident was observed to be dangling over a trash can while attached to a manual Sara-type standing lift The fleece sling was located directly underneath the resident's armpits and the resident was not holding onto the lift bar. The resident was not bearing any weight on the lift stand that left the resident unsupported in the air (no safety belt was noted). The resident's face was reddened, eyes open and his expression was a frowning type scowl.

An interview with the HST when the evening cares had been completed to follow up on what the usual practice was the resident for repositioning and toileting to find that usually the HST would have a second HST to assist but the HST stated my partner was on break and the resident needed to be changed.

An additional observation of resident #33during evening cares on 7/28/05 at 4:20 PM revealed a similar picture as the evening before; the resident was again hanging over the trash can while attached to the manual Sara lift as the HST was changing the incontinence pad over the trash can. The resident was able to hold onto the lift bar with his left hand and was able to partially bear weight on his feet. The resident was awake and stated to the HST, "what in the hell do you think you're doing?" and the HST replied, "just cleaning you up". "An interview with a second HST on 7/28/05 at 10:30 AM, that had cared for the resident on both the day and evening shifts in the past, as to how resident #33 was transferred revealed that the electric Sara or hand (manual) lift could be used. The HST preferred to use the electric Sara as it had a safety belt. The resident required assistance of 1-2 staff depending on mood, behavior or sleepiness. The manual (hand) Sara was totally unsafe for the resident and if used would definitely need another staff to assist.

Review of the care plan dated 5/4/05 direct staff to assist resident #36 by setting up the tray, opening pac...ges a eat. Observation of resident #36 on 7/26/05 at 8:30 AM the resident was in the dining room waiting for his brea Was seated in a chair against the wall with an over bed table in front on him. At 8:40 AM the trays had been serv And resident #36 had his breakfast; there was no staff near him to assist with eating. His milk and juice Had not been opened. Resident #36 was observed to lift his empty fork to his mouth and then put it down. At 9:0 The resident had eaten just two bites of food on his own and had been unable to open his beverage containers. A minutes this surveyor asked staff to assist the resident. His beverages were opened and he was encouraged to eat. AM a staff member sat next to the resident and assisted to feed the resident, no offer was made to heat up the foc Charge nurse was interviewed 7/27/05 at 10:00 AM and stated that this resident should have received assistance set up of his meal and had his beverages opened

TO COMPLY: The written job description for the director of nursing services must include responsibility for:
Assuring that a comprehensive plan of care is established and implemented for each resident.

SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review the current scheduling and resident care plan policies and procedures, revise as needed and instruct appropri... personnel. The Director of Nursing could designate a staff person to do ongoing monitoring to e compliance of resident care plans.

TIME PERIOD FOR CORRECTION: Fourteen (14) days.

10. MN Rule 4658.0510 Subp. 1.

Based on observations, record review and family, staff and resident interviews the facility failed to provide sufficient staff to meet the needs of 21 out of 27 residents in the sample (#s 2, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 17, 18, 19, 20, 30, 31, 33, 34, 35, 36) plus 6 of 6 in the expanded sample (#s 50, 51, 52, 53, 54 & 55) Findings include:

A. Staff reported there were with insufficient staff to meet resident needs.

During an interview with a Human Service Technician (HST) on 7/27/05 at approximately 10:25 AM related to resident #10 not being checked and changed for approximately 3 hours the HST reported that they were responsible for 14 residents and that they were short one HST today. The HST stated they had not been able to change a resident's clothing who had spilled juice on his pants. The HST reported management staff was aware of the frustrations related to the heavy workload and that HST would ... breaks in order to do their best to try to meet the needs of the residents. The HST stated that the administration had known that the current nursing care model for the unit had not been working was looking at a new care model.

In an interview with a HST on unit 17-3 on 7/29/05 at 10:30 AM, the HST reported that 4 HSTs were not adequate to care for 50 residents who needed "lots of care". The HST reported that over the last two weeks the unit had been staffed with 2 nurses and 3 HSTs. The HST stated that there are approximately 10 residents who would need assistance to eat on the unit and their tray's are served but no one helps them to

eat until all are served this is especially true of the breakfast meal. "Eventually everyone gets fed, but no one should have to sit with a try in front of them and watch others eat." The HST relayed an incident from an evening shift as 2 days ago. "A pool HST had worked on the night shift and the day HST noted that during rounds that all the residents in the group were soaked (with urine). The HST discovered that the night HST not only came late to the shift but did not do the work."

A review of the human service technician (HST) assignment sheets updated as of 7/22/05 on unit 6-1 indicated that there were 3 workgroups for the day and evening shifts. Group 1 consisted of 9 residents, 4 of the 9 required a Sara-type standing lift or full mechanical lift with 1-2 staff to assist; 8 of the 9 residents required assistance with toileting or a check and change at intervals of every two hours related to incontinence of bowel and bladder. Group 2 consisted of 8 residents, 4 of the 8 required a Sara-type standing lift with 1-2 staff to assist; 7 of the 8 residents required assistance with toileting or a check and change at intervals of at least every two hours and as needed, related to incontinence of bowel and bladder. Group 3 consisted of 14 residents, 3 of the 14 required a Sara-type standing lift or full mechanical lift with 1-2 staff to assist; 10 of the 14 residents required assistance with toileting or a check and change at intervals of at least every two hours and as needed, related to incontinence of bowel and bladder. In interviews with various staff throughout the survey staff reported that residents who required assistance of two for a lift transfer were being transferred with the assistance of one because of being short of staff or there partners were on their breaks.

A staff member on 3 North approached this surveyor on 7/26/05 at approximately 6:10 PM. During the interview, the staff member stated, "We are real short of help" and indicated that sometimes residents wait up to 30 minutes before a staff member can assist the resident' s who require assistance with feeding. Residents have to wait on a daily basis to receive assistance. The staff reported that the previous Sunday, 7/24/05 there were 2 nursing assistants between 6:30 – 8:00 AM and we were told that a third aide would start at 8:00AM. The third nursing assistance never showed up. The staff reported that during the survey there were people helping that never come up to the floor. The staff stated "You can 't give adequate care and I go home feeling guilty. I go home in tears because residents ask for help and I can' t give it to them because we are short on help." The indicated that there was a lot of falls occurring.

An interview with a licensed practical nurse (LPN) on 7/26/05 at approximately 6:20 PM revealed that there was no consistency with staffing and that they worked "short staff" on a regular basis.

An interview with an administrative staff on 7/29/05 at approximately 10:10 AM related to staffing concerns, mandated overtime and the staff's ability to meet the needs of the residents. The staff stated that there are staff who have jobs outside of the home and they may have already worked 8 hours prior to their shift at the facility and then may be mandated to work an extra shift on top of that. The staff indicated that if a day shift staff worked into the evening shift the officer of the day would allow the staff to go home as soon as the work was done. The staff indicated that the mandated overtime staff would hurry to get their residents to bed and forgo the evening cares so they wouldn't have to work the full second shift. The administrative staff stated that residents have been receiving poor care over the last 5 months. The staff indicated that residents weren't being shaved, soiled clothes weren't changed, and nourishments were not being passed.

B. The Resident Council in the February 16, 2005, April 6, 2005, and May 4, 2005 meetings reported ... snacks were not being passed out on the unit. The resident group interviewed on 7/27/05 at 10:00 AM although composed of residents who were independent in their cares reported that they had concerns about the evening shift. "Don't seem to care." They also indicated the pool staff were not very good.

A nurse manager interviewed on 7/27/05 at 2:15 PM reported there were 67 current vacant shifts for nurses and HSTs on the schedule to be filled for the weeks 8/10/05 – 8/23/05. During the period of 7/27-8/9/05 there were 56 vacant shifts.

C. Family Members reported insufficient staff to meet resident needs.
During an interview on 7/29/05 at 12:50 PM a family member stated that oral cares and shaving are not given da "Sometimes there is not enough staff to get things done." It was stated the resident is not changed every two hou And that he had not been changed since before breakfast today until the family member left the unit at 12:30 PM.

During a meeting with representatives from the family council on 7/27/05 at 1:40 PM when asked if their grievances were being resolved reported that this was a problem with regard to the "short staff issue". Seven out of seven family members present stated that they were frustrated about staffing on the units a gave several examples of care not being completed for their residents. Examples included toileting not be... done every two hours or according to individual needs, oral care not being done daily, and baths not completed weekly or more often if requested, and call lights not being answered. The family indicated that all they were asking for was "basic care". They also indicated there was a lack of supervision of the Human Service Technicians and the pool staff were short and abrupt. The families reported that follow-up to their concerns is slow. A family member indicated that the administrator indicated concerns about not enough help on the unit to assist with toileting needs at mealtimes should be referred to the nurse. The family member indicated that talking to the nurse was not improving the care. The family reported that they often had to be the one to assist with toileting.

The family members stated that problems related to care issues have not been resolved and that there were conce short staffing. The families reported that when staffing concerns are raised they hear about future plans as soluti solutions are not being implemented to correct the issue in the meantime.

The Minnesota Veterans' Home Family Council minutes from April 3, 2005 indicated families were concerned a "Mandatory overtime, second shift. Members expressed concern that their loved one would be shortchanged by staff working 16 hours in a row. The current growth of this practice appeared to be worrisome. " The March mi indicated that a concern was brought up that some of the residents are not getting baths and were "fallin' ugl

During the "Minnesota Veterans Home-Minneapolis Resident Council/Administration Meeting" June 1, 2005 th brought up concerns about nursing regarding staff following care plans. No specifics were included in the minu reflected that the Director of Nursing found the information "disturbing." The July 6, 2005 minutes reported tha issues about the number of staff on weekends.

D.) Administrative staff when interviewed on 7/28/05 at 1:00 PM indicated that some of the empty shifts were w from the supplemental nursing service agencies (pools) and that mandated overtime and in-house volunteers. Th

administrator indicated that they were aware the current staffing model wasn't working and they were trying the model to increase HST hours.

E.) throughout the course of the survey the surveyors observed resident needs were not being met. Fifteen out of in the sample (#2, #5, #6, #7, #9, #10, #11, #12 , #13 , #15, #17, #18, #20, 33 & 36) and 5 out 5 in the expandec 51, 52, 53, & 54) did not receive services in accordance with their plan of care. Services not performed include:

- Residents in restraints were not released and given opportunity for motion and exercise every two hours
- Residents did not receive timely services with incontinent cares and one resident did not receive those services in a dignified manner.
- Residents did not receive assistance with shaving.
- Residents did not receive oral cares.
- Residents did not receive assistance with nail care.
- Residents who were unable to change their own position did not receive assistance with repositioning.
- The facility did not ensure that residents with a history of dehydration were receiving adequate hydration.
- Residents did not receive assistance with eating in a manner that enhanced their dignity.
- Residents who were incontinent did not receive timely assistance with toileting and incontinence cares.

TO COMPLY: A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements.

SUGGESTED METHOD OF CORRECTION: The Administrator and the Director of Nursing could review the current staffing pattern and resident needs, revise the number of staff to meet the resident needs and instruct all appropriate personnel in the revisions. The Administrator could designate a staff person to do ongoing monitoring to ensure compliance with meeting resident's personal needs.

TIME PERIOD FOR CORRECTION: Fourteen (14) days.

10. N Rule 4658.0520 Subp. 2. A.

Based on observation, interview, and record review, the facility failed to provide adequate and kind and considerate treatment at all times for 1 out of 27 residents in the sample (#33) during repositioning and in continence cares. Findings include:

Evening cares were observed for resident #33 on 7/26/05 at approximately 7:06 PM, the resident was observed to be dangling over a trash can while attached to a manual Sara-type standing lift with no shirt on and his pants down around his ankles (mostly naked). The fleece sling was located directly underneath the resident's armpits and the resident was not holding onto the lift bar. The resident was not bearing any weight on the lift stand that left the resident unsupported in the air (no safety belt was noted). The human service technician (HST) was standing behind the resident and removed the incontinence pad and dropped it into the trashcan located underneath the resident. The HST then cleansed the resident's peri-area as the resident had been incontinent of bowel and bladder, the resident continued to dangle during the process. The resident's face was reddened, eyes open and his expression was a frowning type scowl. An interview with the HST when the evening cares had been completed to follow up on what the usual practice was the resident for repositioning and toileting to find that usually the HST would have a second HST to assist but the HST stated my partner was on break and the resident needed to be changed.

An additional observation of resident #33during evening cares on 7/28/05 at 4:20 PM revealed a similar picture as the evening before; the resident was again hanging over the trash can while attached to the manual Sara lift as the HST was changing the incontinence pad over the trash can. The resident was able to hold onto the lift bar with his left hand and was able to partially bear weight on his feet. The resident was awake and stated to the HST, "what in the hell do you think you're doing?" and the HST replied, "just cleaning you up".

A review of the HST assignment sheet last updated as of 7/22/05 indicated that the resident was non-ambulatory, needed assistance of 1-2 staff, was dependent in all cares, was incontinent of urine – needs help to toilet, check, toilet or change, mechanical lift used for transfers as needed. A review of the resident's current plan of care as of 11/3/04 indicated: "Provide for safety"; "12/29/04, May use mechanical lift as needed due to residents inability to stand". An interview with a second HST on 7/28/05 at 10:30 AM, that had cared for the resident on both the day and evening shifts in the past, as to how resident #33 was transferred revealed that the electric Sara or hand (manual) lift could be used. The HST preferred to use the electric Sara as it had a safety belt. The resident required assistance of 1-2 staff depending on mood, behavior or sleepiness. If the resident was antsy then two staff was needed to assist the resident with transfers and incontinence care. The HST stated the resident was able to sometimes sit on the toilet depending on the level of agitation and that two staff to toilet the resident was a good idea. The manual (hand) Sara was totally unsafe for the resident and if used would definitely need another staff to assist. HST indicated that the resident was never changed over the trash.

A review of the facility policy and procedure related to use a Sara lift transfer, dated 9/1993, indicated; "The Sara lift is used for residents who can bear weight through one or both lower extremities but require moderate to maximal assistance of 1-2 persons to stand and /or pivot. Resident transfers in which a Sara lift is used will require the assistance of one person unless otherwise indicated on the resident's care plan." A picture with instructions on how to apply the sling was also included in the procedure and indicated, "Lower the support arms and place the sling around the resident's back so that it lies 1" of so horizontally above the waist line. If possible, the resident should now hold onto the padded frame with one or both hands. Be

careful not to raise the resident too high or this could cause pressure under the arms. Release brakes and move resident and Sara lift to desired location; commode, toilet, wheelchair, bed, etc." The procedure went onto to state, " Residents who have had a stroke and can only hold with one hand, or who cannot hold on at all, may still be lifted by Sara but a second staff person should support the arm(s) or hold the resident's arms in front of the body during the lift. The Sara is designed for quick easy transfers from one sitting position to another and to elevate a resident for toileting, repositioning, changing of incontinence pads, wound dressings, etc. It is not intended for long periods of suspension or transportation.

TO COMPLY: The criteria for determining adequate and proper care include: Evidence of adequate care and kind and considerate treatment at all times. Privacy must be respected and safeguarded.

SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review the policies and procedures for all areas of treatment with resident care, revise as needed and instruct all appropriate personnel. The Director of Nursing could designate a staff person to do ongoing monitoring to ensure compliance of considerate and adequate resident personal needs.

TIME PERIOD FOR CORRECTION: Fourteen (14) days.

11. MN Rule 4658.0520 Subp. 2. D.

Based on observation, interview, and record review, the facility failed to provide assistance with or supervision of shaving of 9 residents (#6, #9, #50, #5, #51, #52, #53, #2, #54) observed randomly in building 6 as necessary to keep them clean and well groomed. Findings include:

Observations during the initial tour of building 6 on 7/26/05 from approximately 11:30 AM until 1:43 PM revealed 7 male residents (#50, #5, #51, #52, #53, #2, #54) who had not been shaved. Observations during the evening shift on 7/26/05 revealed that resident #6 and resident #9 were not shaved. A review of current plans of care for resident #6 (1/10/05) and resident #9 (8/11/04) indicated that both were dependent with grooming and required assistance to shave. An interview with a human service technician (HST) to follow up on ability of residents (#52, #5, #50, #51, #53 and #2)) to shave on 7/29/05 at 9:45 AM revealed that all of the residents identified needed assistance to shave. A review of the standards of practice for the nursing department related to quality resident care, which was received from the administrator on 7/28/05, indicated, "Shaving daily and as needed".

TO COMPLY: The criteria for determining adequate and proper care include: D. Assistance with or supervision of shaving of all residents as necessary to keep them clean and well groomed.

SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review the current policies and procedures for resident care needs, revise as needed and instruct the appropriate personnel. The Director of Nursing could designate a staff person to do ongoing monitoring of residents personal needs to ensure compliance.

TIME PERIOD FOR CORRECTION: Fourteen (14) days.

12. MN Rule 4658.0520 Supb. 2. E.

Based on observation, interview and record review the facility failed to ensure that 5 out of 27 residents in the sample (#s: 12, 15, 18, 19, & 20) received assistance with oral care. Findings include:

Resident #12 and #15's teeth were not brushed.

Resident #12 had diagnoses that included Alzheimer's disease. According to the care plan dated 7/8/05, the resident's teeth were to be brushed. On 7/26/05 at approximately 7 PM, bedtime cares were observed. The Human Services Technician (HST) used a pink swab to cleanse the oral cavity. Upon interview with the HST immediately following the cares she reported the resident had a full set of teeth, but she did not brush the teeth anymore because she swallowed the toothpaste.

Resident #15 had diagnoses that included dementia, and esophageal reflux. The nursing assistant assignment sheet indicated the resident was total care for grooming. During observations of bedtime cares on 7/26/05 at approximately 7:30 PM, the resident's teeth were not brushed. Upon interview with the HST immediately following cares she reported the resident did have natural teeth. The HST reported she use glycerine swabs for oral care, instead of brushing her teeth.

Upon interview with the nurse manager on 7/28/05 at approximately 9 AM, she reported she would expect resident's teeth brushed, if they have them. Review of the facility's oral care policy, dated 4/16/04 directed natural teeth to be brushed at least twice daily.

Oral cares were not done for residents #18, #19, and #20 resulting in plaque build up and reddened gums.

Per record review, resident #18 was admitted to the facility on 6/10/03 diagnosed with senile delusions, history of myocardial infarction and strokes. According to the resident's care plan the staff was to brush teeth after each meal. Resident #18 saw the dentist on 3/22/05 and recommended tooth brushing each morning and evening. Brush teeth and gums for 2 minutes using soft brush and fluoride toothpaste. Be sure that teeth are brushed 2 times a day. The nursing assistant care sheets stated: electric toothbrush use after meals.

Resident #18 was observed during evening cares on 7/26/05 from 7:00 PM through 7:25 PM. During observation, the nursing assistant toileted the resident, put a night gown on, placed a call light in reach and placed the appropriate alarms on. At no time was the resident given oral cares. At 7:25 PM on 7/26/0[illegible] nursing assistant who gave resident #18 evening cares was interviewed. The nursing assistant confirme[illegible] that he did not give the resident any oral care since he started his shift at 3 PM. The surveyor asked the nursing assistant to glove and check the resident's mouth. The nursing assistant gloved and checked the resident's mouth. The nursing assistant confirmed that the resident had a large amount of plaque build up and that the resident's gums both top and bottom were very reddened. The nursing assistant stated, he was sorry for not doing the oral cares and would do it right now.

Resident #18 was observed on 7/27/05 at approximately 12:45 PM to 1:05 PM in the dining room. At 1:05 PM when the nurse manager pushed the resident to her room and positioned the broda chair with the

resident by the resident 's bed and left.. At 1:13 PM the nursing assistant went into the resident's room and put the resident to bed at 1:20 PM. When asked about oral cares the nursing assistant stated that he had not done any oral cares on the resident. The surveyor asked the nursing assistant if he would show the surveyor the resident's toothbrush. The nursing assistant looked in the resident's drawer and found a regular toothbrush. The surveyor then asked if the resident had an electric toothbrush and the nursing assistant did not know. The nursing assistant looked in the resident's top drawer in the bedside stand and found the electric toothbrush in the back of the drawer. This surveyor requested the nursing assistant to put on gloves and check the resident's mouth. The nursing assistant confirmed that there was a large build up of plague and the gums were very red. The nursing assistant then stated "I'm too busy, I did not do her oral cares today. The nursing assistant stated he wasn't aware that he was to do oral cares after each meal.

Resident #19 was transferred to this facility on 10/19/04 due to increased needs for continued skilled nursing care. The resident had been diagnosed with the dementia and paraplegia. Per the resident's care plan 11/3/04; the resident was totally dependent on staff for all grooming/hygiene needs. The nurse manager was interviewed on 7/28/05 at approximately 10:15 AM concerning resident #19's oral care. The nurse manager checked the resident's mouth after donning gloves and agreed that the resident had a large build up of plague. The resident screamed "ouch" as the nurse manager was looking into the resident's mouth. The nurse manager was questioned about the resident's oral care and confirmed by the appearance of the resident' s mouth that the resident had not been receiving oral cares.

Resident #20 was admitted to the facility on 5/22/00 Huntington's chorea, failure to thrive, dysphasia, and dementia without behaviors.

Resident #20's sister was interviewed on 7/28/05 at approximately 6:45 PM. Per the resident's sister, she stated that she visited every day and indicated that she was concerned staff did not give her brother oral care. She stated that she did not think it was being done because he does not like staff getting close to his face and mouth and can become agitated.

During record review it was noted that neither the nursing assistant care sheet stated nor care plan listed oral cares as a need. The nursing assistant on 7/28/05 at approximately 8:45 AM was interviewed. The nursing assistant stated that she did not do the resident's oral care this AM. This surveyor asked the nursing assistant to check the resident's mouth. The nursing assistant gloved and checked the resident's mouth by parting his lips. During this observation of the resident's mouth a large buildup of plague on all teeth was noted. The nursing assistant replied that she would do his oral cares. At 9:00 AM the nursing assistant reported back to the surveyor that she had completed the resident's oral care and got most of the build up food off the gums and teeth.

TO COMPLY: The criteria for determining adequate and proper care include: E. Assistance as needed with oral hygiene.

SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review the current policies and procedures for providing oral care to residents, revise as needed and instruct the appropriate personnel. The Director of Nursing could designate a staff person to do ongoing monitoring.

TIME PERIOD FOR CORRECTION: Fourteen (14) days.

13. MN Rule 4658.0520 Subp. 2 F.

Based on observation, interview, and record review, the facility failed to provide nail care for 3 out 27 residents in the sample (#6, #33, #55)). Findings include:

During random observations on Tuesday 7/26/05 at approximately 1:40 PM a male resident wearing a green plaid shirt, located in the dining room by the nursing station on unit 6-2, was noted to have long, jagged fingernails. Observations of the evening meal in the north dining room on unit 6-1 at approximately 5:31 PM revealed that residents (#55, #33 , #6) had long, jagged fingernails. A review of the bath schedule for resident #55 indicated, "Monday PM"; resident #33 "Wednesday PM"; and resident #6 "Tuesday PM". The facility-nursing standard of practice related to quality resident care indicated that nail care was completed weekly and as needed (clean and trim). The current plan of care for resident #33 as of 11/3/04 indicated, "nail care after bath"; the current plan of care for resident #6 as of 1/10/05 indicated, "nail care after bath". Observations of resident #6 on 7/28/05 at 4:25 PM revealed that the resident's fingernails continued to be approximately one and a quarter inch long and jagged.

TO COMPLY: The criteria for determining adequate and proper care include: F. Fingernails must be kept clean and trimmed.

SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review the current policies and procedures for resident hand/foot care, revise as needed and instruct the appropriate personnel. The Director of Nursing could designate a staff person to do ongoing monitoring of resident hand/foot care to ensure compliance.

TIME PERIOD FOR CORRECTION: Fourteen (14) days.

14. MN Rule 4658.0525 Subp. 4.

Based on observation, interview, and record review, the facility failed to provide a change of position at least every two hours for 6 out of 24 residents in the sample (#6, #7, #11, #12, # 13, and #18) who were unable to change their own position without assist. Findings include:

Resident #6, #7, #11, #12, #13 and #18 were not repositioned as directed by their care plans.

A review of the current plan of care for resident #6 as of 1/10/05 indicated that the resident was to be repositioned every two hours when in the Broda chair. The current plan of care for resident #7 as of 12/7/04 indicated that the resident was to be repositioned every two hours and as needed. A review of the facility standard of nursing practice related to quality resident care stated, "Turning and repositioning is done every 2 hours".

During evening observations on 7/26/05 from approximately 4:40 PM until 7:55 PM resident #6 and #7 were both observed continuously to be seated in Broda-type wheelchairs. No observations were made of

staff repositioning the residents in or out of their chairs during this period. An interview with the human service technician (HST) responsible for the residents at approximately 7:55 PM revealed that neither resident had any position changes since gotten up from their naps before dinner at approximately 4:30 PM

Resident #11 had diagnoses that included anoxic brain injury and history of falls. The resident had physician orders dated 5/29/05 for a locked Posey belt when in the bed or wheelchair. Physician orders directed the restraint to be released for repositioning every 2 hours. According to the care plan dated 5/12/05, the resident was to be repositioned every 2 hours. The RAP (resident assessment profile) dated 5/12/05 described the resident as at risk for skin breakdown, with a stage 1 pressure sore on his left outer ankle. Resident #11 was continuously observed on 7/26/05 from 4:30 PM until 7:50 PM without being released or repositioned, for a total of 3 hours, 20 minutes. At 7:30 PM the surveyor informed the Human Services Technician (HST), who then assisted the resident to bed at 7:50 PM.

Resident #12 had diagnoses that included dementia, and Alzheimer's disease. The RAP dated 7/7/05 described the resident as being severely cognitively impaired. The RAP identified the resident's skin as being at risk for breakdown, with an intervention of assisting with repositioning every 2 hours while in the wheelchair. Physician orders dated 6/10/03 directed staff to monitor the coccyx daily for signs of irritation.

On 7/26/05 at 4:30 PM, resident #12 was observed visiting with her husband in her room until 6 PM and then was escorted to the dining room. Upon interview with the husband at 6 PM he reported he had arrived at 2:45 PM and reported staff had not changed the resident's position since his arrival. At approximately 7:15 PM the surveyor questioned when resident #12 was last repositioned, and was told it was about 3:45 PM. The surveyor informed the HST the husband reported he had arrived at 2:45 PM and resident #12 had not been repositioned. The HST acknowledged resident #12 was past due for repositioning and assisted the resident to bed.

Resident #13 had diagnoses that included Parkinson's disease and arthritis. The resident was identified on 7/14/05 as having a stage 2-pressure ulcer (a partial thickness loss of skin layers that presents as an abrasion, blister, or crater) on his coccyx. According to the care plan dated 5/20/05 the resident was to be repositioned while in the wheelchair every 2 hours. The care plan identified the resident as having fragile skin and at risk for breakdown. On 7/26/05 resident #13 was observed from 4:30 PM until 7:15 PM (2 hours, 45 minutes) without being repositioned. The surveyor ended the observation at 7:15 PM. to follow-up on another resident.

Resident #18 was observed from 5:10 PM through 7:40 PM. Throughout the observation the resident was not repositioned. Per record review, resident #18 was admitted to the facility on 6/10/03 and diagnosed with senile delusions, history of myocardial infarction and strokes, incontinence of bowel and bladder, and history of pressure ulcers. The nursing assistant work sheet stated: assist with all activities of daily living. Lay down the resident three times a day due to pressure area. The resident's care plan states to check seat belt when in wheelchair every half hour and release, reposition resident every two hours.

Resident #18 was observed on 7/26/05 at approximately 5:10 PM sitting in the dining room at her assigned table with her seat belt on in a broda chair leaning to the right side. She remained in the chair leaning off center to the right 7:00 PM a nursing assistant woke up and took the resident to her room. When transferred

to toilet . The resident's buttock was observed and was reddened. The incontinent product the resident ha... been wearing before she was toileted was soaked with urine and a strong urine odor was present.

The nursing assistant was interviewed on 7/26/05 at 7:25 PM and confirmed that he did not know when the resident had last been toileted or repositioned. The nursing assistant stated that he started his shift at 3 PM and this was the first time he toileted the resident and repositioned her.

Resident #18 was observed again on 7/27/05 at 12:45 PM sleeping at the resident's assigned dining room table in her broda chair with her chin on her chest. At 1:07 PM the nurse manager went over to the resident and said, "it's time for your nap" and wheeled the resident to her room in the broda chair. At 1:13 PM the nursing assistant went into the resident's room, woke the resident up, and gloved before starting cares. The incontinent pad that was removed by the nursing assistant was soaked with urine. After cares were completed the nursing assistant was interviewed at 1:20 PM on 7/27/05. The nursing assistant confirmed that the resident's incontinent pad was soaked and also additional cares such as oral cares, repositioning had not been done for this resident. The nursing assistant stated, I'm just too busy to get all the cares done. I have 12 residents that I am giving care to today by myself.

TO COMPLY: Residents must be positioned in good body alignment. The position of residents unabl change their own position must be changed at least every two hours,

SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review the current policies and procedures on resident positioning/repositioning, revise as needed and instruct appropriate personnel. The Director of Nursing could designate a staff person to do ongoing monitoring to ensure compliance of residents positioning needs.

TIME PERIOD FOR CORRECTION: Fourteen (14) days.

15. MN Rule 4658.0525 Subp. 9.

Based on record review and interview the facility failed implement a system to ensure that 3 out of 3 residents in the sample with a history of dehydration (#19, #20 & 34) were receiving adequate hydration. Findings include:

The facility failed to document intake of fluids for 3 out 3 residents in the sample (#19, #20, & #34) at high risk dehydration.

Resident #34 had been hospitalized on 5/9/05, review of the hospital intake records dated 5/9/05 reveal he had decreased oral intake at the nursing home and was dehydrated with a high potassium level and low blood pressu facility medical record progress note reveal the resident returned to the facility, 5/13/05 with a feeding tube, whi accidentally pulled out by the resident, and was again hospitalized from 5/1/5/05 until 6/28/05. Review of the re since 6/28/05 revealed the resident's intake was not being monitored and recorded by the staff at the facility, alt the output was recorded. The resident had a weight loss of nine pounds in less than a month, and was having an ongoing assessment of his ability to swallow. His caloric and fluid intake was not recorded in the medical record

Resident #20 was admitted to the facility on 5/22/00 and diagnosed with Huntington's chorea and failure to thrive, dysphasia, and dementia. The resident was admitted into the hospital on 2/16/05 for failure to thrive with concerns of malnutrition and dehydration. The Nurse Practitioner's note dated 3/22/2005 documented that the resident's sister's goal was not to have her brother die of dehydration. Per the Nurse Practioner's note on 3/17/05 the resident's sister wants to "Just keep pushing fluids." Care conference notes, dated 4/14/05 documented that even after the resident came out of the hospital for IV hydration that the resident was not maintaining his hydration status and in fact was still dehydrated.

Resident #20's sister was interviewed on 7/27/05 at approximately 6:45 PM stating that she was concerned that when she was not in the facility the staff was not offering fluids to the resident. The resident's sister stated that while she visited she did not see staff come in and offering fluids.

Per record review the nursing assistant sheet stated, "document fluids on the form in resident's room." Honey thickened water to be given whenever staff was with resident for cares. Per physician's orders on 2/28/05 and carried forward to present stated honey thick water 200 milliliters 4 times a day and as needed and to encourage fluids

Resident #20 was observed on 7/26/05 at approximately 6:10 PM in the dining room at the table sitting in a wheelchair eating, fed by a nursing assistant. The resident had sunken eyes and was very thin. The nursing assistant taking care of the resident on 7/28/05 was interviewed at approximately 8:45 AM in the resident's room. There were no fluids in the room to offer the resident. The nursing assistant stated she only documented the output at the end of the shift but did not document fluids taken. Shortly after the interview at 9:00 AM, the Licensed Social Worker from the floor was seen hanging up a sheet in the resident's room to track the resident's fluid intake. The health unit coordinator was interviewed on 7/28/05 at approximately 9:10 AM and confirmed that there were no oral intake records in the resident 's chart, only the output sheets were in the chart.

Per resident #20's care plan, the resident was to be weighted according to the physician's order. The MAR dated 7/05 documented that the resident's weight was to be done first Tuesday every month. Resident's weight on 7/19/05 was 95.3 pounds, 7/13/05 was 108.4 pounds, and 7/5/05 was 100 pounds. The weight recorded on 12/14/04 was 116.4 pounds. The weight for the resident was documented as 928 pounds on 3/22/05 without a reweigh.

Resident #19 was transferred to this facility on 10/19/04 due to an increased need for skilled nursing care. The resident was diagnosed with the following: diabetes type II with neuropathy, dementia with behavior, paraplegia, and renal failure. Cognition level per the quarterly MDS on 7/11/05 was a 3, which indicated severe cognition deficit. Per hospital discharge summary, 4/4/05, the resident was initially admitted with hypotension and received aggressive fluid resuscitation. At discharge from the hospital his blood pressure was normal. On 4/12/05 the resident had a diet change to honey thick secondary to progression of dysphagia. Assessment – possible dehydration and urinary tract infection . Per the resident's care plan, 11/3/04; the resident needed staff assist of one with set up of the meal tray, pouring liquids, cutting meat, applying condiments, and buttering bread. Resident #19 was observed on 7/26/05 at approximately 5:45 PM in the dining room. The resident's skin and mucus membranes appeared dry.

The Nurse Practioner's care plan dated 2/10/05 stated: will increase scheduled free water to 250 cc 4 times a day times 3 days. On 2/19/05 the plan by the nurse practitioner indicated staff were to continue scheduled free water. Per record review, resident #19's nursing assistant sheet documented the resident had a Foley catheter and output every shift was to be done. On 4/13/05, the nurse practitioner spoke with family about resident's likely hood of becoming dehydrated because of his poor fluid intake of thickened water. The family wished for the resident to receive thin free water and thin coffee at meals for quality of life.

Per interview with the nurse manager of the unit on 7/27/05 at approximately 5:30 PM it was confirmed that the resident should be on fluid intake in order to assess the resident's intake. The nurse manager agreed that the resident has a history of dehydration, frequent urinary tract infections, and should be on fluid intake not just output.

On the general environment tour, on 7/27/05 at 10:00 AM, the staffs of building six, third floor were observed filling replaceable insert and placing them inside of water pitchers at bedside without cups or glasses. During interview with the Assistant Administrator and Assistant Director of Nurses (ADON), on 7/29/05 at 9:00 AM, in the ADON's office related to the use of water pitcher at the residents beside the assistant administrator indicated that staff would need to access the kitchenette or get cups from the medication carts in the halls to assist the resident with hydration.

TO COMPLY: Residents must be offered and receive adequate water and other fluids to maintain proper hydration and health, unless fluids are restricted.

SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review the resident hydration policies and procedures to ensure residents are receiving adequate hydration, revise as needed and instruct the appropriate personnel. The Director of Nursing could designate a staff person to do ongoing monitoring to ensure resident hydration compliance.

TIME PERIOD FOR CORRECTION: One (1) day.

16. MN Rule 4658.0530 Subp. 1.

Based on observations and interview, the facility failed to assist 2 out of 27 residents (#10, #56) in the sample with assistance to eat in a manner that was unhurried and that enhanced their dignity. Findings include:

During observations of an evening meal on unit 6-1 in the north dining room on 7/26/05 at approximately 6:00 PM it was noted that a human service technician (HST) had been standing to assist resident #10 to eat. The HST then walked over to resident #56 to continue to assist with beverages as another resident. HST had left the dining room to assist another resident that had wandered out. After approximately one minute the other HST returned to sit down and assist resident #56 while the HST returned to assist resident #10 and remained standing. An interview with the HST while offering a chair to sit in revealed that the HST was more comfortable standing to feed resident #10 related to the height of the resident's wheelchair. A review of the nursing standard of practice for the facility related to quality of care indicated that nursing care and services are performed in such a manner as to provide for and maintain resident dignity.

Review of the care plan dated 5/4/05 direct staff to assist resident #36 by setting up the tray, opening packages ar eat. Observation of resident #36 on 7/26/05 at 8:30 AM the resident was in the dining room waiting for his break was seated in a chair against the wall with an over bed table in front on him. At 8:40 AM the trays had been serv and resident #36 had his breakfast, there was no staff near him to assist with eating. His milk and juice had not been opened. Resident #36 was observed to lift his empty fork to his mouth and then put it down. At 9:0 the resident had eaten just two bites of food on his own and had been unable to open his beverage containers. Af minutes this surveyor asked staff to assist the resident. His beverages were opened and he was encouraged to eat AM a staff member sat next to the resident and assisted to feed the resident, no offer was made to heat up the foo charge nurse was interviewed 7/27/05 at 10:00 AM and stated that this resident should have received assistance v set up of his meal and had his beverages opened

TO COMPLY: Residents needing help in eating must be promptly assisted upon receipt of the meals and the assistance must be unhurried and in a manner that maintains or enhances each resident's dignity and respect.

SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review the resident dining policies and procedures, revise as needed and instruct appropriate personnel. The Director of Nursing could designate a staff person to do ongoing monitoring of resident meal assistance to ensure compliance.

TIME PERIOD FOR CORRECTION: Seven (7) days.

17. MN Rule 4658.0530 Subp. 3.

Based on observation, interview, and record review, the facility failed to monitor to prevent the risk of choking for resident #9 who required thickened liquids. Findings include:

Resident #9 who required thickened liquids was given unthickened juice.
A review of the current physician's orders for resident #9 as of 7/7/05 indicated, "Diet: Pureed with nectar thick liquids, ok for regular bananas, French toast, and pancakes." The plan of care dated 10/24/04 indicated the resident should have a pureed diet with nectar thick liquids.

During observations of a medication pass on 7/27/05 at 11:25 AM a licensed practical nurse (LPN) was noted to give resident #9 regular thin cranberry juice with two regular strength Tylenol. The resident proceeded to choke and cough and spit. Earlier observations of the resident receiving an evening meal on 7/26/05 revealed that the resident was to receive nectar thickened liquids. The LPN stated after having given the thin juice to the resident that, "My fault, he should have thickened liquids.

TO COMPLY: A resident identified in the comprehensive resident assessment, and as addressed in the comprehensive plan of care, as being at risk of choking on food must be continuously monitored by nursing personnel when the resident is eating so that timely emergency intervention can occur if necessary.

SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review the current policies and procedures for dispensing of thickened liquids, revise as needed and instruct appropriate

personnel. The Director of Nursing could designate a staff person to do ongoing monitoring to ensure compliance for resident's fluid needs.

TIME PERIOD FOR CORRECTION: Seven (7) days.

18. MN Rule 4658.0610 Subp. 7.

Based on observation and interview, the facility failed to maintain sanitary conditions at all times in the kitchen. The findings include:

During the initial kitchen tour on 7/26/05 at 12:30PM 3 garbage containers were noted in the food prep area without lids. Food waste was evident by inspection. The dietary manager confirmed these findings. On the subsequent kitchen inspection on 7/27/05 at 1:15 PM the garbage containers were once again noted to be coverless. The dietary manager stated that covers had been ordered.

During the initial kitchen tour on 7/26/05 at 12:30PM the hand scoop was stored inside the sugar bin.

TO COMPLY: Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times.

SUGGESTED METHOD OF CORRECTION: The Dietician could review the current sanitation policies and procedures, revise as needed and instruct appropriate personnel. The Dietician could designate a staff person to do ongoing monitoring to ensue sanitization compliance.

TIME PERIOD FOR CORRECTION: One (1) day.

19. MN Rule 4658.0670 Subp. 2

Based on observation and interview the facility failed to thoroughly clean equipment used in the serving of food. Findings include:

During the kitchen inspection on 7/27/05 at 1:30 PM three steam tables were observed to have built up grease and food residue on the underside of the shelf that was directly over the steam table pans from which food was served. The dietary manager agreed with these findings and requested staff to clean the s tables immediately.

TO COMPLY: All equipment must be thoroughly cleaned and must be given sanitization treatment and must be stored in such a manner as to be protected from contamination.

SUGGESTED METHOD OF CORRECTION: The Dietician could review the current sanitation policies and procedures, revise as needed and instruct appropriate personnel. The Dietician could designate a staff person to do ongoing monitoring to ensue sanitization compliance.

TIME PERIOD FOR CORRECTION: One (1) day.

20. MN Rule 4658.0675 Subp. 7.

Based on observation and interview, the facility failed to air-dry pans after sanitizing and prior to storing them in cupboards. Findings include:

During the kitchen inspection on 7/27/05 at 1:30 PM 5 small baking pans and 7 medium baking pans were observed to be stored wet in the cupboard. The dietary manager agreed that the pans should be dry and removed the pans to be rewashed. On a subsequent visit to the kitchen on 7/28/05 at 7:30 AM 2 large pans were observed to be stored wet in the same cupboard.

TO COMPLY: All dishes and utensils must be air-dried before being stored or must be stored in a self-draining position.

SUGGESTED METHOD OF CORRECTION: The Dietician could review the equipment cleaning/sanitization policies and procedure, revise as needed and instruct appropriate personnel. The Dietician could designate a staff person to do ongoing monitoring to ensure compliance.

TIME PERIOD FOR CORRECTION: Seven (7) days.

21. MN Rule 4658.0720 Subp. 1 B.

Based on observation, interview and record review the facility failed to ensure that 5 out of 27 residents in the sample (#s: 12, 15, 18, 19, & 20) received assistance with oral care. Findings include:

See #14. MN Rule 4658.0520 Supb. 2. E

TO COMPLY: A nursing home must provide a resident with the supplies and assistance necessary to carry out the resident's daily oral care plan.

SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review the current policies and procedures for providing oral care to residents, revise as needed and instruct the appropriate personnel. The Director of Nursing could designate a staff person to do ongoing monitoring.

TIME PERIOD FOR CORRECTION: Fourteen (14) days.

22. MN Rule 4658. 0725 Subp. 1

Based on observation, interview and record review the facility failed to ensure that 1 out 27 residents in the sample #19 received routine dental care. Findings include:

Resident #19 was transferred to this facility on 10/19/04 due to increased needs for continued skilled nursing care. The resident had been diagnosed with the dementia and paraplegia. Per the resident's care plan 11/3/04; the resident was totally dependent on staff for all grooming/hygiene needs. The nurse manager was interviewed on 7/28/05 at approximately 10:15 AM concerning resident #19's oral care. The nurse manager checked the resident's mouth after donning gloves and agreed that the resident had a large build up of plague. The resident screamed "ouch" as the nurse manager was looking into the resident's mouth. The nurse manager was questioned about the resident's oral care and confirmed by the appearance of the resident' s mouth that the resident had not been receiving oral cares.

The record did not contain any reports of dental visits. The nurse manager also confirmed that the resident did not have a scheduled dental appointment.

TO COMPLY: A. A nursing home must provide, or obtain from outside resource, routine dental services to meet the needs of each resident.

SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review the current resident dental policies and procedures, revise as needed and instruct appropriate personnel. The Director of Nursing could designate a staff person to do ongoing monitoring to ensure compliance.

TIME PERIOD FOR CORRECTION: Thirty (30) days.

23. MN Rule 4658.0800 Subp. 3.

Based on observation, interview, and record review, the facility failed to provide adequate infection control for 5 out of 27 residents in the sample (#8, 11, 15, 18 & 33) . Findings include:

Gloves were not changed when going from a contaminated area to clean area, and a wet incontinent pad was placed on the floor.

Resident #15 had diagnoses that included dementia. The resident had a Foley catheter in place, with a leg bag on during the day, and a drainage bag during night hours. On 7/27/05 at approximately 7:30 PM personal cares were observed. The Human Services Technician (HST) assisted with changing an incontinent pad, which was soiled with stool. The HST applied gloves and washed the buttocks with disposable cleansing pads, which were then tossed into garbage. Without changing gloves, a new cleansing pad was retrieved from the container and used to clean the resident, a clean incontinent pad was then pl on the resident, the leg bag tubing was disconnected from the catheter and the drainage bag connection tubing wiped with alcohol and hooked to the catheter.

Upon review of the facilities Employee Exposure Control Plan, dated 4/01 it directed staff to change gloves between each site being cared for, on an individual resident.

Resident #11 had diagnoses that included anoxic brain injury, and history of MRSA (methicillin resistant staphylococcus aureus). During observations of personal cares on 7/27/05 at approximately 7:45 PM the HST assisted with incontinent care. The resident's incontinent pad was removed, which was wet, and

placed on the floor. Upon review of the care plan dated 7/12/05 it stated the resident had MRSA in the urine, and to utilize precautions for MRSA. Upon interview with the HST immediately following cares she reported she usually placed soiled incontinent pads in the garbage.

Observations were made of resident #33 during evening cares on 7/26/05 at approximately 7:06 PM. The human service technician (HST) was changing the resident's incontinence pad after episodes of bowel and bladder incontinence.. The HST had gloves on as the process was started and finished but did not change the gloves after cleaning up the resident's soiled peri-area before proceeding with the rest of the resident cares. While wearing the same gloves the HST lowered the resident back into his chair and touching all areas of the Sara lift during the process, placed a clean hospital type gown on the resident and removing the resident's clothes. The HST then removed the gloves to adjust the resident in the wheelchair. The HST re-gloved, no hand washing had been observed and preceded to remove the soiled linen and incontinence product from the trashcan to place into separate garbage bags. The HST touched the handle of the door to leave the room with the gloved hand that had touched the soiled linen and incontinence pad. The HST then went down the hall to the soiled bins and disposed of the soiled items and then removed the gloves; again no hand washing had been observed.

Observations of toileting cares for resident #8 on 7/27/05 at approximately 8:45 AM revealed that the resident had placed himself on the toilet and an incontinent bowel movement all over the toilet seat and on his socks. The HST was assisting the resident with peri-care to clean up the mess wearing gloves. Wearing the same gloves the HST replaced the incontinence pad with a clean one, pulled up the resident's protective hip pads and resident's pants. The HST then proceeded to clean off the toilet seat with a disposable type washcloth and then dried the seat with a paper towel. The HST then removed the gloves, no hand washing observed, and reapplied clean gloves. An interview with the HST after the toileting cares the HST stated he would normally change gloves after cleansing the soiled peri-area, complete hand washing and reapply clean gloves to clean the toilet.

Resident #18's had blood on finger and nail bed and her hands were not washed before she was served her meal tray

Per record, resident #18 was admitted to the facility on 6/10/03 diagnosed with senile delusions, history of myocardial infarction and strokes, basal cell carcinoma of the face, incontinence of bowel and bladder, and Methicillin resistant organisms in the urine on 10/13/04. Per the resident's care plan, the resident needed assistance for all activities of daily living.

Resident #18 was observed in the dining room on 7/26/05 at approximately 5:10 PM sitting at her assigned table. The resident had dried red blood on her right pointer finger and under her nail bed. The resident had a dark black scab on the tip of her nose. At 5:40 PM the resident was served her evening meal on a tray. A RN set up the dining tray for the resident but did not wash the resident's hands.
At 5:50 PM on 7/26/05 the surveyor asked the RN about the finger. The RN confirmed that she was not aware that the resident had blood on her finger nor had she looked at the resident's hands.

A review of the standards of nursing practice for the facility related to quality of resident care indicated that, "Personal protective equipment to be worn during toileting. Wash hands after toileting/changing resident". A review of the policy related to personal protective equipment as of 4/01 indicated, "Gloves should be

changed (and hands washed) between each resident contact and between each site being cared for on an individual resident.". A review of the hand washing policy as of 4/01 indicated when to wash hands: "before and after procedures, before and after gloving, before and after direct resident contact, before and after handling equipment/supplies/laundry".

TO COMPLY: Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program.

SUGGESTED METHOD OF CORRECTION: The Infection Control nurse could review the current policies and procedures for standard infection control during resident cares, revise as needed and instruct appropriate personnel. The Infection Control nurse could designate a staff person to do ongoing monitoring to ensure infection control compliance.

24. MN Rule 4658.1340

Based on surveyor observation and staff interview, the facility failed to assure medications were secured one out of three buildings surveyed, Building #17. Findings include

During observations, on 7/28/05 at 8:55 AM, of the medication carts on second floor of building seventeen, the two south and two north carts, were observed to be unlocked and unattended. The unit staff failed to locate the nurse assigned to the two-north cart that was located in the hallway unattended until 9:05 AM when the nurse returned from break. The two-north medication cart contained medications for 15 residents, topical diabetic supplies, and stock medications. The two south unit medication cart was parked at the nurses station 9:08 AM were it remained unattended and unlocked until 9:13 AM when the assigned nurse returned. The two-south medication cart contained medications for 15 residents.

TO COMPLY: A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys.

Subp. 2. **Storage of Schedule II drugs.** A nursing home must provide separately locked compartments, permanently affixed to the physical plant or medication cart for storage of controlled drugs listed in Minnesota Statutes, section 152.02, subdivision 3.

SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review the current medication storage policies and procedures, revise as needed and instruct appropriate personnel. The Director of Nursing could designate a staff person to do ongoing monitoring to ensure medication storage compliance.

TIME PERIOD FOR CORRECTION: One (1) day.

25. MN Rule 4658.1345

Orders to MN Veterans Home Minneapolis

Based on surveyor observation and staff interview, the facility failed to assure medications labeled. Findings include:

An open unlabeled multi-dose bottle of lidocaine was located in the two south medication cart. During observations, on 7/28/05 at 8:55 AM, of the medication carts on second floor of building seventeen were reviewed. The second floor staff provided the documentation in the resident's medication administration record that the lidocaine was ordered to dilute the Rocephin (an injectable antibiotic) as ordered by the physician.

During the interview with the facility pharmacist, on 7/29/05 at 9:30 AM, indicated that the pharmacy usually labels the lidocane, and that the bottle may have been used from the facility's E-Kit that isn't labeled. The facility's policy requires multi-dose bottles to be labeled with expiration date and the date opened.

TO COMPLY: Drugs used in the nursing home must be labeled in accordance with part 6800.6300.

SUGGESTED METHOD OF CORRECTION: The Consultant Pharmacist and the Director of Nursing could review the current medication labeling policies and procedures, revise as needed and instruct appropriate personnel. The Director of Nursing could designate a staff person to do ongoing monitoring to ensure compliance of medication labels.

TIME PERIOD FOR CORRECTION: Fourteen (14) days.

26. MN Rule 4658.1415 Subp. 2

During the environment tour, on 7/27/05 at 9:00 AM, with the assistant administrator and the director of physical maintenance department observation of the following areas of concerns were noted.

Building six

Male and female bathrooms next to the activity room (G13) were open to the corridor, the door hardware included a locking mechanism. Observation of both bathrooms with the assistant administrator verified no call light system was installed.

Through out the ground floor corridor the areas near doorways and corners had a build up of dust, debris and wax.

The smoke room (G24) had streaked areas of brown tar stains on walls and windows. The floor, chairs and tabletops had multiple areas of cigarette burns and the ceiling tiles and air supply ducts were covered with brown tar stains. The area had an internal air filter system that the director of physical maintenance stated had filters that were changed on a 1-2 month rotation.

The dining rooms (332 and 312) had multiple chairs observed to be soiled and stained with unidentified substance, the executive housekeeper indicated that the chairs where cleaned on a monthly schedule but many were stained and no longer cleanable.

Window frames in the dining room (332) had areas of dents and chips exposing the metal corner bead. When interviewed the director of physical maintenance stated that painting and wall repair was not part of the preventive maintenance program and that the staff identified areas of need using the facilities computer program.

Tub rooms on third and second floors contained tubs that had the rubber bumpers repaired with tape, the tape was coming loose in many areas leaving a sticky residue that collected water, soap and other unidentified substances. The second floor tub had gray flaked substance covering the horizontal surface of the seat and the bottom near, director of physical maintenance explained that it was a nursing duty to clean the tubs after use.

The kitchenette on second floor had areas of damage on the walls and corners.

Resident room (213) had the thermostat pushed through the dry wall, bed #2's closet ha areas to both sides of the door frame damaged exposing the metal corner beading.

Building 17

The tub rooms on all floors have accumulations of dust and debris under the whirlpool tubs. Tub room floors have collection of white and brown substances in the corners under sinks and behind the stool. The three south tub room had broken tiles in the shower area. In the second south tub room baseboard area tiles had come off the wall exposing the drywall and a dark gray substance along the floor.

The floor surface of building 17 are vinyl sheet that was curled up around the walls forming a baseboard, per the director of physical maintenance this was a poor instillation currently the plan was to fix areas that became loose by reattaching and screwing the vinyl to the walls. Areas of detached vinyl observed during the tour: hall areas near rooms # 439, 247, and 286 and the bathroom of room 247.

The smoking area of building 17 had areas of tar staining on walls, windows, and ceilings. The executive housekeeper indicated the room was cleaned twice on days and once evenings. Furnishings in the smoke room have areas if cigarette burns, when approach the director of physical maintenance stated in the last 16 months he has not identified a need to replace furnishings in the smoke room. The facility's plan with damaged or unsafe furnishings would be for staff to take it out of service and notify physical maintenance through a work order.

Resident Room 367 had damage to the walls by the windows exposing metal beading. Resident Room 288 had a strong urine odor noted throughout the room and into the hall both on initial tour 7/26/05 and during the environment tour on 7/27/05.

Main dining area of building seventeen had four suspended ceiling tiles in the center of the room over a resident tables had areas of brown stains. The director of physical maintenance stated the stains could have been caused by condensation on overhead pipes.

TO COMPLY: A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible.

SUGGESTED METHOD OF CORRECTION: The Environmental Director could review the current cleaning/maintenance policies and procedures, revise as needed and instruct appropriate personnel. The Environmental Director could designate a staff person to do ongoing monitoring to ensure compliance.

TIME PERIOD FOR CORRECTION: Thirty (30) days.

27. MN Statute § 144A.04 Subd. 11

Based on observation, interview, and record review, the facility failed to residents every two hours with incontinence care for 5 of 27 residents in the sample (#6, #7, #10, #11, #18). Findings include:

During evening observations on 7/26/05 from approximately 4:40 PM until 7:55 PM resident #6 and resident #7 were not observed to be toileted, checked or changed. An interview with the human service technician (HST) at approximately 7:55 PM revealed that the two residents had not been toileted, checked or changed since before dinner at approximately 4:30 PM. The HST assignment sheet last updated as of 7/22/05 indicated that both residents are incontinent of bowel and bladder and are to be toileted, checked and changed every two hours. A review of the current plan of care for resident #6 as of 1/10/05 indicated, "Resident incontinent of bowel and bladder. Wears incontinence pad at all times. Toilet/change q (every) 2hrs and prn (as needed).". A review of the current plan of care of resident #7 as of 12/7/04 indicated, "Toilet/change q 2hrs and prn".

Evening observations of resident #10 on 7/26/05 from approximately 4:40 PM until 7:45 PM revealed that the resident had not been toileted or checked and changed. An interview with the HST at 7:45 PM revealed that the last time the resident had been checked and changed was at approximately 3:30 PM. Morning observations of resident #10 on 7/27/05 from approximately 7:30 AM until 10:25 AM revealed that the resident was not observed to be checked and changed. An interview with the HST at 10:25 AM revealed that the last time the resident was checked and changed was at approximately 7:30 AM before breakfast. A review of the HST assignment sheet updated as of 7/22/05 indicated that the resident was incontinent of bowel and bladder and was to be toileted, checked and changed every two hours. A review of the current plan of care for resident #10 as of 12/30/04 indicated, "Toilet/change q 2hrs and prn".

A review of the standards of nursing practice for the facility related to quality of resident care indicated, " Promptly assist resident on and off toilet as needed. Offer toileting a minimum of every two hours to resident requiring assistance. Incontinent residents to use disposable garment at all times with disposable padding under the resident while in bed (check care plan for proper garment size). Change wet/soiled garment, wash peri-rectal area with periwash and disposable wash cloth; and replace disposable garment. Follow this procedure every 2 hours. Provide privacy throughout procedure."

The facility failed to ensure resident #11 was toileted as directed on the care plan.

Resident #11 had diagnoses that included anoxic brain damage, and history of falls.
Physician orders dated 5/29/05 included a locked Posey belt when in the wheelchair to enhance safety. According to the care plan, dated May 12 2005 the resident was described as requiring total assistance with toileting. The minimum data set (MDS) dated 5/12/05 described the resident as having inadequate control of the bladder, with multiple daily episodes of incontinence. The care plan directed staff to assist with toileting every 2 hours, and to check for incontinence every 2 hours. Resident #11 was observed on 7/26/05 from 4:30 PM until 7:50 PM without being toileted (3 hours, 20 minutes). The surveyor alerted staff at 7:30 PM, and at 7:50 PM the resident was assisted to bed. The resident's incontinent pad was changed, and was noted to be wet.

The facility failed to toilet resident #18 according to needs.

Resident #18 was observed on 7/26/05 at approximately 5:10 PM sitting in the dining room at her assigned table with her seat belt on in a broda chair leaning to the right side. She remained in the chair leaning to right until shortly after 7:00 PM when a nursing assistant took the resident to the her room. The restraint was released at 7:40 when she was transferred. The resident's buttock was reddened. The incontinent product the resident had been wearing before she was toileted was soaked with urine and a strong urine odor was present. The nursing assistant was interviewed on 7/26/05 at 7:25 PM and confirmed that he did not know when the resident had last been toileted or repositioned. The nursing assistant stated that he started his shift at 3 PM and this was the first time he toileted the resident and repositioned her. The nursing assistant confirmed that the incontinent pad he removed was very wet.

Resident #18 was observed on 7/27/05 at 12:45 PM sleeping at her assigned dining room table in her broda chair with her chin on her chest. At 1:07 PM the nurse manager went over to the resident and said, "it's time for your nap" and wheeled the resident to he room in the broda chair. At 1:13 PM the nursing assistant went into the resident's room, woke the resident up and started cares. The incontinent pad that was removed by the nursing assistant was soaked with urine.

After cares were completed the nursing assistant was interviewed at 1:20 PM on 7/27/05. The nursing assistant c the resident's incontinent pad was soaked. The nursing assistant stated, I'm just too busy to get all the cares done residents that I am giving care to today by myself.

TO COMPLY: An incontinent resident must be checked according to a specific time interval written in resident's care plan. The resident's attending physician must authorize in writing any interval longer than two hours unless the resident, if competent, or a family member of legally appointed conservator, guardian, or health care agent of a resident who is no competent , agrees in writing to waive physician involvement in determining this interval.

SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review the policies and procedures for all areas of treatment with resident care, revise as needed and instruct all appropriate

personnel. The Director of Nursing could designate a staff person to do ongoing monitoring to ensure compliance of considerate and adequate resident personal needs.

TIME PERIOD FOR CORRECTION: Fourteen (14) days.

28. MN Statute §144.651 Subd. 5.

Based on observation, interview, and record review, the facility failed to treat residents with courtesy and respect for their individual differences. Findings include:

During random observations during the initial tour on 7/26/05 multiple call lights in resident rooms in building 6 were noted to be out of reach, hanging behind the bed, hanging over a recliner, hanging on a nightstand towel bar, and wrapped around the call light unit on the wall. An interview with the HST on unit 6-1 on 7/29/05 at 8:40 AM related to call lights observed that morning in resident #57 and #58 rooms that were not in reach revealed that resident #58 will use the call light and the resident #57 the HST was not sure if the resident could use the call light or not. Another interview with and HST from unit 6-2 on 7/29/05 at 9:30 AM related to a call light that was not in reach for resident #59 that morning revealed that the resident was able to use the call light. A review of the policy and procedures for resident safety indicated, "Always make sure call light is positioned within resident reach.". A review of the standards of nursing practice for the facility related to quality resident care indicated, " Call lights are accessible to residents".

Observations of incontinence care for resident #33 on 7/26/05 at 7:06 PM revealed that resident #33 was dangling from a manual Sara-type lift stand with only the fleece sling under his arms holding the weight of his body, while the human service technician (HST) changed the soiled incontinence pad and gave the resident peri- care over the trash can. An interview with a licensed practical nurse (LPN) on 7/28/05 at 10:10 AM related to the above mentioned observation of the resident dangling, the LPN stated that the HST should not have used the Sara lift if the resident could not hold on and should not have done this over a trash can. A review of the standards of practice for nursing related to quality resident care indicated, "Provide for and maintain resident dignity". A review of the policy and procedure related to use of the Sara lift as of 9/1993 indicated, "The Sara is designed for quick easy transfers from one sitting position to another and to elevate a resident for toileting, repositioning, changing of incontinence pads, wound dressings, etc. It is not intended for long periods of suspension or transportation". Resident #17 did not have his catheter bag emptied as needed. Per record review, resident #17 was admitted to the facility on 08/26/03 with diagnoses that included neurogenic bladder, and diabetes. According to the residents care plan, the staff was to empty and record Foley catheter output every shift and complete catheter care per physician order. The nursing assistant sheet instructed the nursing assistant to empty Foley every shift and report and to "check bag often – fills quickly."

Resident #17 was observed on 7/27/05 at 7:45 AM while lying in bed in his room. The resident had a leg bag on for urine collection that was full. The resident's sweat pants were soaked in the groin area. Resident #17 was interviewed at 7/27/05 at 7:45 AM and stated "cares are not very good, you have to wait a long time to get help." The staff does not empty my urine bag when they should so it overflowed. The spillage

happens so often that I don't feel real good about it. The night staff went home today without emptying my bag and now I am all wet.

The nursing assistant came into the resident's room on 7/27/05 at approximately 7:47 AM and started AM cares. The resident said to the nursing assistant as she tried to remove the residents wet sweat pants, "why don't you empty my bag first?" The nursing assistant replied to the resident, "I was going to get these wet pants off you first. The nursing assistant emptied the leg bag of 500 milliliters of urine. The maximum capacity of the leg bag was 500 milliliters.

The nursing assistant was interviewed after cares at approximately 8:00 AM and confirmed that resident #17's urine leg bag had not been emptied by the night staff.

TO COMPLY: Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility

SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review the current policies and procedures for courteous/respectful resident treatment, revise as needed and instruct the appropriate personnel. The Director of Nursing could designate a staff person to do ongoing res treatment to ensure compliance.

TIME PERIOD FOR CORRECTION: Fourteen (14) days.

cc: Original - Facility
Licensing and Certification File
Records and Information
Ellie Laumark, Unit Supervisor
Minnesota Department of Human Services
Hennepin County Social Services
Mr. Frank Budd, MD, President Governing Body

STATE OF MINNESOTA
VETERANS HOMES BOARD
MINNESOTA VETERANS HOME – MINNEAPOLIS
5101 MINNEHAHA AVENUE SOUTH
MINNEAPOLIS, MINNESOTA 55417-1699
(612) 721-0600

September 7, 2005

Ms. Ellie Laumark, Unit Supervisor
Minnesota Department of Health
Health Policy, Information and Compliance Monitoring Division
Licensing and Certification Program
1645 Energy Park Drive, Suite 300
St. Paul, MN 55108-2970

RE: Minneapolis Veterans Home – Plan of Correction

Dear Ms. Laumark,

Attached is the plan of correction for the Minnesota Department of Health survey that was conducted on July 26 – 29th, 2005 at the Minnesota Veterans Home – Minneapolis. As the result of the survey, the Minnesota Board of Director's responded with an action plan that was deliberate and decisive to respond to the citations and make significant changes in key personnel at the facility. The Administrator was replaced by Stephen Musser, Executive Director and the Director of Nursing replaced by Diane Vaughn, RN. In addition, one Assistance Administrator and the quality manager were removed.

We believe that the actions taken in the plan of correction demonstrate a thoughtful and comprehensive approach to correcting those items that require immediate attention and a longer range plan for ensuring that there are systems in place to proper monitoring and compliance with Health Department standards.

We look forward to your return visit so we can demonstrate that we have corrected the citations and installed procedures to ensure that ongoing compliance is met.

Sincerely,

Stephen J. Musser
Executive Director/Administrator

MN Veterans Home – Minneapolis
MDH Survey Plan of Correction
July 25-29, 2005

Abbreviation legend:
RNM: Registered Nurse Manager
IDT: Interdisciplinary Team
PCN: Position Control Number
RTF: Request to Fill form

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
1. 4658.0110 INCIDENT AND ACCIDENT REPORTING. All persons providing services in a nursing home must report any accident or injury to a resident, and the nursing home must immediately complete a detailed incident report of the accident or injury and the action taken after learning of the accident or injury. IR not completed on #34.	The incident report has been completed on resident #34. The RNM has received a review of the expectations of Incident reporting procedures.	8/8/05	RNM 2N	See attachments: 1a (Incident Report)
	To improve monitoring of incident reports, an electronic incident report is being initiated through the clinical software program. This allows for "real time" monitoring of incident reports.	Electronic IR initiated 9/1/05	Assistant Administrator of Resident Life Services	1b (Incident Report procedure)
	Incident reports will be continued to be tracked and trended on an on-going basis.	9/1/05	Director of Nursing	1c (Sample of electronic incident report tracking list)

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
2. 4658.0300 USE OF RESTRAINTS **Subp. 4. Decision to apply restraint.** The decision to apply a restraint must be based on the comprehensive resident assessment. The least restrictive restraint must be used and incorporated into the comprehensive plan of care. The comprehensive plan of care must allow for progressive removal or the progressive use of less restrictive means. A nursing home must obtain an informed consent for a resident placed in a physical or chemical restraint. A physician's order must be obtained for a physical or chemical restraint which specifies the duration and circumstances under which the restraint is to be used, including the monitoring interval. Nothing in this part requires a resident to be awakened during the resident's normal sleeping hours strictly for the purpose of releasing restraints. Lap Buddies without doctor's orders - residents #'s 4,9,30, 31, 18, 19 No assessment of least restrictive device 14 days	Those residents noted in the survey requiring documentation, reassessment, and/or a plan for reduction were brought to the individual resident's clinical rounds (IDT) team for reassessment. The social workers and behavioral analysts performed a complete house audit of all devices to assure that required documentation is present. The audits were reviewed by the Clinical Rounds (Interdisciplinary Team - IDT). Reviews and reassessments were completed as indicated. To continue a restraint reduction process the Resident Safety Workgroup will add restraint rounds to its process to ensure reduction is occurring throughout the facility. Resident Safety processes were reviewed and updated. On-going education re: "restraint proper environments" will be developed through this rounds team. An educational event is scheduled for 9/14 and 15/05.	9/2/05 8/25-30/05 8/31/05 to 9/2/05 9/2/05 9/14 & 15/05	Director of Nursing	See attachments: #2a (Team instructions) #2b (Device audit) #2c (Team instructions for reassessment)

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
3. 4658.0300 USE OF RESTRAINTS **Subp. 5 C. Physical restraints.** At a minimum, for a resident placed in a physical restraint, a nursing home must also: C. provide an opportunity for motion, exercise, and elimination for not less than ten minutes during each two-hour period in which a restraint is employed; and Repositioning - residents not repositioned for greater than 3 hours #4, 11, 9, 18 14 days	Unit by unit education was given to ensure the expectation that all residents are provided an opportunity for motion, exercise, and elimination for not less than ten minutes during each two-hour period in which a restraint is employed. Monitors (Internal surveyors) are in place to observe this occurs and intervene to eliminate the barriers when this is challenged.	9/2/05	Director of Nursing	See also Licensing violation # 10-2

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
4. 4658.0400 Subp 2I Dental Subp. 2. **Information gathered.** The comprehensive resident assessment must include at least the following information: I. dental condition; **14 days**	We respectfully disagree with this citation as the existing system does meet the regulatory requirements. The residents in the survey sample had an initial oral exam by Appletree Dental. An excel file exists that tracks resident dental visits. To continuously improve service, the existing policy was modified.	9/2/05	Director of Health Information Management	See attachments #4 a and #4b (oral exam forms) #4c (scheduling procedures - changes circled) #4d (existing Dental Services Protocol) #4e Dental Director Program

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
5. 4658.0405 Subp 1 Failure to develop care plans **Subpart 1. Assessment.** A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care as defined in part 4658.0405. No smoking assessment #35 General lack of assessment #20, 27 20 days	Individual resident assessments have been completed. Met with the IDT department managers and reviewed the documentation policy - which remains compliant with the regulations. IDT departments are reviewing the expectation with their staff. On-going surveillance for timeliness of assessment and for re-assessments is instituted.	9/8/05	Director of Nursing and Assistant Administrator of Resident Life Services Quality Manager	See attachment #5a (meeting minutes) #5b (related policies)

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
6. 4658.0405 COMPREHENSIVE PLAN OF CARE. **Subp. 3. Use.** A comprehensive plan of care must be used by all personnel involved in the care of the resident. Toileting Repositioning Oral care I&O Residents: 20, 17,. 11, 13, 12, 7, 10, 6 14 days	The plan of care and HST worksheets were reviewed for completeness on the noted residents. Educational review and enforcement with HST's and staff nurses HST sheets are care plan based On-going surveillance for timeliness of assessment and for re-assessments is instituted.	9/2/05	Director of Nursing Quality Manager	

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
7. 4658.0405 COMPREHENSIVE PLAN OF CARE. **Subp. 4. Revision.** A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. Not revised resident #34 (thickened liquid diet change -) **14 days**	IDT review of individual resident case. Review and enforcement of IDT responsibilities to update care plan as orders are obtained.	9/2/05	Director of Nursing Assistant Administrator of Resident Life Service	See attachments # 5b (documentation policy)

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
8. 4658.0470 Subp 2 **4658.0470 RETENTION, STORAGE, AND RETRIEVAL.** Subp. 2. **Storage.** Space must be provided for the safe and confidential storage of residents' clinical records. Records of current residents must be stored on site. 7 days	The charts racks at building 6 nursing stations have been relocated to the charting room which has a locked door. IDT members will have key access.	8/26/05	Director of Health Information Management	Completed

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
9.4658.0505 Subp 1 Comprehensive care plan carried out **14 days**	Unit by unit on all shift education was given to review the basic methods of care plan implementation involving HST duties. The daily HST sheets are care plan based. RNMs reviewed them for completeness.	9/2/05	Director of Nursing	Completed

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
10. 4658.0510 sp 1: Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. **14 days** Staffing Needs: through interviews and observations, staff were unable to meet resident needs; toileting, repositioning, shaving, nail care and nourishments not being passed.	Major administrative changes were made. The administrator, assistant administrator of resident clinical services, Director of Nursing, and Quality Manager have separated employment. An interim administrator and interim DON are in place. Initially 4 HST shifts were added to building 6; On 8/26/05 14 shifts of HST's per 24 hours was added within the nursing home care units. Meeting was held with temporary agency vendors to improve availability and continuity of care givers on 8/31/05. Priority of replacing shift vacancies is: volunteers for extra hours, temporary agency, and as a last resort - mandation. The system of RTF's and PCN was reviewed and the process improved to decrease the time a vacancy is open. Absenteeism policies are being enforced. We are continuing to refine staffing patterns / distribution of staff	8/30/05 8/29 and 30/05 8/26/05 8/31/05 8/22/05 9/2/05 On-going On-going	Administrator, Director of Nursing, and Director of Human Resources	

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
10-2. 4658.0520 ADEQUATE AND PROPER NURSING CARE. **Subp. 2.A. Criteria for determining adequate and proper care.** The criteria for determining adequate and proper care include: A. Evidence of adequate care and kind and considerate treatment at all times. Privacy must be respected and safeguarded. 14 days Toileting, mechanical lift transfers, oral hygiene, repositioning, and clean clothing.	Nursing care standards were reviewed. Unit by unit - all shift inservicing was done to review expectations of care and resident treatment. A care audit was designed and is used on every shift to ensure cares are being delivered. Intermittent monitors are scheduled to assure cares are being delivered properly and with respect. A comprehensive inservice is being designed by social services for use in additional HST training and to replace current general orientation education on resident dignity and respectful treatment. HST orientation competency processes are being revised. Current HST's will go through re-competency testing over the next two quarters. Leadership training for licensed nurses will be presented within the next 2 quarters.	9/2/05 9/2/05 Started 8/30/05 10/1/05 10/1/05 1/1/06 1/1/06	Director of Nursing	See attachments 10-2a (standards) 10-2b (audit) 10-2c (monitor packet)

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
11. 4658.0520 ADEQUATE AND PROPER NURSING CARE. Subp 2 D D. Assistance with or supervision of shaving of all residents as necessary to keep them clean and well-groomed. 14 days	See #10-2 above	9/2/05	Director of Nursing	
12. 4658.0520 ADEQUATE AND PROPER NURSING CARE. Subp 2 E E. Assistance as needed with oral hygiene to keep the mouth, teeth, or dentures clean. Measures must be used to prevent dry, cracked lips. **14 days**	See #10-2 above	9/2/05	Director of Nursing	
13. 4658.0520 ADEQUATE AND PROPER NURSING CARE. Subp 2F F. Proper care and attention to hands and feet. Fingernails and toenails must be kept clean and trimmed. **14 days**	See #10-2 above	9/2/05	Director of Nursing	

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
14. 4658.0525 REHABILITATION NURSING CARE. **Subp. 4. Positioning.** Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval. 14 days Residents # 6, 7, 12, 18	See #10-2 above The individual residents noted in the survey sample have been reviewed by the nurse manager.	9/2/05	Director of Nursing	

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
15. 4658.0525 REHABILITATION NURSING CARE. **Subp. 9. Hydration.** Residents must be offered and receive adequate water and other fluids to maintain proper hydration and health, unless fluids are restricted. No I & O No cups provided with water pitchers Residents # 34, 20, 19 1 day	The individual residents noted in the survey were reviewed by the RNM. These situations are remedied. An interdisciplinary team including Speech Therapy Nursing, Medical Director, and Dietitians met to review the hydration procedures. The following decisions were made: The current water passing procedure will be continued and the RNM and OD's are accountable to enforce that it is followed. See also # 17	8/24/05	Director of Nursing	

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
16. 4658.0530 ASSISTANCE WITH EATING. **Subpart 1. Nursing personnel.** Nursing personnel must determine that residents are served diets as prescribed. Residents needing help in eating must be promptly assisted upon receipt of the meals and the assistance must be unhurried and in a manner that maintains or enhances each resident's dignity and respect. Adaptive self-help devices must be provided to contribute to the resident's independence in eating. Food and fluid intake of residents must be observed and deviations from normal reported to the nurse responsible for the resident's care during the work period the observation of a deviation was made. Persistent unresolved problems must be reported to the attending physician. 7 days Staff standing while feeding residents Staff not assisting with feeding residents Resident # 10 , 36	See also #10-2 A Meal Assistance Program was developed to increase the assistance available to the residents. A paging system was developed to page for additional assistance if an individual units mealtime is challenged. It was reviewed with staff regarding proper feeding assistance (e.g. do not stand while assisting a resident with feeding.) Long-term Plans: Tray-line meal service is being changed to buffet style dining after the dining rooms are renovated. There are funds encumbered for the required construction required. When completed, this will allow greater flexibility in schedule meals and setting up unit routines as compared to the tray line system.	8/26/05 9/9/05 Summer 2006	Director of Nursing Director of Dietary Administrator	

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
17. Subpart 3. Risk of Choking A resident identified in the comprehensive resident assessment, and as addressed in the comprehensive plan of care, as being at risk of choking on food must be continuously monitored by nursing personnel when the resident is eating so that timely emergency intervention can occur if necessary. #9 given regular juice when an order for thickened liquid was in place 7 days	An interdisciplinary team including Speech Therapy Nursing, Medical Director, and Dietitians met to review the hydration procedures. An improved system for identification of residents who require thickened liquids was designed. The Resident Dining and Nutrition Committee will be revitalized to address on-going issues related to nutrition and hydration. Residents with thickened liquids will have this noted on the individual resident guide in the MAR in additional to the existing diet order locations.	8/26/05 and 8/31/05 Designed 8/31/05, to be implemented by 10/1/05 8/31/05 9/9/05	Director of Nursing, Director of Rehab and Director of Dietary	See attachment 17-a (Thickened Liquids procedure)

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
18. MN 4658.0610 Subp 7 **Sanitary conditions.** Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. **1 day** Based on observations and interview, the facility failed to maintain sanitary conditions at all times in the kitchen. The findings include: 3 garbage containers without lids. Also, a hand scoop was stored inside a sugar bin.	**Immediate Correction:** Garbage can lids were ordered, please see attached invoice. An in-service was given on 8-4-05 and 8-10-05. Please see attachments. **Long term correction:** A sanitation rounds checklist was developed and will be completed monthly by a dietitian. Immediate correction will follow for any areas of concern. Please see the attached checklist.	8/20/05	Director of Dietary	

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
19. 4658.0670 Subp 2 **Sanitization; storage.** All utensils and equipment must be thoroughly cleaned, and food-contact surfaces of utensils and equipment must be given sanitization treatment and must be stored in such a manner as to be protected from contamination. Cleaned and sanitized equipment and utensils must be handled in a way that protects them from contamination. Based on observations and interview the facility failed to thoroughly clean equipment used in the serving of food. Findings include: the under part of the shelves over the steam tables and prep area was found to be soiled with food debris. **1 day**	**Tag #4658.0670 Subp. 2** **Immediate correction:** A staff member was ordered to clean the area and was checked by the Dietary Director and found to be cleaned. An in-service was given on 8-4-05 to discuss this procedure. Please see attachment. **Long term correction:** A sanitation rounds checklist was developed and will be completed monthly by a dietitian. Immediate correction will follow for any areas of concern. Please see the attached checklist.	8/20/05	Director of Dietary	

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
20. 4658.0675 Subp 7 **4658.0675 MECHANICAL CLEANING AND SANITIZING. Subpart 7 Air drying.** Dishes and utensils must be air dried before being stored or must be stored in a self-draining position. Properly racked sanitized dishes and utensils may complete air drying in proper storage places, if available. Based on observations and interview, the facility failed to air-dry pans after sanitizing and prior to storing them in the cupboard. Findings include: baking pans were observed to be stored wet in the cupboard. **7 days**	**Tag #4658.0675 Subp. 7** **Immediate correction:** All wet pans were removed, sent through the dishmachine and properly air-dried before putting away. An in-service was given on 8-4-05 and 8-10-05. Please see attachments. **Long term correction:** A sanitation rounds checklist was developed and will be completed monthly by a dietitian. Immediate correction will follow for any areas of concern. Please see the attached checklist.	8/26/05	Director of Dietary	

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
21. 4658.0720 PROVIDING DAILY ORAL CARE. Subpart 1. **Daily oral care plan.** A nursing home must establish a daily oral care plan for each resident consistent with the results of the comprehensive resident assessment. B. A nursing home must provide a resident with the supplies and assistance necessary to carry out the resident's daily oral care plan. The supplies must include at a minimum: toothbrushes, fluoride toothpaste, mouth rinses, dental floss, denture cups, denture brushes, denture cleaning products, and denture adhesive products. Not provided for resident # 19, 20, 18, 12, 15 14 days	The individual residents noted in the survey have been reviewed and supplied are provided. See also #10-2	9/2/05	Director of Nursing	
22. 4658.0725 PROVIDING ROUTINE AND EMERGENCY ORAL HEALTH SERVICES. Subpart 1. **Routine dental services.** A nursing home must provide, or obtain from an outside resource, routine dental services to meet the needs of each resident. Routine dental services include dental examinations and cleanings, fillings and crowns, root canals, periodontal care, oral surgery, bridges and removable dentures, orthodontic procedures, and adjunctive services that are provided for similar dental patients in the community at large, as limited by third party reimbursement policies. Not done on all residents **30 days**	We respectfully disagree with this citation as the existing system does meet the regulation requirements. We apologize that the survey team was not made aware of the existing system and tracking. The residents in the survey sample had an initial oral exam by Appletree Dental. An excel file exists that tracks resident dental visits. To continuously improve service, the existing policy was modified.	9/2/05	Director of Health Information Management and Director of Nursing	See attachments #4 a and #4b (oral exam forms) #4c (scheduling procedures - changes circled) #4d (existing Dental Services Protocol) #4e Dental Director Program

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
23. 4658.0800 INFECTION CONTROL. Subp. 3. **Staff assistance with infection control.** Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. No timeframe listed # 15 gloves not changed from dirty to clean # 11 incontinent pad on floor	A handout was designed to review proper glove use and included in the education noted in #10-2.	9/2/05	Director of Nursing	See attachments 10-2a (standards), 10-2b (audit) and #23a (Glove use handout)

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
24. 4658.1340 MEDICINE CABINET AND PREPARATION AREA. **Subpart 1. Storage of drugs.** A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. Subp. 2. **Storage of Schedule II drugs.** A nursing home must provide separately locked compartments, permanently affixed to the physical plant or medication cart for storage of controlled drugs listed in Minnesota Statutes, section 152.02, subdivision 3. **1 day** Unlocked med carts bldg 17, 2nd and 3rd	Current policy requires the securing of the medication carts including the double locking of narcotics. To enforce the policy and monitor medication / treatment cart compliance, a routine audit will be done by the pharmacy. Random audits will be done by the Quality Manager, Officers of the Day, and RNM's.	8/24/05	Director of Nursing Director of Pharmacy	See attachment #24a (audit)
25. 4658.1345 LABELING OF DRUGS. Drugs used in the nursing home must be labeled in accordance with part 6800.6300. **14 days** Unlabeled meds 2nd fl bldg 17	All vials for individual residents will be labeled individually versus labeling only the larger container of the vials.	9/2/05	Director of Pharmacy	

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
26. 4658.1415 Subp 2 **4658.1415 PLANT HOUSEKEEPING, OPERATION, AND MAINTENANCE.** Subp. 2. **Physical plant.** The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. 30 days	See individual items listed below: Daily rounds are being conducted.	See individual items below	Physical Plant Manager	
BUILDING 6 **4658.1415**				
G-13 bathrooms	No call light system. 1. Get quotes from vendor & install	9/17	Maint Sup	9/2/ Quote to arrive Can be installed 10 days after aproval.
Bsmt. Corridor & area near doorways	Build up of dust, debris and wax. 1. Clean corridor	8/26	Hskp	Done
Smoke RM G24	Brown stains on walls, windows, ceiling tiles & air ducts. Burns on floor, chairs and tabletops. * See overall plan for both lounges.	10/7	Chief Eng	Contracts for work being obligated and work on both smoking lounge Bldg 9 & 17
Dining RMS 332 & 312 *(include all dining rooms and overflow areas)*	Stained & soiled chairs. 1. Clean chairs. 2. Redistribute good chairs. 3. Recover or replace? Minncor	8/26	Hskp Hskp Project Mgr	Done Recover seats/backs
Dining RM 332	Dents & chips in window frames exposing metal corner bead.	9/30	Maint Sup	Contact obligated

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
2nd & 3rd FL tub rooms	Tubs had rubber bumpers repaired with tape that was loose leaving residue. 1. Repair bumpers w/ adhesive	9/27	Maint Sup	In progress
2nd FL Kitchenette	Damaged walls and corners on laminate. 1. Repair sheetrock & paint. 2. Repair or replace laminate.	9/27	Maint Sup	In progress
Resident RM 213	Damaged door frame w/exposed metal corner beading 1. Repair sheetrock 2. Paint 3. Install corner protectors.	9/27	Maint Sup	In progress
BUILDING 17				
Tub Rooms all floors	Dust & debris under tubs. 1. Clean all tub rooms	8/30	Hskp.	*Status: 4th floor done 3rd floor done 1 on 2nd floor done.
3-North Tub Room	Repair all broken, crack & chipped wall tiles in shower & toilet rm.	9/17	Maint Sup	In progress
3-South Tub Room	Repair broken tiles in shower.	9/17	Maint Sup	In progress
2-North Tub Room	Repair crack corner on wall/base.	9/1	Maint Sup	Done
2-South Tub Room	Replace tile baseboard.	8/30	Maint Sup	
Hall areas near RMS 439,247,286 & bathroom of RM 247	Detached vinyl that has curled up around the walls forming a baseboard.	9/17	Project Mgr	In progress
Smoking area	Tar stains on walls, windows & ceilings. Damaged/unsafe furniture. * See overall plan for correction	9/17	Chief Eng	In progress

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
Resident RM 367	Damaged walls by windows exposed metal beading.	9/17	Maint Sup	9/1 Ready for painting
Resident RM 288	Strong urine odor throughout room into hall.	9/17	Hskp	In progress
Main dining RM	Brown stains on suspended ceiling tiles.	8/31	Maint Sup	Completed 8/31/05
4655:4110 Safety issue	Lack of non-slip strips on floor in shower Review all showers in DOMS, THP for loose or no strips - Replace immediately Incorporate this into Environmental and Nursing Rounds	9/27	Maint Sup Nursing and Environ-mental Services	Work In-process Replace all loose and missing strips immediately or after regrouting has occurred
MSFC 703.1 **Repair damage or seal opening to fire-resistive construction with approved materials and methods.**	Bldg 6,9: Repair wall penetrations from wires and pipes throughout the buildings 1. Seal penetrations 2. Policy to manage construct projects	8/31/05	Chief Eng Maint Sup Plant Mgr	Repairs 100% complete Mgt Action: P/P draft completed for construction mgt.
MSFC 304.1 **Remove combustible material from dryers and vent pipes.**	Remove all lint and combustibles from behind the dryers and clean vent piping from dryers in building 17. 1. Clean ducting 2. Install new access panel for future inspections & cleaning 3. Write a PM to Archibus.	8/31/05	Chief Eng Chief Eng Chief Eng	Mgt Action: New inspection access to be installed & *PM written in Archibus*

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
MSFC 1010.5 **Emergency lighting shall be provided installed and maintain operational in the following areas where two or more means of egress are required. This includes the following areas: 1. interior corridors passageways aisles and spaces, 2) exit stairways, 3) windowless areas having student occupancy, an d4) shops and laboratories.**	Provide emergency lighting for all buildings. Emergency lighting shall provide at least one foot candle power at the floor throughout all means of egress. At this time, the emergency generator comes on-line only if the public utility power supply is interrupted. If the electrical power is interrupted to a single building or section or a building, no emergency power is provided for the effected building or section.	Project included in FY07 Bonding request to State legislature	Plant Mgr& & Project Mgr	Study in progress to construct time extension. Meeting with state architect office has been set-up. Major project - will need extension Cost $800K for fix $1.2 mil. To do it right. Bond request
MSFC 3006.4 **Medical gas (liquid oxygen) shall comply with NFPA 99 Bldg. 16 Because it is occupied and MVH is the owner**	Building 6,9,16, 17: Liquid oxygen is transferred in resident rooms. Fire Marshal omitted B16 for orders.	This project is in progress and will be funded once a design work complete - in progress	Project Mgr Asst Admin	Project design in progress for asset preservation resources for Bldg. 6
MSFC 903.2 **Provide an approved automatic fire sprinkler system. Such system shall be installed in accordance with NFPA standards 13, 13-R, and 13-D, as appropriate**	Building 17, 17 are not fully sprinklered. Provide automatic sprinkler coverage in walk-in type coolers and freezers. Building 17 Electrical/Telephone Room is not sprinklered. 1. Get bids for contractor to repair	9/29	Plant Mgr & Project Mgr Chief Eng	Work to begin week of 9/12/05.

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
27. MN Statute 144A.04 Subd 4 (reissued at Subd 11) Subd. 11. **Incontinent residents.** Notwithstanding Minnesota Rules, part 4658.0520, an incontinent resident must be checked according to a specific time interval written in the resident's care plan. The resident's attending physician must authorize in writing any interval longer than two hours unless the resident, if competent, or a family member or legally appointed conservator, guardian, or health care agent of a resident who is not competent, agrees in writing to waive physician involvement in determining this interval, and this waiver is documented in the resident's care plan. 14 days	See # 10-2 Individual residents were reviewed by the RNM. The nurse practitioners, interim director of nursing, and OT developed a urinary incontinence management process to be implemented for residents with UI over the next 6 months as their individual quarterly assessments or significant change assessments come due.	9/2/05 9/2/05 2/23/06	RNM Director of Nursing	See attachment # 27a (UI Management procedures - draft 2)
28. MN Statute 144.651 Subd 5 courtesy Subd. 5. **Courteous treatment.** Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. 14 days	A comprehensive inservice is being designed by social services for use in additional HST training and to replace current general orientation education on resident dignity and respectful treatment. See also #10-2	10/1/05	Director of Social Services Administrator	

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
Boarding Care Rules:				
1. 4655.4700 Physical Exams **Subpart 1** Subpart 1. **Physical examination at admission.** Each patient or resident shall have an admission medical history and complete physical examination performed and recorded by a physician within five days prior to or within 72 hours after admission. The medical record shall include: the report of the admission history and physical examination; the admitting diagnosis and report of subsequent physical examinations; a report of a standard Mantoux tuberculin test or, if the Mantoux test is positive or contraindicated, a chest X ray within three months in advance of admission and as indicated thereafter; reports of appropriate laboratory examinations; general medical condition including disabilities and limitations; instructions relative to the patient's or resident's total program of care; written orders for all medications with stop dates, treatments, special diets, and for extent or restriction of activity; physician's orders and progress notes; and condition on discharge or transfer, or cause of death. **14 days**	A procedural review was performed by the DON and DOM's NP. The HIM will audit all admissions by day 2 of admission to ensure the MD has signed the H&P.	9/2/05	Medical Director HIM Director	

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
2. 4655.4000 Subp. 2. **Types of information reported.** The care record for each resident shall contain the resident's weight at the time of admission and at least once each month thereafter and a summary completed at least monthly by the person in charge indicating the resident's general condition, actions, attitude, changes in sleeping habits or appetite, and any complaints. A detailed incident report of any accident or injury and the action taken shall be recorded immediately. All dates and times of visits by physicians or podiatrists and visits to clinics, dentists, or hospitals shall be recorded. No monthly progress notes for 1 of 6 residents 14 days	The individual residents review was completed. A full house audit was done to determine that all residents monthly reviews are being done. The RNM will monitor this through the electronic medical record to ensure that all are completed timely.	9/2/05	RNM Director of Nursing	

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
3.4655.7000 Resident Rooms **Subpart j** J. All furnishings and equipment shall be maintained in a usable, safe, and sanitary condition. All rooms and beds shall be numbered. All beds shall be identified with the name of the patient or resident. Beds not marked with resident names 27 days	All beds have been marked with resident names.	8/1/05	Physical Plant Director	
4. 4655.9000 Environment Subpart 1. **General requirements.** The entire facility, including walls, floors, ceilings, registers, fixtures, equipment, and furnishings shall be maintained in a clean, sanitary, and orderly condition throughout and shall be kept free from offensive odors, dust, rubbish, and safety hazards. Accumulation of combustible material or waste in unassigned areas is prohibited.	See individual items listed below Daily rounds will be conducted	See individual items below	Physical Plant Director	
Urine smell MMS 311 & 307	Resident relocated	Complete	Housekeeping Supervisor	
RM 114 bath/ shower rm.	Black on floor & Walls, tub dingy 1. Remove old caulking & clean. 2. Regrout shower & caulk tub. 3. Clean return grill & vent.	8/26 9/1	Housekeeping Supervisor Maintenance Supervisor	1. DS 9/1/05 2. Done 9/1/05
RM 214 bath/ shower rm.	One loose tile. Tub black areas, metal disc on ceiling rusted. 1. Remove old caulking & clean. 2. Regrout shower & caulk tub. 3. Preplace cover. 4. Clean return grill & vent.	8/26	Housekeeping Supervisor Maintenance Supervisor	

Licensing Violation	Plan of Correction	Goal Date	Person(s) Responsible	Follow-up
RM 314 bath/ shower rm.	Black in grout, tub dingy, black grout under sink. Rust on radiator cover. Dust in vent by shower. Non-slip missing. 1. Remove old caulking & clean. 2. Regrout shower & caulk tub. Preplace cover. 3. Clean return grill & vent. 4. Paint radiator cover	9/27	Housekeeping Supervisor Maintenance Supervisor	*Vent cleaned. Need help of Howard behind vent grid. Work order sent for radiator needs repainting.
3rd Floor lounge.	Soiled carpet, couch & pillow. 1. Clean carpet. 2. Remove exiting furniture.	8/25 8/26	Housekeeping Supervisor Maintenance Supervisor	Replace carpet? Pictures taken.
3rd Floor phone	Plaster peeling around window	9/27	Maintenance Supervisor	Ready for paint 9/1/05
2nd Floor alcove	Plaster peeling around window	9/27	Maintenance Supervisor	Ready for final coat.
1st Floor alcove	Plaster peeling around window	9/27	Maintenance Supervisor	Ready for final coat
1st dayspace	Plaster peeling around window	9/27	Maintenance Supervisor	Ready for final coat
Paint chipped	In lobby & dayroom.	9/27	Maintenance Supervisor	In progress
RM 315 lounges	Soiled carpet 1. Clean carpet	8/25	Housekeeping Supervisor	Replace carpet

Licensing Violation	Plan of Correction	Comp Date	Person(s) Responsible	Follow-up
OVERALL PHYSICAL PLANT CORRECTION ACTIVITIES				
Tub Rooms	1. Repair chemical pumps to all tubs 2. Repair all tile walls/floors 3. Deep clean floors 4. Replace all rusty metal objects 5. Replace any worn curtains. 6. Replace worn soap/towel dispensors. 7. Replace old vents.		Maint Sup Maint Sup Hskp Hskp Hskp Hskp Chief Eng	Mgt Action: Training for hskp recognition of needed repairs. New construction project planned for tub room in B17.
Plaster work (Bldg 9) **Painting**	Repair walls & paint 1. Develop daily tracking log. Update daily 2. Weekly access workload. 1. Develop plan a. Door frame & Handrails (B17) b. Lower B17 corridor walls. c. Door & Frames in B6 & B9. d. Follow plastering e. Day spaces f. Main Dining Room g. Resident rooms		Maint Sup Maint Sup/Plant Mgr	Create a wall chart to track daily work. Work possible till midnight and on weekends. Mgt Action: Develop plan to address needs of facility [redacted]
Hallways (all)			Maint Sup	
BLD 6 Mudding			Maint Sup	
Housekeeping	Assess all areas. Attention to baseboards and corners, Condition of furniture. Clean all tubs.		Hskp	Document daily rounds. Use Susan T-C as additional auditor.
Smoke Rooms	1. Replace ceilings & grid. 2. Order new metal furniture. 3. Paint with Epoxy. 4. Install 2nd cleaner in both. 5. Remove vinyl in B6. 6. Install new fan in B6 7. Create monthly GI cleaning day. Coordination -Safety Mgr		Chief Eng	Use contractor to do work. Copy Env. Secretary with all POs for contracted work. Mgt Action: Create monthly deep cleaning day. Shutdown lounge for up to 8 hours.
Flooring Issues	StP Linoleum to repair? - B17 hallways? - Resident rooms - B6 Nurses sta. - B6 dayrooms. - B9 vending areas/VCT		Project Eng	8/29 - StP Linoleum due in.

Minnesota Veterans Home - Minneapolis
Resident Incident/Variance Report

Attachment 1a

Employee's Description of Variance/Incident

Date/Time of report 5/15/05 7p Date/Time of Variance (if different) 5/15/05 7p

Resident's name [redacted] Bldg/Rm # 711 MR# 12863 DOB 12-25-1932

Name/title of witness(es) —

Type of Variance:

Non-Falls: (check only one)

___ Behavioral altercation ___ Biting ___ Superficial Soft Tissue Injury unrelated to a fall

___ Burn ___ Choking ___ Unsafe Smoking ___ Restraint incident

___ ETOH/Chemical Use ___ Elopement X Other

Falls: ___ unwitnessed fall or found on floor ___ witnessed fall

Location of Variance (check only one)

X Bedroom ___ Bathroom ___ Other Resident's Room ___ Unit Hallway

___ Elevator: ____ ___ Other Unit ___ Outdoors ___ Main Dining Room 17

___ Unit Dining Room ___ Unit Day Room ___ Smoking lounge ___ Chapel of Peace

___ Tub/Shower Room ___ Other: ____

Situational Information

___ From bed ___ From toilet ___ Mechanical Lift involved

___ From chair or (w/c) ___ Other: ____ ___ Tub/shower equipment involved

Description of Event: (facts, no opinions)
Resident wheeled self to window and pulled fdg peg out. Sent to VAMC per transportation and admitted to 3F

Was eating and/or incontinence a factor? No If so, last time resident toileted: ____

What time did resident last eat? TF and have fluids? TF

Was resident standing ____ walking ____ reaching up ____ reaching down ____?

Any environmental issues? (i.e. poor lighting, wet floor, etc.) No

Immediate Triage: Head to Toe exam:

Did resident hit head? (No) / Yes If yes, initial neuro exam: ____

Temperature: 100.5 Pulse: 76 Respiration: 20 B/P: 120/70 (Usual B/P: WNL)

Describe any injury: Bleeding from peg site was controlled c pressure. Clotting occurred. Area was cleansed. ct drsg applied

Action Taken: None ____ First Aid X Emergency room ____ Hospitalized X

Comments: ____

Physician notified: Person notified/Date/time Call log MD aware Dr. L Fang

Family notified: Date/time 5/15/05 7p Name/relationship: Wife present when incident occur

C/P updated or temporary CP started? admitted to hosp Nurses' Note made: (Yes) / No

Nurse Signature Margaret Shrake LPN Date/Time 5/15/05 22:41

24 Hour review of incident/variance reveals:

___ No Injury ___ Minor Injury ✓ Complicated Minor Injury ___ Major Injury

Describe: *Peg tube dislodgement, upon G I bleed secondary to dislodge*

Take vital signs when reproducing circumstances of a fall (e.g., at same time of day as fall or if resident fell 10 minutes after eating a large meal, take vital signs 10 minutes after the resident eats): ______

[Ly]ing/Standing B/P: *hospitalized*

Lying: ______ / ______ Pulse ______

1 minute after standing: ______ / ______ Pulse ______

3 minutes after standing : ______ / ______ Pulse ______

Changes in resident requiring reassessment of the care plan:

hospitalized will review careplan upon readmission to VAMC to MVH

Interdisciplinary Discussion of Variance: *Mary Gleason NP LaVonne Tiaden RN*

Signature *LaVonne Tiaden RN* Date *8/8/05* Time *10a*

Route to Nurse Manager

Review for quality improvement:

Did the care plan address potential for this type of variance? Yes / **No** If yes, was the care plan followed? Yes / No

For falls only:

Internal Factors

#___ past falls (0-180 days) ___ Isolated event ___ Cardiovascular ___ Neurological

___ Orthopedic ___ Perceptual ___ Psychological /cognitive ___ New illness / onset

___ Elimination needs ___ Pain - Does the resident have an identified pain management plan? Yes / No

Comments: ______

External Factors

___ Medications ___ Appliances / devices ___ Environmental /situational hazards

Is resident receiving: ___ antipsychotics ___ antianxiety/hypnotics ___ antidepressants

___ cardiovascular medications ___ diuretics

Comments: ______

For any type of variance:

Modifications to the Resident Care Plan: Yes / **No** (describe changes or why no change is made *will reassess plan of care upon readmission MVH*

Referral Necessary:

___ OT/PT/ST ___ Vision ___ Audio ___ Medical

Comment: ______

[RN] Manager (when section complete) *LaVonne Tiaden RN* Date: *8/18/05*

[Sum]mary of Contributing factors: [illegible]

Corrective Action: *Back from hospital - no feeding tube 6/28/05 diet dysphagia II c̄ nectar thick liquids (pureed) offer 8 oz. thickened liquids 6X q.d. sitting when eating or drinking*

ADON Review

Vulnerable Adult Act - Is external report required? Yes ______ No ✓

Date/time/name report made to CEP: ______ / ______ / ______ Date original reporter notified: ______

Comments: ______

Signature: *Sue Garretson RN* Date *08-08-05*

M01-131F REV 11-01

H:\01\M01-131F.doc MVH01-02

STATE OF MINNESOTA
VETERANS HOME - MINNEAPOLIS

OPERATING POLICY AND PROCEDURES

Title: (Agency) – Resident Incident Report

Number: 01-06

Approvals: Admimistrator

Date: DRAFT 8/30/05

OBJECTIVE:

- To define the role/responsibility of staff for reporting resident incidents/accidents.
- To describe the procedure for completing an electronic resident incident report.
- To establish a method that will provide direction for the assessment and appropriate medical intervention when a resident incident occurs.
- To assure that appropriate persons are notified of incidents, i.e., staff, physicians, family members, etc.
- To assess the cause of incidents and implement corrective/preventive action when indicated.

POLICY:

All resident incidents/accidents, and injuries must be reported. An incident report that details the circumstances surrounding/leading up to the accident/injury must be completed. The report shall also define the action taken after learning of the incident/accident or injury.

- A resident incident report shall be completed for any incident/accident occurring on or off the facility campus.
- The person arriving first on the scene or first to be made aware of the incident shall initiate the Observation Report. The only exception is for medication errors. Observation forms will be completed for medication errors only by pool staff, pharmacy staff and all non-nursing staff. A nurse finding a medication error will complete the Resident Incident Report.
- Licensed nurse intervention/assessment should be sought as soon as possible after the incident.
- All incident reports are to be reviewed by the Director/Assistant Director of Nursing and the Quality Manager to determine the need for further assessment, investigation, to identify possible vulnerable adult issues, and to ensure appropriate follow-up action.
- Incident reports will be retained according to the Agency Record Retention Schedule.

FORMS:

Momentum Agency Incident Report

DEFINITIONS:

Staff: Any person employed by or volunteering for the Minneapolis Veterans Home including persons providing contract services/care.

Incident: A sudden, unforeseen, and unexpected occurrence or event. Any unusual occurrence that causes harm or has the potential for causing harm to a resident. Any resident behavior which may put the resident or others at risk (i.e., physical/verbal aggression, unauthorized leave, use of non-prescribed mood altering substances, etc.). Any physical injury (with or without a known cause) noted upon examination of a resident.

PROCEDURE:

When a staff member is made aware of or witnesses an incident the following steps are to be taken:

1. Immediate intervention to ensure the safety of the resident. *NOTE*: In the case of a physical threat to safety, such as a fall or noted injury, a licensed nurse/nurse practitioner should do an assessment and initiate follow-up. In emergency situations stay with the resident while summoning a licensed nurse; provide first aid to the resident within the scope of training and ability.

2. Immediately report the incident to the unit nurse.

3. The licensed nurse will initiate the Resident Incident Report. Rehab staff will initiate a resident incident report for incidents occurring while in therapy. Recreational Therapy staff will initiate a resident incident report for incidents occurring while at an RT Program. Social Service will imitate a resident incident report for behavioral incidents

   NOTE:
   - ♦ Altercations/incidents involving two or more residents require a separate incident report for each resident.
   - ♦ Identify residents by full name and medical record number.
   - ♦ Complete Incident Report for observations from a mandated reported
   - ♦ Contact the ADON during regular business hours and the Nursing Supervisor during off-hour shifts for immediate triage for Vulnerable Adult concerns.

4. Triage the resident situation
   A. Handle any acute issues for the resident's status using emergency nursing procedures. Once the resident is determined to be in a stable situation initiate the completion of the report
   B. For non-acute incidents refer to attachment one for examples of types of incidents.?????
   C. Contact the ADON during regular business hours and the Nursing Supervisor during off-hour shifts for immediate triage for Vulnerable Adult concerns.

5. Initiate the Resident Incident Report
   A. Section A for all incidents
   B. Section B for all falls
   C. Section C for all medication/pharmacy incidents
   D. Section D for all behavioral related incidents
   E. Section E for all other incidents including mandated reporter observations Section F for all incidents

Completion and Routing Guidelines:

D. The nurse manager/designee/nursing supervisor will review the incident report on the shift of occurrence or as soon as possible and note review in the Section F comment box. The review shall include care plan adjustments to meet the needs of the resident.

E. The assistant director of nursing/designee will complete Section G – Nursing Administration review within 24 hours of occurrence. The nursing supervisor will complete Section G for nights/weekends/holiday within 24 hours of occurrence. Section G includes reviewing all incidents for CEP/DA Criteria.

F. Pharmacist will review and sign off all incident reports related to medication/pharmacy incidents on the shift of occurrence or as soon as possible..

~~G.~~ **Assistant Director of Nursing will trigger administration to review specific incidents reports via Morning meeting.** Assistant Director of Nursing will approve the electronic Incident report ~~within 24 hours of occurrence.~~

H:\DRAFT\POL-PROC\01-06 8-30-05.doc

Listing of Incidents

Attachment

Patient: <All>
Unit: <All>
Incident Category: <All>
Date Range: Sep 6, 2004 to Sep 6, 2005

Incident Category	Resident Name	Unit	Date Occured	Status
[illegible]sive/Aggressive	[redacted]	2N	08/31/2005	Entered
[illegible]sive/Aggressive		2N	08/31/2005	Entered
Abusive/Aggressive		3N	08/31/2005	Entered
Falls		2N	09/05/2005	Entered
Falls		4N	09/01/2005	Entered
Falls		2N	09/05/2005	Entered
Falls		3S	09/05/2005	Entered
Falls		3S	09/03/2005	Entered
Falls		3N	09/05/2005	Entered
Falls		4N	09/02/2005	Entered
Falls		U2-62	09/02/2005	Entered
Falls		4N	09/02/2005	Entered
Falls		2S	09/02/2005	Entered
Falls		4N	09/05/2005	Entered
Falls		2N	09/04/2005	Entered
Falls		4N	09/02/2005	Entered
Falls		U3-63	09/03/2005	Entered
[illegible]		2N	09/02/2005	Entered
Falls		2N	09/02/2005	Entered
Falls		U1-61	09/05/2005	Entered
Falls		U2-62	09/05/2005	Entered
Falls		U2-62	09/01/2005	Entered
Falls		U3-63	09/03/2005	Entered
Falls		U2-62	09/03/2005	Entered
Falls		U2-62	09/02/2005	Entered
Falls		U2-62	09/05/2005	Entered
Falls		3S	09/02/2005	Entered
Falls		3S	09/01/2005	Entered
Medications		2N	09/05/2005	Entered
Medications		2N	09/05/2005	Entered
Medications		2N	09/02/2005	Entered
Medications		2N	09/03/2005	Entered
Medications		U3-93	09/01/2005	Entered
[illegible]		3S	09/06/2005	Entered
[illegible]		2N	09/01/2005	Entered
Misc.		U1-12	09/02/2005	Entered
Misc.		2N	09/05/2005	Entered
Misc.		U2-62	09/04/2005	Entered
Misc.		3N	09/05/2005	Entered

August 25, 2005

To: Interdisciplinary Team Members (IDT)

From: Diane Vaughn

Re: Restraint Audits

Thank you for letting me alter the routine of your day in regards to survey follow-up. I appreciate your willingness to participate in this urgent process.

The goal of this audit is to:

- Inventory the actual devices each resident is using
- Ensure that proper assessment and documentation were done in the selection of this intervention
- Assess the needs for immediate reassessment of any individual resident by the IDT
- Ensure the care plan coveys required documentation
- Ensure residents have a documented plan for reassessment for least restrictiveness

The methodology is:

- Utilize the restraint audit and device listing
- Evaluate each resident on the unit as to if they are utilizing any devices
- If the resident is utilizing a device, complete the audit and update the device listing
- Note which residents require follow-up and what type (e.g. need MD order, or care plan changes, etc)

What happens then:

- The resident specific clinical rounds team will convene to reassess the items requiring follow-up
- We are assured the residents are in the least restrictive device and are aware of the risks of a device
- We regain survey compliance

Examples of devices:

- Alarms
- Siderails
- Belts
- Lap buddy's
- Chairs that prevent rising
- Other individualized devices

Restraint Audit

Documentation Requirement	Compliance	Comments for Variances	Follow-up Required
Type of Device(s)	Confirm is actual device in use		
Device is an enabler			
Device is a positioner			
Device is a restraint			
Medical Symptom of device	List Med. Symptom:		
Goal of device	List Goal:		
Pain assessment was completed prior to the initiation of a device			
Rehab was consulted	Date Rehab consulted:		
OT recommended device	Yes / No		
Least restrictive steps taken prior to initiation of device	Please list:		
Documentation exists that the medical decision maker has been informed of the **risks** of the device including serious injury and death	Date/Location of information		
Progress notes indicate the resident's tolerance to the device	Date(s) of progress note:		
CARE PLAN DOCUMENTATION			
Device is on the care plan including:			
Goal and Medical Symptom			
Time out from being in device (e.g. to walk)			
Interventions to meet toileting needs			
Interventions to meet repositioning needs			
Interventions to meet hydration / nourishment needs			
The care plan contains steps to decrease the use of the device over time			
Other comments regarding the device use:			

Resident: _____ **Unit:** _____ **Date:** _____

August 31, 2005

To: Clinical Rounds Teams

From: Diane Vaughn

RE: Restraint Audit / Review

Thank you to the social workers and behavior analysts that worked so diligently on the restraint documentation audits.

Our next step is to have an IDT review of the audits. The IDT should review for:

- Is the device identified a positioner/enabler/or restraint
- Is medical symptom present
- Is there a goal for the device
- Are there parameters set as to when to use
- Is there informed consent for devices that can cause harm – if it says, "archived" we need to re-do it
- Is there a progress note for resident tolerance to the device
- Are all of the details on the care plan:
- interventions to meet toileting, repositioning, hydration
- Do they have a restraint reduction plan

Most of this is done on the audit – where items are missing, unclear or archived, please write a IDT progress note. Here is an example:

IDT met to review the use of device). The IDT continues to find this device to be the least restrictive device (include previous attempts if relevent) , the resident is tolerating it well (examples are best). Reduction plan: We will continue this device for the next quarter at which time will reassess the device.

Oral Health Screening Form

Facility Code: VM

Screening Date: 10-26-04

Facility Staff - Please complete this section

Resident Last Name: [redacted]

First Name & MI: [redacted]

Room & Bed#: [redacted] Date of Birth: 10-31-24 Gender: (M) [F]

Type of Screening: [M] Initial [ ] Annual [ ] Status Change

Soc Sec #: [redacted]

Payment Type: [ ] MA [ ] PVT [ ] PPS

Diet and Nutrition Problems: [ ] Weight Loss [ ] Nutrition Problem [ ] Feeding Tube [ ] Mechanically Altered Diet

(1) Minimum Data Set Information

a.

	Heavy Debris
	Heavy Plaque
	Heavy Calculus

b.

[✓] None	Dentures
Upper	[ ] Full [ ] Partial
Lower	[ ] Full [ ] Partial

c.

✓	Missing Teeth w/o Replacement
	Doesn't wear Dentures or Partials
	Problems with Dentures or Partials
✓	Natural Teeth are Present

d.

	Loose Teeth
	Decayed Teeth
	Broken Teeth/Fillings
	Root Tips Present

e.

	Swollen or Bleeding Gums
	Oral Abscesses, fistulas
	Ulcerations, Denture Sores
	Soft or Hard Tissue Lesions

f.

✓	Daily Oral Care Needed

SECTION K: ORAL/ NUTRITIONAL STATUS

1.	a. Chewing Problems	a.
	b. Swallowing Problems	b.
	c. Mouth Pain	c.
	d. *NONE OF ABOVE*	d. ✓

SECTION L: ORAL/DENTAL STATUS

1.	a. Debris (soft, easily movable substances) present in mouth prior to going to bed at night	a.
	b. Has dentures and/or removable bridge	b.
	c. Some / all natural teeth lost - does not have or does not use dentures (or partial dentures)	c. ✓
	d. Broken, loose, or carious teeth	d.
	e. Inflamed gums (gingiva); swollen or bleeding gums; oral abscesses; ulcers or rashes	e.
	f. Daily cleaning of teeth/dentures or daily mouth care – by resident or staff	f. ✓
	g. *NONE OF ABOVE*	g.

(2) Daily Oral Care Plan

[ ] Resident Maintains Oral Care Independently
[✓] Resident Needs Staff Supervision
[ ] Resident Needs Direct Staff Assistance

The items checked below are recommended to maintain the oral health of this resident:

[✓] **Toothbrushing** Each morning and evening, brush teeth and gums for 2 minutes using a soft toothbrush and fluoride toothpaste.
[ ] Remove Partial(s) before brushing teeth [ ] Provide dental floss [ ] Electric toothbrush recommended
[ ] Each morning and evening, swish with 2-3 teaspoons of Fluorigard or ACT fluoride rinse for one minute, then spit out.

[ ] **Denture and Partial Denture Care** Once daily, use a toothbrush or denture brush and mild soap to brush dentures and partials –soaking alone will not remove harmful plaque. At bedtime, remove and brush dentures, then soak them in a denture cup overnight. Soak dentures in plain water, or use a cleaning product such as Efferdent or Polident, but do not let the dentures dry out.
[ ] Apply a denture adhesive, such as Fixodent or Polygrip each morning

(✓) only a few teeth - brush them as above & then swab / rinse mouth as needed.

(3) Dental Care Referral Recommendations

[ ] No Dental Referral. Resident has no need for dental referral at this time.
[✓] Routine Dental Referral. Resident has routine dental care needs.
[ ] Immediate Dental Referral. Resident has urgent dental needs.

Screening and Referral Notes: Stee at lunch - will try next month. 10-26-04

Screened as above today 11-23-04

D. Olson RDH
Apple Tree Screener

Vicki Cuno (612) 721-0690
Facility Staff Responsible for Referrals

Oral Health Screening Form

Facility Code: VA

Screening Date: 11/26/02

Facility Staff - Please complete this section

Type of Screening: [ ] Initial [X] Annual [ ] Status Change

Resident Last Name: [redacted]

First Name & MI: [redacted]

Soc Sec #: [redacted]

Room & Bed#: [redacted] Date of Birth: 12/19/53 Gender: [M] [F] Payment Type: [ ] MA [ ] PVT [ ] PPS

Diet and Nutrition Problems: [ ] Weight Loss [ ] Nutrition Problem [ ] Feeding Tube [ ] Mechanically Altered Diet

(1) Minimum Data Set Information

a.

✓	Heavy Debris
✓	Heavy Plaque
	Heavy Calculus

b.

		Dentures
✓	None	
	Upper	[ ] Full [ ] Partial
	Lower	[ ] Full [ ] Partial

c.

	Missing Teeth w/o Replacement
	Doesn't wear Dentures or Partials
	Problems with Dentures or Partials
✓	Natural Teeth are Present

d.

	Loose Teeth
	Decayed Teeth
	Broken Teeth/Fillings
	Root Tips Present

e.

✓	Swollen or Bleeding Gums
	Oral Abscesses, fistulas
	Ulcerations, Denture Sores
	Soft or Hard Tissue Lesions

f.

✓	Daily Oral Care Needed

SECTION K: ORAL/ NUTRITIONAL STATUS

1.	a. Chewing Problems	a.
	b. Swallowing Problems	b.
	c. Mouth Pain	c.
	d. *NONE OF ABOVE*	d. ✓

SECTION L: ORAL/DENTAL STATUS

1.	a. Debris (soft, easily movable substances) present in mouth prior to going to bed at night	a. ✓
	b. Has dentures and/or removable bridge	b.
	c. Some / all natural teeth lost - does not have or does not use dentures (or partial dentures)	c.
	d. Broken, loose, or carious teeth	d.
	e. Inflamed gums (gingiva); swollen or bleeding gums; oral abscesses; ulcers or rashes	e. ✓
	f. Daily cleaning of teeth/dentures or daily mouth care – by resident or staff	f.
	g. *NONE OF ABOVE*	g.

(2) Daily Oral Care Plan

[ ] Resident Maintains Oral Care Independently
[ ] Resident Needs Staff Supervision
[✓] Resident Needs Direct Staff Assistance

The items checked below are recommended to maintain the oral health of this resident:

[✓] **Toothbrushing** Each morning and evening, brush teeth and gums for 2 minutes using a soft toothbrush and fluoride toothpaste.
[ ] Remove Partial(s) before brushing teeth [ ] Provide dental floss [ ] Electric toothbrush recommended
[ ] Each morning and evening, swish with 2-3 teaspoons of Fluorigard or ACT fluoride rinse for one minute, then spit out.

[ ] **Denture and Partial Denture Care** Once daily, use a toothbrush or denture brush and mild soap to brush dentures and partials –soaking alone will not remove harmful plaque. At bedtime, remove and brush dentures; then soak them in a denture cup overnight. Soak dentures in plain water, or use a cleaning product such as Efferdent or Polident, but do not let the dentures dry out.
[ ] Apply a denture adhesive, such as Fixodent or Polygrip each morning

(3) Dental Care Referral Recommendations

[ ] No Dental Referral. Resident has no need for dental referral at this time.
Routine Dental Referral. Resident has routine dental care needs.
mmediate Dental Referral. Resident has urgent dental needs.

Screening and Referral Notes:

Heidi Dze RDH
Apple Tree Screener

Vicki Cuno (612) 721-0690
Facility Staff Responsible for Referrals

Oral Health Screening Form

Facility Code: VM

Screening Date: 7-27-04

Facility Staff - Please complete this section

Type of Screening: [ ] Initial [X] Annual [ ] Status Change

Resident Last Name: [redacted]

First Name & MI: [redacted]

Soc Sec #: [redacted]

Room & Bed: [redacted] Date of Birth: 12/19/63 Gender: [M] [F] Payment Type: [ ] MA [ ] PVT [ ] PPS

Diet and Nutrition Problems: [ ] Weight Loss [ ] Nutrition Problem [ ] Feeding Tube [ ] Mechanically Altered Diet

(1) Minimum Data Set Information

a.

	Heavy Debris
	Heavy Plaque
	Heavy Calculus

b.

[ ] None		Dentures
	Upper	[ ] Full [ ] Partial
	Lower	[ ] Full [ ] Partial

c.

	Missing Teeth w/o Replacement
	Doesn't wear Dentures or Partials
	Problems with Dentures or Partials
	Natural Teeth are Present

d.

	Loose Teeth
	Decayed Teeth
	Broken Teeth/Fillings
	Root Tips Present

e.

	Swollen or Bleeding Gums
	Oral Abscesses, fistulas
	Ulcerations, Denture Sores
	Soft or Hard Tissue Lesions

f.

	Daily Oral Care Needed

SECTION K: ORAL/ NUTRITIONAL STATUS

1.	a. Chewing Problems	a.
	b. Swallowing Problems	b.
	c. Mouth Pain	c.
	d. *NONE OF ABOVE*	d.

SECTION L: ORAL/DENTAL STATUS

1.	a. Debris (soft, easily movable substances) present in mouth prior to going to bed at night	a.
	b. Has dentures and/or removable bridge	b.
	c. Some / all natural teeth lost - does not have or does not use dentures (or partial dentures)	c.
	d. Broken, loose, or carious teeth	d.
	e. Inflamed gums (gingiva); swollen or bleeding gums; oral abscesses; ulcers or rashes	e.
	f. Daily cleaning of teeth/dentures or daily mouth care – by resident or staff	f.
	g. *NONE OF ABOVE*	g.

(2) Daily Oral Care Plan

[ ] Resident Maintains Oral Care Independently
[ ] Resident Needs Staff Supervision
[ ] Resident Needs Direct Staff Assistance

The items checked below are recommended to maintain the oral health of this resident:

[ ] **Toothbrushing** Each morning and evening, brush teeth and gums for 2 minutes using a soft toothbrush and fluoride toothpaste.
[ ] Remove Partial(s) before brushing teeth [ ] Provide dental floss [ ] Electric toothbrush recommended
[ ] Each morning and evening, swish with 2-3 teaspoons of Fluorigard or ACT fluoride rinse for one minute, then spit out.

[ ] **Denture and Partial Denture Care** Once daily, use a toothbrush or denture brush and mild soap to brush dentures and partials –soaking alone will not remove harmful plaque. At bedtime, remove and brush dentures, then soak them in a denture cup overnight. Soak dentures in plain water, or use a cleaning product such as Efferdent or Polident, but do not let the dentures dry out.
[ ] Apply a denture adhesive, such as Fixodent or Polygrip each morning

(3) Dental Care Referral Recommendations

[ ] No Dental Referral. Resident has no need for dental referral at this time.
[ ] Routine Dental Referral. Resident has routine dental care needs.
[ ] Immediate Dental Referral. Resident has urgent dental needs.

Screening and Referral Notes: Would not Cooperate for screening 7-27-04

AD Olson RDH
Apple Tree Screener

Vicki Cuno (612) 721-0690
Facility Staff Responsible for Referrals

Oral Health Screening Form

Facility Code: VM

Screening Date: 7-27-04
8-31-04

Facility Staff - Please complete this section

Type of Screening: [ ] Initial [X] Annual [ ] Status Change

Resident Last Name: [redacted]

First Name & MI: [redacted]

Soc Sec #: [redacted]

Room & Bed# [redacted] Date of Birth: 12/19/63 Gender: [M] [F] Payment Type: [ ] MA [ ] PVT [ ] PPS

Diet and Nutrition Problems: [ ] Weight Loss [ ] Nutrition Problem [ ] Feeding Tube [ ] Mechanically Altered Diet

(1) Minimum Data Set Information

a.

	Heavy Debris
	Heavy Plaque
	Heavy Calculus

b.

	Dentures
[ ] None Upper	[ ] Full [ ] Partial
Lower	[ ] Full [ ] Partial

c.

	Missing Teeth w/o Replacement
	Doesn't wear Dentures or Partials
	Problems with Dentures or Partials
	Natural Teeth are Present

d.

	Loose Teeth
	Decayed Teeth
	Broken Teeth/Fillings
	Root Tips Present

e.

	Swollen or Bleeding Gums
	Oral Abscesses, fistulas
	Ulcerations, Denture Sores
	Soft or Hard Tissue Lesions

f.

	Daily Oral Care Needed

SECTION K: ORAL/ NUTRITIONAL STATUS

1.	a. Chewing Problems	a.
	b. Swallowing Problems	b.
	c. Mouth Pain	c.
	d. *NONE OF ABOVE*	d.

SECTION L: ORAL/DENTAL STATUS

1.	a. Debris (soft, easily movable substances) present in mouth prior to going to bed at night	a.
	b. Has dentures and/or removable bridge	b.
	c. Some / all natural teeth lost - does not have or does not use dentures (or partial dentures)	c.
	d. Broken, loose, or carious teeth	d.
	e. Inflamed gums (gingiva); swollen or bleeding gums; oral abscesses; ulcers or rashes	e.
	f. Daily cleaning of teeth/dentures or daily mouth care – by resident or staff	f.
	g. *NONE OF ABOVE*	g.

(2) Daily Oral Care Plan

[ ] Resident Maintains Oral Care Independently
[ ] Resident Needs Staff Supervision
[ ] Resident Needs Direct Staff Assistance

The items checked below are recommended to maintain the oral health of this resident:

[ ] **Toothbrushing** Each morning and evening, brush teeth and gums for 2 minutes using a soft toothbrush and fluoride toothpaste.
[ ] Remove Partial(s) before brushing teeth [ ] Provide dental floss [ ] Electric toothbrush recommended
[ ] Each morning and evening, swish with 2-3 teaspoons of Fluorigard or ACT fluoride rinse for one minute, then spit out.

[ ] **Denture and Partial Denture Care** Once daily, use a toothbrush or denture brush and mild soap to brush dentures and partials –soaking alone will not remove harmful plaque. At bedtime, remove and brush dentures, then soak them in a denture cup overnight. Soak dentures in plain water, or use a cleaning product such as Efferdent or Polident, but do not let the dentures dry out.
[ ] Apply a denture adhesive, such as Fixodent or Polygrip each morning

(3) Dental Care Referral Recommendations

[ ] No Dental Referral. Resident has no need for dental referral at this time.
[ ] Routine Dental Referral. Resident has routine dental care needs.
[ ] Immediate Dental Referral. Resident has urgent dental needs.

Screening and Referral Notes: Would not Cooperate for screening 7-27-04
Will not cooperate for screening 8-31-04

AO Olsen RDH
Apple Tree Screener

Vicki Cuno (612) 721-0690
Facility Staff Responsible for Referrals

Oral Health Screening Form

Facility Code: VM

Screening Date: 7-27-04
8-31-04
9-28-04

Facility Staff - Please complete this section

Type of Screening [ ] Initial [X] Annual [ ] Status Change

Resident Last Name: [redacted]

First Name & MI: [redacted]

Soc Sec # [redacted]

Room & Bed# [redacted] Date of Birth: 12/19/53 Gender: [X] [F] Payment Type: [ ] MA [ ] PVT [ ] PPS

Diet and Nutrition Problems: [ ] Weight Loss [ ] Nutrition Problem [ ] Feeding Tube [ ] Mechanically Altered Diet

(1) Minimum Data Set Information

a.

	Heavy Debris
	Heavy Plaque
	Heavy Calculus

b.

	Dentures
[ ] None Upper	[ ] Full [ ] Partial
Lower	[ ] Full [ ] Partial

c.

	Missing Teeth w/o Replacement
	Doesn't wear Dentures or Partials
	Problems with Dentures or Partials
	Natural Teeth are Present

d.

	Loose Teeth
	Decayed Teeth
	Broken Teeth/Fillings
	Root Tips Present

e.

	Swollen or Bleeding Gums
	Oral Abscesses, fistulas
	Ulcerations, Denture Sores
	Soft or Hard Tissue Lesions

f.

	Daily Oral Care Needed

SECTION K: ORAL/ NUTRITIONAL STATUS

1.	a. Chewing Problems	a.
	b. Swallowing Problems	b.
	c. Mouth Pain	c.
	d. *NONE OF ABOVE*	d.

SECTION L: ORAL/DENTAL STATUS

1.	a. Debris (soft, easily movable substances) present in mouth prior to going to bed at night	a.
	b. Has dentures and/or removable bridge	b.
	c. Some / all natural teeth lost - does not have or does not use dentures (or partial dentures)	c.
	d. Broken, loose, or carious teeth	d.
	e. Inflamed gums (gingiva); swollen or bleeding gums; oral abscesses; ulcers or rashes	e.
	f. Daily cleaning of teeth/dentures or daily mouth care – by resident or staff	f.
	g. *NONE OF ABOVE*	g.

(2) Daily Oral Care Plan

[ ] Resident Maintains Oral Care Independently
[ ] Resident Needs Staff Supervision
[ ] Resident Needs Direct Staff Assistance

The items checked below are recommended to maintain the oral health of this resident:

[ ] **Toothbrushing** Each morning and evening, brush teeth and gums for 2 minutes using a soft toothbrush and fluoride toothpaste.
[ ] Remove Partial(s) before brushing teeth [ ] Provide dental floss [ ] Electric toothbrush recommended
[ ] Each morning and evening, swish with 2-3 teaspoons of Fluorigard or ACT fluoride rinse for one minute, then spit out.

[ ] **Denture and Partial Denture Care** Once daily, use a toothbrush or denture brush and mild soap to brush dentures and partials –soaking alone will not remove harmful plaque. At bedtime, remove and brush dentures, then soak them in a denture cup overnight. Soak dentures in plain water, or use a cleaning product such as Efferdent or Polident, but do not let the dentures dry out.
[ ] Apply a denture adhesive, such as Fixodent or Polygrip each morning

(3) Dental Care Referral Recommendations

[ ] No Dental Referral. Resident has no need for dental referral at this time.
[ ] Routine Dental Referral. Resident has routine dental care needs.
[ ] Immediate Dental Referral. Resident has urgent dental needs.

Don't try again

Screening and Referral Notes: Would not Cooperate for screening 7-27-04
Will not Cooperate for screening 8-31-04
Will not allow screening 9-28-04

D. Olson RDH
Apple Tree Screener

Vicki Cuno (612) 721-0690
Facility Staff Responsible for Referrals

Oral Health Screening Form

Facility Code: VM

Screening Date: 5-8405

Facility Staff - Please complete this section

Type of Screening: [ ] Initial [X] Annual [ ] Status Change

Resident Last Name: [redacted]

First Name & MI: [redacted]

Soc Sec #: [redacted]

Room & Bed#: [redacted] Date of Birth: 12/19/53 Gender: [M] [F] Payment Type: [ ] MA [ ] PVT [ ] PPS

Diet and Nutrition Problems: [ ] Weight Loss [ ] Nutrition Problem [ ] Feeding Tube [ ] Mechanically Altered Diet

(1) Minimum Data Set Information

a.

	Heavy Debris
	Heavy Plaque
	Heavy Calculus

b.

	Dentures
[✓] None	
Upper	[ ] Full [ ] Partial
Lower	[ ] Full [ ] Partial

c.

	Missing Teeth w/o Replacement
	Doesn't wear Dentures or Partials
	Problems with Dentures or Partials
✓	Natural Teeth are Present

d.

	Loose Teeth
	Decayed Teeth
	Broken Teeth/Fillings
	Root Tips Present

e.

	Swollen or Bleeding Gums
	Oral Abscesses, fistulas
	Ulcerations, Denture Sores
	Soft or Hard Tissue Lesions

f. ✓ Daily Oral Care Needed

SECTION K: ORAL/ NUTRITIONAL STATUS

1.	a. Chewing Problems	a.
	b. Swallowing Problems	b.
	c. Mouth Pain	c.
	d. *NONE OF ABOVE*	d. ✓

SECTION L: ORAL/DENTAL STATUS

1.	a. Debris (soft, easily movable substances) present in mouth prior to going to bed at night.	a.
	b. Has dentures and/or removable bridge	b.
	c. Some / all natural teeth lost - does not have or does not use dentures (or partial dentures)	c.
	d. Broken, loose, or carious teeth	d.
	e. Inflamed gums (gingiva); swollen or bleeding gums; oral abscesses; ulcers or rashes	e.
	f. Daily cleaning of teeth/dentures or daily mouth care – by resident or staff	f.
	g. *NONE OF ABOVE*	g.

(2) Daily Oral Care Plan

[-] Resident Maintains Oral Care Independently
[ ] Resident Needs Staff Supervision
[✓] Resident Needs Direct Staff Assistance

The items checked below are recommended to maintain the oral health of this resident:

[✓] **Toothbrushing** Each morning and evening, brush teeth and gums for 2 minutes using a soft toothbrush and fluoride toothpaste.
[ ] Remove Partial(s) before brushing teeth [ ] Provide dental floss [ ] Electric toothbrush recommended
[ ] Each morning and evening, swish with 2-3 teaspoons of Fluorigard or ACT fluoride rinse for one minute, then spit out.

[ ] **Denture and Partial Denture Care** Once daily, use a toothbrush or denture brush and mild soap to brush dentures and partials –soaking alone will not remove harmful plaque. At bedtime, remove and brush dentures, then soak them in a denture cup overnight. Soak dentures in plain water, or use a cleaning product such as Efferdent or Polident, but do not let the dentures dry out.
[ ] Apply a denture adhesive, such as Fixodent or Polygrip each morning

(3) Dental Care Referral Recommendations

No Dental Referral. Resident has no need for dental referral at this time.
Routine Dental Referral. Resident has routine dental care needs.
Immediate Dental Referral. Resident has urgent dental needs.

Screening and Referral Notes: Not too cooperative per screening above info was as best I could do with his level of cooperation.

D. Olson RDH
Apple Tree Screener

Vicki Cuno (612) 721-0690
Facility Staff Responsible for Referrals

State Of Minnesota Veterans Homes Board
Minnesota Veterans Home - Minneapolis
5101 Minnehaha Avenue South
Minneapolis, MN 55417
612-721-0600 Fax 612-728-1259 MN Relay: 1-800-627-3529

A-19-003-C (6/98)

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please Return Information to the Attention of: _____

TO: VAMC ADDRESS: One Veterans Drive Mpls MN 55417	Name of Resident/Patient: [redacted] Date of Birth 12/19/1953 Social Security Number [redacted] Date Admitted to MVH- 5/22/2000

This is your full and sufficient authorization to release to the Minnesota Veterans Homes Board of Directors, its agents, representatives or employees, the HOSPITAL OR MEDICAL information checked below. This authorization specifically includes records prepared prior to and after the date of this authorization. I authorize conversations between the bearer of this authorization and medical, psychiatric, psychological and social services personnel. This authorization includes the release of information concerning drug abuse, alcoholism, psychiatric/psychological information and HIV/AIDS.

Information is needed for the following dates of stay: all / Any or requested

- ☐ Discharge Summaries
- ☐ Outpatient Records, Summaries, Interdisciplinary Notes, Physician and Nurses' Notes
- ☐ Labs/X-rays
- ☐ Medical, physical, social, psychological/psychiatric histories and assessments
- ☐ Statements regarding applicant's participation in programs, including compliance with treatment plans, rules, care plan and abstinence from mood-altering substances
- ☒ Other, including the following: Dental notes from Dec. 2004 - Aug 2006

NOTICE UNDER MN. GOVERNMENT DATA PRACTICES ACT, MN STATUTES, CHAPTER 13

A. *Information collected through use of this release will not be disclosed or disseminated to individuals, business entities or state or federal government agencies without your informed consent, except as required/permitted by law.*

B. *This release will expire one (1) year from the date of your signature.* Attention Public Facilities: Minnesota Statutes §13.05, subd. 4(d)(7) requires automatic expiration of this authorization one year from the date of its execution.

C. *Information will be used to determine your eligibility for admission and continued stay at the Minnesota Veterans Homes.*
You may refuse to sign this release of information, but such refusal may result in a denial of your admission to a Minnesota Veterans Home or in the Homes inability to meet your care needs.

I have read and understand the conditions of this release of information as stated on this form. I hereby authorize you (NAMED ABOVE) to disclose the requested information to the MN Veterans Homes Board.

_____ _____ [redacted] 8/26/05

Applicant/Resident Signature Date Responsible Party Signature/Relationship Date

Reason Applicant/Resident Cannot Sign: Huntington's Disease

THE MINNESOTA VETERANS HOMES BOARD IS AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER.

Note Text

TITLE: PATIENT CONTACT NOTE
DATE OF NOTE: DEC 21, 2004@15:45 ENTRY DATE: DEC 21, 2004@15:45:10
AUTHOR: OFSTEHAGE,JOHN C EXP COSIGNER:
URGENCY: STATUS: COMPLETED

Name of Veteran: [redacted]

Name/Relationship of Contact if other than Veteran:
[redacted]- pt's sister

Date & Time of Contact: Dec 21,2004@15:45

Type of Contact: Telephone

Reason for Contact: I spoke with Pt's sister [redacted] regarding dental care for [redacted]m.
Option?s discussed include 1. No treatment.
2. Admission to VA medical center for evaluation in the OR of dental problems and necessary tooth extractions.

[redacted] is going to meet with [redacted] Hospice team in the near future at the MVH. Following a discussion of Pt's comfort issues, risks and Benefits of Dental surgery in the OR we will determine if we should admit [redacted] for dental treatment.

Next: [redacted] will call me following her meeting with the Hospice team

/es/ JOHN C OFSTEHAGE
STAFF DENTIST
Signed: 12/21/2004 15:53
Facility: MINNEAPOLIS VAMC

Minnesota Veterans Home
Minneapolis
Dental Program
Scheduling Admission/Annual Exams

Admissions

1. An admission referral for a dental exam is completed when an admission dental packet is compiled and sent to Apple Tree Dental (ATD). An admission dental packet includes an oral health plan, dental referral form, current physician order sheet, history and physical and diagnosis list. Date the admission dental packet is sent will be tracked in the Excel Tickler Dental File
2. Upon receipt of the packet ATD will schedule the admission dental exam.
3. ADT will fax the appointment list to HIM.
4. HIM will provide nursing with the list.
5. Nursing will offer the dental appointment to the resident and involve the Social Worker, as indicated, if a responsible party is involved.
6. Nursing will return the list to Unit HIC indicating the resident acceptance/refusal of the dental appointment. Unit HIC will inform the HIM dept. of refusals. Refusals are to be documented in the Excel Tickler Dental File, Momentum progress notes and Health Maintenance Monitoring form. If the resident/representative accepts the appointment the HIC will note the appointment on the calendar.
7. ATD will be notified of the refusal and schedule the resident for another dental exam.
8. Residents will be offered three consecutive opportunities to accept a dental appointment. After the third refusal, ATD will place the resident on an inactive list and HIM will track for the next annual appointment.

Annual Exams

1. Dept. HIC will track and refer all residents due for an annual dental exam. ATD will track/schedule annual dental exam and fax the appointment list to HIM approximately one week prior to the visits. HIM distributes the list to the units.
2. Nursing will offer the dental appointment to the resident and involve the Social Worker, as indicated, if a responsible party is involved.
3. Nursing will return the list to Unit HIC indicating the resident acceptance/refusal of the dental appointment. Unit HIC will inform the HIM dept. of refusals. Refusals are to be documented in the Excel Tickler Dental File, Momentum progress notes and Health Maintenance Monitoring form. If the resident/representative accepts the appointment the HIC will note the appointment on the calendar.
4. ATD will be notified of the refusal and re-schedule the resident for another dental exam.
5. Residents will be offered three consecutive opportunities to accept a dental appointment. After the third refusal, ATD will place the resident on an inactive list and HIM will track for the next annual appointment.
6. Unit HIC will track in Excel Dental Tickler File all annual dental visits refused by residents. By the fifth working day of every month the Dept. HIC will generate a Dental Referral Exam list for residents who refused the last annual exam and residents due for an annual exam. Dental packets will be completed upon request by ATD..

MINNESOTA VETERANS HOME
Minneapolis

Attachment

APPLE TREE DENTAL SERVICES PROTOCOL

I. SCHEDULING

A. Admissions

Residents will be referred for a dental examination within 90 days after admission.
*Admission Dental Packet = Oral Health Plan, Dental Referral Form, Physician Order Sheet, History and Physical and Diagnosis list
**Documentation in the progress notes to include: "Resident missed/refused dental appointment on (date). See ATD progress note". Or, "Resident seen by ATD on (date). See ATD progress note".

1. On Admission, the Unit HIC will initiate the Oral Health Plan and Dental Referral by noting the resident name, room number and medical record number on the bottom of the form. The Oral Health Plan will be sent to the Social Worker for completion. The Dental Referral will be sent to Nursing for completion.
2. MVH Social Worker will be responsible to meet with the new resident or resident's representative to complete the Oral Health Plan by or at the time of the Initial Care Conference. Social Worker will complete the Oral Health Plan indicating a determination to receive dental services from Apple Tree or other dental provider and identifying who will make treatment decisions. The Oral Health Plan will be given to the Unit HIC.
3. Nursing will complete the Dental Referral by the Initial Care Conference. The Dental Referral will be given to the Unit HIC.
4. A copy of the Oral Health Plan and Dental Referral is placed in the *admission dental packet and the originals are filed in the medical record under consultation.
5. Admission Dental Packet* is completed for the admission annual dental referral and sent to the Dept HIC who will deliver the packet to Apple Tree Dental during the next visit. Referral will be entered in Momentum by the Dept. HIC
6. Upon receipt of the packet ATD will schedule the admission dental exam.
7. ADT will fax the appointment list to HIM.
8. HIM will provide nursing with the list.
9. Nursing will offer the dental appointment to the resident and involve the Social Worker, as indicated, if a responsible party is involved.
10. Nursing will return the list to Unit HIC indicating the resident acceptance/refusal of the dental appointment. Unit HIC will inform the HIM dept. of refusals. Refusals are to be documented in the Excel Tickler Dental File, Momentum progress notes and Health Maintenance Monitoring form by the unit HIC. If the resident/representative accepts the appointment the Unit HIC will note the appointment on the calendar.
11. ATD will be notified of the refusal and schedule the resident for another dental exam.
12. Residents will be offered three consecutive opportunities to accept a dental appointment. After the third refusal, ATD will place the resident on an inactive list and HIM will track for the next annual appointment.
13. The medical record and a copy of the current medication/treatment sheet accompany the resident for admission exams.
14. Nursing will initiate the Oral Care Plan by the time of the Initial Care Conference

B. ANNUAL EXAMINATIONS

Residents will be referred for an annual dental examination every 12 months.

1. Dept. HIC will track and refer all residents due for an annual dental exam. Referral will be documented in the progress notes by the Dept. HIC.
2. ATD will track/schedule annual dental exam and fax the appointment list to HIM approximately one week prior to the visits.
3. HIM distributes the list to the units.

4. Nursing will offer the dental appointment to the resident and involve the Social Worker, as indicated, if a responsible party is involved.
5. Nursing will return the list to Unit HIC indicating the resident acceptance/refusal of the dental appointment. Unit HIC will inform the HIM dept. of refusals. Refusals are to be documented in the Excel Tickler Dental File, Momentum progress notes and Health Maintenance Monitoring form by the Unit HIC. If the resident/representative accepts the appointment the HIC will note the appointment on the calendar.
6. ATD will be notified of the refusal and re-schedule the resident for another dental exam.
7. Residents will be offered three consecutive opportunities to accept a dental appointment. After the third refusal, ATD will place the resident on an inactive list and HIM will track for the next annual appointment.
8. Unit HIC will track in Excel Dental Tickler File all annual dental visits refused by residents. By the fifth working day of every month the Dept. HIC will generate a Dental Referral Exam list for residents who refused the last annual exam and residents due for an annual exam. Dental packets will be completed upon request by ATD..

II. RETURN FROM DENTAL APPOINTMENT

A. Apple Tree Dental will complete a progress note for every resident seen that includes the name of the dentist or dental hygienist, date of service, specific dental services provided (documentation needs to reflect if this appointment included an annual exam), medications administered, medical or dental consultations, follow-up orders and follow-up appointments.
B. Nursing will review progress notes and follow-up with any orders according to policy and procedure for transcribing physician orders. (Attending physician shall verify/clarify all orders prior to implementation).
C. Dept. HIC will provide the unit HIC with the appointment list noting if the resident was seen for an annual exam. The unit HIC will document the admission/annual dental visits on the Health Maintenance Monitoring form and in the progress notes. **
D. Unit HIC will file the dental (nursing) referral and dental progress notes under the consultation tab in the medical record . Unit HIC will note dental visit in the progress notes.

III. EMERGENCY/DENTAL CONCERNS

A. Emergency/Dental Concerns will be initiated by Nursing on the Request for Dental Exam Form and given to the Unit HIC. Nursing will document request in the progress notes.
B. Unit HIC will send the request to the Dept HIC.
C. Dept. HIC will fax the request to Apple Tree Dental or call it in depending on the situation/time until the next visit.
D. Apple Tree Dental will schedule the appointment and notify the Dept. HIC via a phone call or on the next schedule.

IV. MISCELLANEOUS

A. After every examination or check-up Apple Tree Dental provides a written treatment plan to the resident or their representative. The resident or their representative signs a consent form, a tear-off section which is part of the treatment plan letter. Consent forms must be received by Apple Tree Dental before treatment is started. Treatment plans will not be sent out for emergency visits.
B. Unit HIC notifies the Department HIC of cancellations. Department HIC will notify Apple Tree Dental.
C. All missed appointments will be noted on the Health Maintenance Monitoring form and in the progress notes the Unit HIC.
D. Oral Health Plan will be updated by the Social Worker

maker changes.

E. The Dept.HIC will be the contact between MVH-Mpls and Apple Tree Dental for scheduling all dental appointments and all scheduling concerns. Clinical concerns will be directed to the DON and administrative concerns to the Director of HIM and/or the Assistant Administrator.

F. Dept. HIC will notify Apple Tree Dental of all admissions, discharges and room changes on a monthly basis.

H:\16\Dental\ATDPROTOCOL.doc MVH 3/20/00
REV 08/31/0505

MINNESOTA VETERANS HOME
Minneapolis

ORAL HEALTH PLAN – NURSING CARE UNIT

As part of your admission to the Minnesota Veterans Home, you are being offered dental services through Apple Tree Dental, a private, non-profit, contracted dental service. An Apple Tree dental hygienist will provide an initial oral health screening within the first two months after admission and an oral health screening annually. Should additional dental work be needed, a referral will be made and Apple Tree will provide you or your responsible party a detailed plan of treatment for approval before any work is initiated. At present, most dental services are at no cost to you.

***Admission and annual dental exams will be provided as services allow. You may wish to continue seeing your present dentist, especially if you are currently having dental problems which your dentist is addressing.**

To be completed by/at initial care conference.

Date of last dental exam (check-up): _____

☐ I authorize Apple Tree Dental to provide dental examinations and routine preventive and diagnostic services. Following each exam, as indicated, I understand that I will be provided with a treatment plan, and treatment will not be started without further consent.

☐ I will make arrangements with my dentist, Dr. _____, to provide oral health care and will also provide this health care facility with a written record of a dental exam provided within the last year. (Required by MN Health Department Regulations)

☐ I refuse an admission dental examination. I understand that a dental examination to include routine preventive and diagnostic services will be offered to me on an annual bases. Services will be provided by Apple Tree Dental.

_____ _____
Resident's/Resident Representative's Signature **Date**

TREATMENT DECISIONS

1. Does the resident make treatment decisions? ____ No ____ Yes
   If yes, the resident must sign below.

   _____ _____
   Resident's Signature Date

2. Does the resident's representative make treatment decisions? ___ No ___ Yes
   If yes, the resident's representative must sign below:

   _____ _____ _____
   Representative's Signature Relationship **Date**

   _____
   Representative's Name (PRINTED)

   _____ _____
   Address **Phone Number**

   _____
   City **State Zip Code**

_____ _____ _____ _____ _____
Resident Name **Bldg/Rm#** **MR#** **Social Security #** **Birth Date**

Distribution: Original- Resident Chart/ Consultation Tab
Copy – Medical Record Clerk/Apple Tree Dental

MINNESOTA VETERANS HOME
Minneapolis

ORAL HEALTH PLAN - BOARDING CARE

As part of your admission to the Minnesota Veterans Home, you are being offered dental services through Apple Tree Dental, a private, non-profit, contracted dental service.

Admission and annual dental exams will be provided as services allow. Should additional dental work be needed, Apple Tree will provide you or your responsible party a detailed plan of treatment for approval before any work is initiated. At present, most dental services are at no cost to you. You may wish to continue seeing your present dentist, especially if you are currently having dental problems which your dentist is addressing.

To be completed by/at initial care conference.

Date of last dental exam (check-up): _____

☐ I authorize Apple Tree Dental to provide dental examinations and routine preventive and diagnostic services. Following each exam, as indicated, I understand that I will be provided with a treatment plan, and treatment will not be started without further consent.

☐ I will make arrangements with my dentist, Dr. _____, to provide oral health care and will also provide this health care facility with a written record of a dental exam provided within the last year. (Required by MN Health Department Regulations)

☐ I refuse an admission dental examination. I understand that a dental examination to include routine preventive and diagnostic services will be offered to me on an annual bases. Services will be provided by Apple Tree Dental.

_____ _____
Resident's/Resident Representative's Signature **Date**

TREATMENT DECISIONS

1. Does the resident make treatment decisions? ____ No ____ Yes
   If yes, the resident must sign below.

   _____ _____
   Resident's Signature Date

2. Does the resident's representative make treatment decisions? ___ No ___ Yes
   If yes, the resident's representative must sign below:

   _____ _____ _____
   Representative's Signature **Relationship** **Date**

   _____
   Representative's Name (PRINTED)

   _____ _____
   Address **Phone Number**

   _____
   City **State** **Zip Code**

_____ _____ _____ _____ _____
Resident Name **Bldg/Rm#** **MR#** **Social Security #** **Birth Date**

Distribution: Original- Resident Chart/ Consultation Tab
Copy – Medical Record Clerk/Apple Tree Dental

MINNESOTA VETERANS HOME
Minneapolis

DENTAL REFERRAL

Resident Name:_____ Bldg/Rm#:_____ MR#:_____

Attending Physician: _____ Date of Appointment:_____

COMPLETED BY MVH STAFF

PROBLEMS TO BE EVALUATED

Reason for Appointment (√) ☐Admission Exam ☐Annual Exam ☐Other (Explain)

_____

_____

Check all that apply: (√) ☐Own Teeth ☐ Denture
☐Upper Full
☐Lower Full
☐Upper Partial
☐Lower Partial

MEDICAL ALERTS

Allergies/Sensitivities: (√)
☐No Known Allergies/Sensitivities

☐ Penicillin	☐ Codeine	☐NSAID:_____
☐Amoxicillin	☐ Aspirin	☐ Other:_____
☐Erythromycin	☐ Lidocaine	☐ Other:_____
☐Tetracycline	☐Novocaine	☐ Other:_____
☐Sulfa	☐ Latex	☐Other:_____

Other Alerts: (√)

☐Premed, heart	☐None
☐Premed, joint	☐Chemotherapy
☐Pacemaker	☐Head/Neck Radiation
☐DNR/DNI	☐Coumadin
☐Steroids	☐ Other:_____
	☐Other:_____

See Attached: Current medical history /Current medications / Current diagnosis list

Requires monitoring for wandering (√) ☐Yes ☐No (If yes, make arrangements for an escort)
Ambulatory? (√) ☐Yes ☐No Needs assistance with transfers? (√) ☐Yes ☐No
Special Needs:_____

Mental Status and Decision Making

	Normal	Slightly Impaired	Severely Impaired
Memory	☐	☐	☐
Orientation	☐	☐	☐
Judgement	☐	☐	☐

☐ This Client makes their own treatment decisions.
☐ This Client's Representative makes treatment decisions.
Representative Name:_____
Phone #:_____

Cooperation, Communication, Behavior Management

☐ Generally Cooperative
☐ Sometimes Uncooperative
☐ Usually Uncooperative
☐ Always Uncooperative

Approaches for managing behavior:
_____
_____
_____

SIGNATURE:_____ DATE:_____
(Nurse Completing Request)

Minnesota Veterans Home
Minneapolis

Health Care Maintenance Monitoring

Influenza Vaccine				Pneumococcal Vaccine		Tetanus Vaccine	
Other Immunizations							

Mantoux 1st Step							Mantoux 2nd Step			Chest X-ray			
Date Read							Date Read						
Induration (mm)							Induration (mm)						

Health Maintenance (record date of lab/test in box)											
Guaiac (date/results)											

Dental Examination											
Date of Exam	Admission										
Date of Refusal											
Date of Missed Appt											

Resident Name _____ Room # _____ MR# _____

Apple Tree Dental Phone: 763-784-7993 Fax: 763-784-597

Dental Concern: Request For Dental Exam

Resident:	Facility: Minnesota Veterans Home 5101 Minnehaha Ave. So. Minneapolis, MN 55417 Phone #: 612-721-0690 Attention: Health Information Fax #: 612-728-1237	Bldg# Rm# MR#

Resident currently an Apple Tree Patient? ☐ Yes ☐ No ** If no, send a copy of the following to MVH dental liaison: OHP, Physician Order Sheet, H&P, Diagnosis List

☐ Denture Concern

- ☐ Upper Full
- ☐ Lower Full
- ☐ Upper Partial
- ☐ Lower Partial

- ___ Broken Denture
- ___ Broken/BentClasp
- ___ Broken/MissingTooth
- ___ Ill Fitting Denture
- ___ Sore/Bleeding Gums
- ___ Patient Lost Denture
- ___ Staff Lost Denture
- ___ Check-Up (12 month)
- ___ Other_____

☐ Tooth Concern

- ☐ Upper
- ☐ Lower
- ☐ Front
- ☐ Back
- ☐ Left
- ☐ Right

- ___ Pain
- ___ Swelling
- ___ Chipped/Broken Tooth/Teeth
- ___ Sensitive Tooth/Teeth
- ___ Loose Tooth/Teeth
- ___ Lost Filling
- ___ Lost Crown
- ___ Cleaning Needed
- ___ Other_____

Requested on Oral Health Screening Form by Apple Tree Dental Screener Date:_____

Reported _____ Date:_____

FOR DENTAL LIAISION USE ONLY

Date ATD contacted:_____ Contacted:_____

Date DC Faxed to ATD:_____

Attention: Sharon Pederson or Marcia Marks

Notes: _____

MVH Dental Liaison: Vicki Cuno, Health Information

***Send completed form to MVH Department Health Information Clerk**

For MVH Dental Liaison Use

Appointment Date:_____

Notes:_____

Minnesota Veterans Home
Minneapolis

Dental Progress Note File

MINNESOTA VETERANS HOME – Minneapolis
DENTAL DIRECTOR PROGRAM

Apple Dental will provide a Dental Professional Screener to visit the Minnesota Veterans Home monthly to perform the oral screening section of the Minimum Data Set (MDS) and recommend daily oral care plans for every new resident of your facility.

Prior to Dental Director Visit:

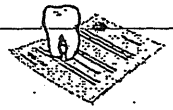
- HIC will fill out the information in the top box (plus room and bed numbers) of the Oral Health Screening Form. Nursing will fill in nutritional section.
- Screenings will be completed on:
  - ✓ Anyone due for annual MDS Screening (current month and next month).
  - ✓ New Admits
  - ✓ Residents with significant status change.

When Apple Tree Dental Screener is Present for the MDS Screening Visit:

- Upon arrival to the nurses' station the HIC will present forms for those needing MDS screenings to Apple Tree Dental Screener.
- A staff member escorts the screener to the resident's room for the screening.
- When the Apple Tree Dental Screener is finished at each nurses' station, she will give the completed Screening Forms to the HIC to make copies: Copy goes to screener original form will be filed in the chart.

After Dental Director Visit:

- Nursing will review *Section 2 Daily Oral Care Plan* to see if *Daily Oral Care Plans* have changed.
- HIC will review *Section 3.*
  - ✓ If there is an immediate *Dental Referral Recommendation,* the HIC will initiate a *Dental Concern Form* and send to the HIM Department.
  - ✓ If there is a *Routine Dental Referral Recommendation* Apple Tree Dental will schedule their routine examination when it is due.
- Department HIC who is responsible for making the dental referral will sign the bottom of the *Oral Health Screening Form.*
- The original *Oral Health Screening Form* should be filed in the resident's facility chart after it has been reviewed/initialed off by nursing.



Oral Health Screening Form

Facility Code: _____

Screening Date: _____

Facility Staff - Please complete this section

Resident Last Name: _____

First Name & MI: _____

Room & Bed#: _____ Date of Birth: _____ Gender: [M] [F]

Type of Screening: [ ] Initial [ ] Annual [ ] Status Change

Soc Sec #: _____

Payment Type: [ ] MA [ ] PVT [ ] PPS

Diet and Nutrition Problems: [ ] Weight Loss [ ] Nutrition Problem [ ] Feeding Tube [ ] Mechanically Altered Diet

(1) Minimum Data Set Information

a.

	Heavy Debris
	Heavy Plaque
	Heavy Calculus

b.

[ ] None	**Dentures**
Upper	[ ] Full [ ] Partial
Lower	[ ] Full [ ] Partial

c.

	Missing Teeth w/o Replacement
	Doesn't wear Dentures or Partials
	Problems with Dentures or Partials
	Natural Teeth are Present

d.

	Loose Teeth
	Decayed Teeth
	Broken Teeth/Fillings
	Root Tips Present

e.

	Swollen or Bleeding Gums
	Oral Abscesses, fistulas
	Ulcerations, Denture Sores
	Soft or Hard Tissue Lesions

f.

	Daily Oral Care Needed

SECTION K: ORAL/ NUTRITIONAL STATUS

1.	a. Chewing Problems	a.
	b. Swallowing Problems	b.
	c. Mouth Pain	c.
	d. *NONE OF ABOVE*	d.

SECTION L: ORAL/DENTAL STATUS

1.	a. Debris (soft, easily movable substances) present in mouth prior to going to bed at night	a.
	b. Has dentures and/or removable bridge	b.
	c. Some / all natural teeth lost - does not have or does not use dentures (or partial dentures)	c.
	d. Broken, loose, or carious teeth	d.
	e. Inflamed gums (gingiva); swollen or bleeding gums; oral abscesses; ulcers or rashes	e.
	f. Daily cleaning of teeth/dentures or daily mouth care – by resident or staff	f.
	g. *NONE OF ABOVE*	g.

(2) Daily Oral Care Plan

[ ] Resident Maintains Oral Care Independently
[ ] Resident Needs Staff Supervision
[ ] Resident Needs Direct Staff Assistance

The items checked below are recommended to maintain the oral health of this resident:

[ ] **Toothbrushing** Each morning and evening, brush teeth and gums for 2 minutes using a soft toothbrush and fluoride toothpaste.
[ ] Remove Partial(s) before brushing teeth [ ] Provide dental floss [ ] Electric toothbrush recommended
[ ] Each morning and evening, swish with 2-3 teaspoons of Fluorigard or ACT fluoride rinse for one minute, then spit out.

[ ] **Denture and Partial Denture Care** Once daily, use a toothbrush or denture brush and mild soap to brush dentures and partials –soaking alone will not remove harmful plaque. At bedtime, remove and brush dentures, then soak them in a denture cup overnight. Soak dentures in plain water, or use a cleaning product such as Efferdent or Polident, but do not let the dentures dry out.
[ ] Apply a denture adhesive, such as Fixodent or Polygrip each morning

(3) Dental Care Referral Recommendations

[ ] No Dental Referral. Resident has no need for dental referral at this time.
[ ] Routine Dental Referral. Resident has routine dental care needs.
[ ] Immediate Dental Referral. Resident has urgent dental needs.

Screening and Referral Notes: _____

_____ Apple Tree Screener

Vicki Cuno (612) 721-0690
Facility Staff Responsible for Referrals

MN Veterans Homes Mpls
Interdisciplinary Comprehensive Assessment
August 25, 2005
Minutes

The team members reviewed the current policy for comprehensive assessment / clinical rounds process and accountabilities.

No changes were made to the existing procedures. Review and enforcement of the policy/procedures is required.

It was clarified that the Social Worker will initiate the Safe Smoking Assessment upon admission, smoking incident, and PRN. The IDT will review the assessment as a team and determine if the resident requires any interventions regarding their smoking practices.

Department directors will review the policy with their staff and enforce the timely completion of assessments and related documentation.

An additional meeting will be set up to review the Clinical Rounds and Care Conference meetings to ensure all IDT members are clear on their responsibilities.

STATE OF MINNESOTA
VETERANS HOME - MINNEAPOLIS
OPERATING POLICY AND PROCEDURES

Title: Resident Assessment Instrument (RAI) Number: 01-71

Approvals: Administrator A.S. 11/01 Date: 11/01

POLICY: It is the policy of MVH-Mpls. that a comprehensive assessment, i.e. RAI, including the MDS, RAP's (Resident Assessment Protocols…in conjunction with the RAP Guidelines), be completed upon admission of a resident, quarterly, annually, and if a significant change in status occurs. The Lead MDS Coordinator/designee will track and provide a schedule for MDS completion and monitor for compliance.

PROCEDURE:

I. New Admission:

A. Nursing, Recreation Therapy, Mental Health Services (MHS), PT, and Dietary will complete a departmental assessment between day 2 and day 8 (admission day = day "one") for each newly admitted resident. Data from the departmental assessments will correspond to appropriate sections of the MDS, i.e. MHS= Sections **B**, **E**, and **F**; Dietary = **K**; PT = **G-3**, **G-4**; Recreation Therapy = **N**; Nursing = all other sections.

B. The Admission MDS, and Resident Assessment Protocols (RAP's) will be completed by the unit MDS Coordinator by day 14 of the resident's stay. By signing lines **AA-9a** and **R-?**, the MDS Coordinator is attesting to the accuracy of the submitted MDS data. By signing line **V-B1**, the MDS Coordinator is assuring completion of the RAP's. After RAP and care plan review, the staff person leading the care conference (any interdisciplinary team member, i.e. RN, Social Worker, Dietician etc.) will sign line **V-B2** to assure that appropriate problem areas as identified by the MDS are addressed within the resident's plan of care. The initial care conference will be scheduled by day 21 via Health Information Management.

II. Quarterly MDS Review:

A. Each resident will be reassessed every 84-90 days utilizing the Quarterly MDS form to monitor for changes in resident status. The MDS Coordinator will complete all sections of the Quarterly MDS via staff/resident interview, and utilizing data from the resident's

written record including, Nurses' Weekly Charting, and Quarterly Range of Motion Data Collection Form, and will sign lines **AA-9a** and **R2** attesting to the accuracy and completion of the assessment. A care conference will be scheduled via Health Information Management corresponding with the completion date of the Quarterly MDS.

III. Annual MDS Reassessment:

A. The RAI will be completed within 365 days of the resident's last comprehensive assessment, i.e. Admission MDS, Significant Change MDS, or last Annual MDS Assessment.

B. Eleven days prior to the Annual MDS due date the Lead MDS Coordinator will notify the interdisciplinary team of the seven-day observation period for completing departmental assessments. Each section of the MDS will correspond to a departmental assessment as per the Admission MDS, except Social Services (not MHS) will be responsible for sections **B**, **E**, and **F**.

C. The unit MDS Coordinator will be responsible for completing the MDS and RAP's as per the Admission section above. Health Information Management will schedule care conferences as above.

IV. Significant Change MDS:

A. If at any time during the year a resident experiences a significant change in health status, as defined in the HCFA RAI Version 2.0 Manual (located on all units) and per an interdisciplinary team dialogue, another comprehensive assessment ("Significant Change MDS") will be initiated per the above manual instructions. Subsequent care conferences and MDS's will be scheduled from the date of Significant Change MDS completion.

Minnesota Veterans Home-Minneapolis DATE:_____
Clinical Rounds Review ☐ Admission ☐ Quarterly ☐ Annual ☐ Significant Change

Quality of Life	Comments from Clinical Rounds Discussion
Vulnerabilities Reviewed ☐	
Long Term Goal	
Discharge Plan ☐ Long-term placement ☐ Plans to discharge ☐ Level of care change	
Resuscitation Code Status *Review MD Orders ☐ Full Code ☐ DNR ☐ DNI ☐ Hospice ☐ Comfort Care ☐ LTP	☐ referral to MD for "ability to make HC Decisions"
Social/Personal Support Personal / Business Management/ Psychosocial support services provided ☐ Strengths_____ ☐ Has support of family/friends _____ ☐ 1:1 counseling support_____ ☐ Financial mgt._____ ☐ Group(s)_____ ☐ End of life_____ ☐ Other_____	
Spiritual Care ☐ Worship Services ☐ Recent loss/life change Faith Concerns ☐ yes ☐ no	☐ Chaplain Visit Referral
Therapeutic Recreation Frequency groups attended_____ Program type_____ Goal Met: ☐ yes ☐ no ☐ partially_____ ☐ Goal continue ☐ Goal Change _____ ☐ work therapy program Comments	
Smoking Smoker? ☐ yes ☐ no Any unsafe incidents? ☐ yes ☐ no Any change in risk factors? ☐ yes ☐ no	
Mental Health ☐ Baseline Status ☐ Change From Baseline Status Describe:_____ ☐ Target Behavior:_____ ☐ No Psychotropics used ☐ Psychotropics used Consent in place ☐yes ☐no (circle) antidepressant antipsychotic hypnotic antianxiety ☐ Routine ☐ PRN DX:_____ Describe Problems with: ☐ Behavior: _____ ☐ Cognition: _____ ☐ Mood/thought ☐ MHS Referral for Behavior, Assessment, Therapy Services, Psychiatry Currently involved in:	☐ Referral for Decision Making Assessment

Resident Name: _____ Bldg/RM#: _____ MR#: _____

Quality of Care	Comments from Clinical Rounds Discussion
Medical Condition Baseline? ☐ yes ☐ no Describe _____ Infection: ☐ MRSA ☐ VRE ☐ HX of TB Location: Precautions: ☐ Contact ☐ Isolation Pain: ☐ No pain ☐ Chronic pain managed Location: _____ Acute/new pain: ☐ yes ☐ no Location: _____ Pain Management Plan: Effective : ☐ yes ☐ no ☐ Routine analgesics/tx's: ☐ PRN's used Update pain management plan: ☐ yes ☐ no	Medical Referral Needed : _____ _____ Temp. Care Plan needed: ☐ yes ☐ no
Skin Skin Impaired ☐ yes ☐ no ☐Chronic Condition Treatment _____ Describe: Location:	Treatment
Nutrition Current Weight (lbs.): _____ Weight: ☐ stable ☐ loss #_____ ☐ gain #_____ Diet/texture: ☐ Hydration Plan Comments:	
Elimination Bladder Continent ☐ yes ☐ no ☐ Assisted _____ ☐ SIC ☐ Foley ☐ S/P Bowel Continent ☐ yes ☐ no ☐ Ostomy Change: _____ At Risk:	
Falls/Safety/ Mobility ☐ No falls Frequency over past quarter(#): _____ ☐ bed alarm ☐ wheelchair alarm ☐locked unit ☐ TAS unit ☐ thigh belt ☐ front closure ☐ rear closure ☐ lap tray ☐ lap buddy ☐ wedge cushion ☐ perimeter mattress ☐ floor matt ☐ Other: _____ Siderails: ☐ half ☐ full ☐ 1 or 2 Straps: ☐ foot ☐ ankle ☐ shoulder Why: Consent in place ☐ yes ☐ no	☐ PT/OT Referral Restraints Reviewed – ☐ Remains least restrictive ☐ Recommend Change
Rehab Status ☐ PT _____ Attends: ☐ OT _____ ☐ Speech _____ Dysphagia Diagnosis / Swallowing Guide in place _____ ☐ Fitness Gym:	
Clinical Rounds Attendee's Signature:	
CARE CONFERENCE REVIEW **DATE:**	
☐ **No change since clinical rounds notation** ☐ **Changes/updates since clinical rounds notation** **Describe:**	
Resident/Family Concerns or Comments:	
Care Conference Attendee's Signature (including resident and family):	

Resident Name: _____ Bldg/RM#: _____ MR#: _____

Title: Resident Focused Documentation System for MVH-Mpls Interdisciplinary Team

Number: 01-76

REV: 12/1/04

Approvals: Administrator A.S. 12-1-04

Date: 01/03

Objective: Resident focused care planning has been proven to improve outcomes for residents. Having individualized problem/issue identification completed by an interdisciplinary team will improve the resident's quality of life and quality of care.

Policy: Pre-screening to discharge is a continuous process versus a segmentation. The work of one part of the team becomes a formal part of the next steps. Interdisciplinary teaming is built in, duplication is minimized, and residents are not asked repeated questions. The framework of this process is:

- Pre-Admission documents are a permanent part of the medical record
- The RNM puts in place predictable interventions prior to admission.
- The designated Nurse further assesses the resident upon admission and adds to the document.
- The interdisciplinary team assessments begin.
- The care plan is developed.
- Interventions are implemented.
- Evaluation towards goals is performed.
- Reassessment is started.

PROCEDURE:

1. **Pre-screening:** Clinical Nurse Specialists
   - A. Determine eligibility of resident
   - B. Determine if holistic needs can be met within the MVH-Mpls Continuum of Care
   - C. Complete Pre-Screening Assessment (M02-298C.vsd)
   - D. Communicate to applicant
   - E. Communicate to Interdisciplinary Team

2. **Pre-admission:** Registered Nurse Manager (RNM)
   - A. RNM or designee begins pre-coordination of care
   - B. Coordinate plan for safety and pressure ulcer prevention so it may be implemented the day of admission
     1. Estimated Braden Score and Proactive interventions
     2. Predictable Fall Potential / Safety Issues / Proactive interventions
     3. Pre-care plan any other issues that need to be addressed for the resident upon admission

3. **Admission:** Nursing
   A. RNM or designated Nurse admits resident
      (1). Complete indicated sections of the Admission Assessment (M02-302C) and scheduled Momentus assessments.
      (2). Initiate Admission Vital Sign /Narrative Notes in Momentus
   B. Add initial resident issues to the Interdisciplinary Care Plan Templates. (MCP-002)
   C. Start communication link with family
   D. Insures all required physician orders are obtained and transcribed
   E. HIM schedules in Momentus
      1. Admission height and weight
      2. Admission vital signs q 4hrs x 24
      3. Admission narrative notes q 4hrs x 24
      4. Risk for falls assessment
      5. Skin Check Questionnaire
      6. Admission Base Care Path

4. **Assessments:** Nursing
   A. RNM or Designated Nurse implement assessment process
   B. Complete the Admission Nursing Data Collection Coordination Form (M02-300C) to assign the assessments.
      1. Assessments include:
         a. Bowel and bladder Incontinence Assessment (02-035c/02-174C)
         b. Pain Assessment (M02-282C)
         c. Risk for Falls (Momentus)
         d. Resident Functional Abilities Form (M02-299C.vsd)
         e. Skin check questionnaire (Momentus)
      2. Assign Mantoux
      3. Assign Skin Inspection
   C. Review the following vulnerable areas for resident specific vulnerabilities.
      1. Exhibiting psychotic or psychopathic behavior, manic-depressive, hallucinations, delusions, delirious, clinically depressed
      2. Combative or physically assaultive
      3. Verbally threatening, poor impulse control
      4. Chemical health drugs, alcohol
      5. Agitated, anxious
      6. Socially isolated – withdrawn, alienated from other residents or staff
      7. Unable to make decisions
      8. Persons unable to perform ADL's
      9. Impaired memory, judgement
      10. Impaired speech and communications
      11. Sensory deficits – visual, auditory
      12. Neurological impairments
      13. Self harm
      14. Suicidal ideation
      15. Persons easily exploited by other residents
      16. Sound deficits
      17. Isolation

5. **RAI Process (MDS, Triggers, RAPs)** Interdisciplianry Team Members
It is the policy of MVH-Mpls. that a comprehensive assessment, i.e. RAI, including the MDS, RAP's (Resident Assessment Protocols...in conjunction with the RAP Guidelines), be completed upon admission of a resident, quarterly, annually, and if a significant change in status occurs.
Accountabilities: The Lead MDS Coordinator/designee will track and provide a schedule for MDS completion and monitor for compliance.

A. **New Admission / Initial MDS:**

1. Nursing, Social Services, Therapeutic Recreation, Mental Health Services (MHS), Rehabilitation, Chaplaincy, and Dietary will complete interdisciplinary assessments between day 2 and day 8 (admission day = day "one") for each newly admitted resident. Data from the departmental assessments will correspond to appropriate sections of the MDS, i.e. MHS= Sections B, E, and F; Dietary = K; PT = G-3, G-4; Recreation Therapy = N; Nursing = all other sections.
2. The Admission MDS, and Resident Assessment Protocols (RAP's) will be completed by the Unit MDS Coordinator by day 14 of the resident's stay. By signing lines **AA-9a** and **R-2**, the MDS Coordinator is attesting to the accuracy of the submitted MDS data. By signing line **V-B1**, the MDS Coordinator is assuring completion of the RAP's. After RAP and care plan review, the staff person leading the care conference (any interdisciplinary team member, i.e. RN, Social Worker, Dietician etc.) will sign line **V-B2** to assure that appropriate problem areas as identified by the MDS are addressed within the resident's plan of care. The initial care conference will be scheduled by day 21 via Health Information Management and / or MDS Coordinator.

B. **Quarterly MDS Review:**

1. Each resident will be reassessed every 84-90 days utilizing the Quarterly MDS form to monitor for changes in resident status. The MDS Coordinator will complete all sections of the Quarterly MDS via staff/resident interview, and utilizing data from the resident's record including, Nurses' Weekly Charting, and Quarterly Range of Motion Data Collection Form, and will sign lines **AA-9a** and **R2** attesting to the accuracy and completion of the assessment. A care conference will be scheduled via Health Information Management corresponding with the completion date of the Quarterly MDS.

C. **Annual MDS Reassessment:**

1. The RAI will be completed within 365 days of the resident's last comprehensive assessment, i.e. Admission MDS, Significant Change MDS, or last Annual MDS Assessment.
2. Eleven days prior to the Annual MDS due date the Lead MDS Coordinator will notify the interdisciplinary team of the seven-day observation period for completing departmental assessments. Each section of the MDS will correspond to a departmental assessment as per the Admission MDS, except Social Services (not MHS) will be responsible for sections **B, E,** and **F.**
3. The unit MDS Coordinator will be responsible for completing the MDS and RAP's as per the Admission section above. Health Information Management will schedule care conferences as above.

D. **Significant Change MDS:**

1. If at any time during the year a resident experiences a significant change in health status, as defined in the CMS RAI Version 2.0 Manual (located on all units) and per an interdisciplinary team dialogue, another comprehensive assessment ("Significant Change MDS") will be initiated per the above manual instructions. Subsequent care conferences and MDS's will be scheduled from the date of Significant Change MDS completion.
2. Significant Change in Status monitoring for a NCU resident will be done at Clinical Rounds:
   a. The MDS coordinator will bring the form to Clinical Rounds
   b. The Clinical Rounds team will review residents who:
      i. have returned from the hospital
      ii. having a change in status per MDS Manual definitions
      iii. have received a new significant diagnosis or newly found terminal diagnosis
   c. The clinical rounds team will have up to 14 days to determine if there is a significant change in status. The decision will be documented on the Significant Change in Status Form M02-312C.
   d. The form is filed under the MDS section of the individual resident's medical record.

6. **Developing the Interdisciplinary Care Plan**

A. As the assessments are completed the interdisciplinary team starts to develop the initial plan of care for the resident.

(1). Each interdisciplinary team member documents - by dating and initialing each entry - indicated problems, goals, approaches required for the involved resident

a. Each member will include indicated risk factors, measurable goals as indicated, and approaches to eliminate or minimize problems, and approaches to strengthen resident's goal achievement.

b. The vulnerable areas that would place the resident at risk for abuse, including self-abuse, neglect and/or financial exploitation are noted on the care plan by an asterisk. Specific measures/approaches to be taken to minimize the risk of abuse shall be part of the care plan.

(2). The MDS Coordinators will take this information and prepare a computerized copy of the care plan and bring it to the Clinical Rounds meeting for approval/editing

(3). The templates may be thinned at the time of approval of the computerized copy of the care plan.

(4). The care plan is reviewed/revised with the resident/family at the Care Conference

(5). It is the responsibility of the Clinical Rounds Team to maintain the accuracy of the resident care plan.

7. **Progress Towards Goals:**

A. Clinical Rounds

(1). Disciplines:

- Nurse Practitioner
- RNM or designated Partnering Nurse
- MDS Coordinator
- Social Worker
- Dietician
- Rehabilitation
- Mental Health Services
- Therapeutic Recreation

- Chaplaincy
- Pharmacist
- Others as indicated

(2). Resident Selection

- Residents due for MDS and Care Conference
- Residents experiencing Significant Change
- Residents who are experiencing problems or change during the week of the Clinical Rounds (Residents with temporary care plans in place)

(3). Content

- Completion of the Clinical Rounds Review Form (MCP-001) See attached.

8. Reassessment Processes

A. Weekly Charting (M02-297c)

(1). Collection of data to determine the resident's progress towards care planned goals
(2). Noting declines and improvements
(3). Noting Acute illness

B. Temporary Care Plans

(1). Temporary Care Plan Goals: (TCP01-04)

a. To provide a high quality time efficient process to communicate temporary changes in status of residents in the NCU.
b. To enhance the care planning process so that the care plan reflects the current condition of the resident in between monthly/quarterly interdisciplinary updates.

(2). Temporary Care Plan Definitions:

a. *Temporary Care Plan*: A care plan that includes problems that a member(s) of the interdisciplinary team considers to be lasting < 30 days
b. *Template:* A care plan option, which contains basic standards of practice and/or policy/procedure reminders that can be individualized for each resident situation.

(3). Temporary Care Plan Procedure

a. When there is a change in a resident's status requiring intervention it should be documented in the nurses'/interdisciplinary Notes and on either the permanent care plan or Temporary Care Plan.
b. Determine if resident qualifies for significant change in condition per MDS criteria: The interdisciplinary team member(s) will **determine if the situation is expected to last <30 days.** If the change is <30 days, the nurse or interdisciplinary team member may:
   - Complete an individualized plan of care using the blank temporary care plan template
   - Utilize the temporary care plan template for resident illness
   - Utilize the temporary care plan template for resident injury
   - The interdisciplinary team member will determine what elements on the template are appropriate for the resident situation and add additional information to individualize it. (See instructions below)
c. **If the resident change is expected to be longer that 30 days in length,** the interdisciplinary team member should alert the MDS Coordinator and ADON to assess the resident for significant change (by MDS definition). If determined that

a significant change has occurred, the care plan will be updated through the significant change assessment process.

d. Directions for completing a Temporary Care Plan Template
- Date and initial the left hand column of the template
- As further changes are made, date and initial the changes as on any legal document. Highlighting out discontinued sections of the plan is acceptable as long as it is dated and initialed.
- Place in the MAR so on-coming nurses will see
- Insure a nurses' note or interdisciplinary note has been written on the situation
- When resolved, the template should be filed behind the permanent care plan in the individual resident's medical record.

C. Significant Change in Condition:

1. When a condition is identified that is considered by clinical judgement to be permanent and/or meets the MDS Significant Change Criteria a significant change in status assessment process is to take place (Comprehensive MDS - Refer to Assessment section above.)

D. Re-admission

(1). Pharmacy will print out the most current listing of the resident's medication on a duplicate carbonless form when the resident is admitted to the hospital. This will have holes for the chart punched in it. It will be delivered to the floor through the pharmacy delivery system.

(2). The Health Information Clerks will place the form in the front of the resident's chart

(3). Upon receipt of the readmission orders form, the GNP will review the previous and new orders. She/he will mark R,C, or D by each order – noting specifics of changes at the bottom of the form. The GNP will bring the duplicate page of the form and a copy of the readmission orders to the pharmacy

(4). The pharmacy will produce a MAR/TAR from the information and send the order listing, MAR/TAR to the station. The timeframe will be approximately 1-2 hours if received before 2:30 PM. If received after, call the pharmacy to see if MAR/TAR will be available.

a. The partnering nurse will send the following to the pharmacy:
- review the ancillary orders
- review the allergy listing
- attach a copy of the discharge summary if available
- return medications needed a label change

(5). The nurse on duty will transcribe the orders. She/he will also include reviewing the chart for **any orders or ancillary orders missed from prior to the hospitalization**

(6). If the nurse practitioner or pharmacy services are not available, the nurse will call the Medical Officer of the Day for confirmation of the orders.

Minnesota Veterans Home
Minneapolis
Procedure for Admission Documentation

Phase I: Pre-Screening / Clinical Specialist RN

A. The Clinical Specialist RN's will document information obtained on a resident through the pre-screening process on the **NURSING PRE-ADMISSION ASSESSMENT.**

B. The original **NURSING PRE-ADMISSION ASSESSMENT** will be filed in the administrative folder in Admissions Office.

C. A copy will be attached to the admission packet that goes to the RN Nurse Manager on the admitting unit.

Phase II: Pre-Admission / RN Nurse Manager (RNM)

A. The RNM will review the **NURSING PRE-ADMISSION ASSESSMENT.** He/she will then initiate the **ADMISSION CARE PLAN.** At a minimum, the resident's safety plan, pressure ulcer prevention plan, and ADL plan will be addressed.

B. The RNM will make arrangements for specialized equipment, pressure relieving mattresses, safety devices to be available prior to the admission.

C. The RNM will delegate assignments for new admission assessments on the **ADMISSION NURSING DATA COLLECTION COORDINATION** form.

Phase III: Admitting RN/LPN

A. The admitting RN/LPN will:

1. Greet the resident
2. Review the **NURSING PRE-ADMISSION ASSESSMENT**
3. Review the RNM comments
4. Review the **ADMISSION CARE PLAN**

B. Update with additional information:
1. Communication
2. Behavioral concerns initially noted
3. ADL's
4. Nutrition/Hydration
5. Elimination
6. Mobility

7. Safety Plan
8. Pain Management plan
9. Sleep pattern concerns
10. Acute diagnosis concerns
11. Pressure Ulcer Prevention Plan
12. Complete the **ADMISSION ASSESSMENT** including
13. Skin inspection
14. Height / weight
15. Last bowel movement
16. Neurological baseline
17. Vital signs every 4 hours times 24 hours (record in Momentus).
18. Pain rating with vital signs
19. Lying and standing blood pressure baseline
20. Noting special personal devices: dentures, hearing aids, pacemaker check boxes, glasses, etc.
21. ***Write an incidental status entry in the Nurses' Notes every 4 hours times 24 hours in Momentus.***

C. Interdisciplinary Team Assessments:

1. Range of motion
2. Cognition assessment
3. Dietary
4. Therapeutic recreation
5. Social Service
6. Spirituality
7. Rehabilitation as indicated
8. Others as indicated by resident need

Minnesota Veterans Home
Minneapolis
Guide for Completing "Clinical Rounds / Care Conference Form"

This form is meant not only as a way to more fully capture the interdisciplinary discussion of residents at clinical rounds who are scheduled for upcoming care conferences, but as a guide and documentation tool for the care conference itself. In the future, some version of this form (and attached informational letter) could also be used as a routine communication tool for families.

What follows is a step-by-step guide for the interdisciplinary (ID) team members attending Clinical Rounds (page 1) and those attending the Care Conferences (side 2) for completing the form.

1. Each Clinical Rounds group is to designate a **recorder.** The recorder is to complete the **"Clinical Rounds / Care Conference Form"** and also document indicated aspects of the clinical discussion in the individual resident's medical record.
   A. Here are options for selecting a recorder:
      1. Each ID member selects one of the residents on the schedule
      2. A fixed rotation of one designated recorder
      3. Selecting a volunteer
      4. * Note: For the sake of experience it is more beneficial to rotate this role, i.e. not having the same person be designated as the recorder each week.
2. The residents reviewed at Clinical Rounds are scheduled for the next week's care conferences. This will include residents up for **annual, quarterly, admission** and **significant change** review. Non-scheduled residents with concerns, multiple falls, or other acute health or safety issues are also to be brought up at this time (discussion of non-scheduled residents should be documented in a progress note versus the Clinical Rounds form).

3. The date of the Clinical Rounds discussion and review type should be recorded at the top of the page 1.

4. The Long-Term Goal should be written in the space provided. The resident's current long-term goal can be found on the cover sheet at the beginning of the care plans. If the team finds the goal has been met or is outdated, a recommendation can be made to review/rewrite the goal at the care conference.

5. Designate with a "✓" the current Discharge Plan (located on the care plan cover sheet). If changes to the plan are to be made, check the appropriate option. Follow-up documentation will be recorded at the care conference.

6. Medical Condition can be answered with the GNP's and unit nurse's input.

7. Indicate the Resuscitation Code Status. The current order can be found on the Physician's Order form in the Physician Order portion of the chart.

8. Information regarding Restraints and non-restraining (NR) devices can also be found on the Physician's Order form. The GNP, partnering nurse, RNM, or OT staff can help provide accurate information.

9. Any ID member can help provide input regarding Mood / Behavior / Cognition, and if referrals should be made to MHS, VA psychiatry, or Chaplaincy. A nurse or GNP can help indicate if psychotropics are used and if an accompanying diagnosis is listed.

10. Spiritual Care information and needs should be indicated, or if there are "no concerns at this time". Referrals to Chaplaincy may be indicated here.

11. Data regarding Therapeutic Recreation should be indicated by the TR staff.

12. Skin status can be indicated with input from the partnering nurse, RNM, or GNP.

13. The dietician will have information regarding Nutrition, including current weight.

14. Data regarding Falls can be found on the Falls Flow Sheet (in the Flow Sheet portion of the chart).

15. Representatives from PT and OT can help the recorder complete the Rehab Status section of the form. Resident communication or swallowing issues/concerns indicating a need for Speech Therapy services can be documented here (referrals need an MD order).

16. Clinical Rounds Attendee's Signatures to be recorded. ** Prior to the care conference, each discipline should review their resident goals, document this review by highlighting the last review date (next to the goal on the care plan), write in the next date of review, initial next to this date, and indicate the discipline responsible.**

17. Upon completion of page 1, the form should be filed in the Care Plan portion of the chart, after the resident's care plan and before the MDSs.

18. Those staff attending the Care Conference can review the Clinical Rounds documentation on page 1 with the resident and family at the care conference. On page two, designate with a "✓" if the information on page 1 remains current and correct. If changes have occurred, "✓" the appropriate space and provide an explanation in the Comments section. Resident goal review and care plan updates may be documented here as well as resident and family comments.

19. After the care conference, Page 2 should be signed by those attending including the resident and family and dated. Both pages should have the resident's name, room #, and medical records # documented at the spaces provided at the bottom.

MN Veterans Home – Minneapolis
MDS Significant Change Determination

Reason for Significant Change Discussion: A Decline / Improvement is noted that: (Check all that apply)

☐ Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, is not self-limiting.	☐ Impacts more than one area of the resident's health status; and Requires interdisciplinary review and/or revision of the care plan.

Improvement in two of more of the following	**Decline in two or more of the following or Primary Discipline Requests a Significant Change in Status Assessment be done**	
☐ Any improvement in an ADL physical functioning area where a resident is newly coded as 0,1, or 2 when previously scored as 3,4, or 8 G1A	☐ Resident's decision-making change from 0 or 1 to 2 or 3 for item B4	☐ Unplanned weight loss problem (5% in 30 days or 10% in 180 days) K3a
☐ Decrease in the number of areas where Behavioral Symptoms or Sand or Anxious Mood are coded as "not easily altered" E2 and E4B	☐ Emergence of sad or anxious mood pattern as a problem that is not easily altered (Item E2)	☐ New pressure ulcer at Stage II or higher, when no pressure ulcers were previously present at Stage II or higher M2a
☐ Resident's decision-making changes from 2 or 3 to 0 or 1: B4	☐ Increase in the number of areas where Behavioral Symptoms are coded as "not easily altered"	☐ Resident begins to use trunk restraint or a chair that prevents rising when it was not used before P4c and e
☐ Resident's incontinence pattern changes from 2,3, or 4 to 0 or 1 H1a or b	☐ Any decline in an ADL physical functioning area where a resident is newly coded as 3,4, or 8 for G1A	☐ Overall deterioration of resident's condition; resident receives more support Q2=2
☐ Overall improvement of resident's condition; resident receives fewer supports Q2=1	☐ Resident's incontinence pattern changes from 0or 1 to 2,3,or 4 (H1a or b) or there was placement of an indwelling catheter (Item H3d);	

☐ Does not meet significant change criteria: (must include rationale)

_____
_____
_____
_____

☐ Does meet significant change criteria:

_____
_____
_____
_____

Assessment Reference Date:	Date MDS Due:
I Notified on:	Date Care Conference Scheduled:

Date / Interdisciplinary Team Signatures:

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

Resident: _____ Med. Rec. #_____ / Room # _____

"Serving Those Who Have Served"

MN Veterans Homes – Minneapolis
Quality of Care Standards – Nursing Care Units

Nursing care and services are performed to:

- maximize the residents' current abilities
- preserve and/or restore functional status
- support residents' freedom of choice
- provide for resident privacy and ensure a safe environment.
- follow the residents' plan of care
- provide for and maintain resident dignity and right to confidentiality
- perform tasks within the scope of the employee's training and ability
- administer care which promotes dignity and respect.
- communicate significant resident information to appropriate care team members
- comply with MVH policies/procedures
- comply with MDH and VA regulations

Promote a resident-centered environment:

- primary focus is physical, mental and emotional well-being of each resident
- supports an environment of trust dignity and caring.
- maximize the comfort level of the residents through pain management. Pain assessment is the 5th vital sign.

Comprehensive Resident Assessment and Care Planning:

- all residents receive a comprehensive assessment through the RAI/MDS process.
- RAPS are completed
- items of concern are communicated on the resident focused care plan
- goal attainment is measured during the quarterly process and when a significant change in status is identified
- all nursing staff are aware of the contents of individual residents in their care.

Personal Cares :

- Bathing:
  1. Each resident receives a bathe or shower a minimum of one time per week and as needed and as desired.
  2. Provide for resident privacy throughout the procedure including to and from the tub room
  3. The safety belt is applied to and worn by all residents in the tub throughout the bath.
  4. Observe and report skin conditions to licensed staff

  Note: NCU residents are not to be unsupervised in tub/shower rooms.

- Dressing:
  1. Clothing is changed daily and as needed
  2. Residents are dressed appropriately for weather, activity level, social acceptability and to maintain privacy / dignity.
  3. Clothing protectors are applied as needed while dining and are removed before the resident leaves the dining area.
  4. Footwear is appropriate to the resident mobility status.
  5. Privacy and dignity are maintained throughout the process of dressing.
  6. Clothing items are labeled with the resident's name.

- Grooming

  Monitor, encourage participation, assist and/or perform resident grooming which includes:

  1. Shaving: daily and as needed
  2. Deodorant: daily
  3. Nail Care: weekly and as needed (clean and trim)
  4. Hair care: Combed daily, washed weekly and as needed
  5. Oral Care: Twice a day and as needed

"Serving Those Who Have Served"

Nutrition and Dining:

- Nursing staff will assist resident's in completing hand hygiene prior to each meal and follow infection control policies through out the meal
- Trays are picked up and served promptly within 5-10 minutes of arrival.
- Trays are served to all residents at each dining room table before assisting individuals.
- Staff is present throughout the meal. Licensed staff is available on the unit.
- Resident focused atmosphere and conversation are maintained throughout the dining experience
- Residents receive the required (including care planned items) assistance through out the meal.
- Staff are seated while assisting residents with their meal
- Nutritional supplements are provided in the type, amount and time indicated
- Documentation of nutritional supplement consumption is completed promptly
- Fluids are offered to the residents frequently throughout the day.
- Intake report and/or record is monitored/documented as indicated.
- Fresh water {at the proper consistency} will be supplied every shift.

Positioning:

- Residents are positioned in a manner to promote comfort and allow for maximum freedom of movement.
- Turning and repositioning is done every 2 hours or as care planned through individual assessments.
- Positioners, enablers, and restrictive devices all are <u>least</u> restrictive, have a physician / NP order including medical symptom, and a plan for re-evaluation of tolerance and effectiveness.

Resident mobility:

It is the goal of the nursing department to assist the resident to maintain their highest level of functioning. All residents will be assessed and care planned for their individualized mobility plan containing:

- Transfer technique
- Plan for ambulating as assessed
- AROM / PROM as assessed
- Bed mobility

Resident / Staff Safety:

- Suspected abuse or neglect is reported immediately to the nursing supervisor, nurse manager, director of nursing or social worker
- Mechanical lifts will be used as assessed specific to type. This will be noted on the care plan
- The use of transfer belts is <u>required</u> on all physically assisted transfers.
- Nursing and housekeeping staff promptly resolves spills and wet spots on the floor.
- Equipment that is in disrepair, inoperable or unsafe is reported to the maintenance department and removed from the patient care area.

Customer Service:

- Call lights will be answered within 3-5 minutes and tub room/bathroom call lights are responded to immediately.
- Each resident will be addressed by the name they prefer and in a respectful way.
- All nursing staff are responsible for answering call lights in a timely and courteous manner.
- The call light cord is accessible for the resident's use.

Infection Control policies and guidelines will be followed and include:

- Hand hygiene
- Use of Personal Protective Equipment
- Providing nursing services in a way that minimizes the transfer of pathogens.

"Serving Those Who Have Served"

Resident and staff safety:

- Residents are monitored a minimum of every two hours and more frequently as indicated.
- Resident environment is maintained free of hazards and obstacles
- Egress paths are consistently clear of obstacles.
- Rooms and beds are labeled with resident names.
- Wrist bands are legible and on all residents.

Resident Dignity and Privacy

- Knock before entering rooms
- Always ensure privacy for conversation and cares
- Use respectful tones
- Resident medical records are not left unattended in the public view
- MAR's are closed or covered when away from the cart
- Queries into resident status by others are referred to the nurse

Minnesota Veterans Home-Minneapolis
Resident Care Audit

Date / Shift of Audit: _____ / _____ Unit: _____
Auditor: _____
Instructions: Record resident's name, complete the audit with yes or no answers. If the answer is no, contact RNM before leaving the unit. Return completed audit form to RNM..

Standard / Resident	Name	Name	Name	Name	Name	Name	Name	Name
Resident appears well groomed.								
*Oral hygiene has been done								
Fingernail are clean and trimmed								
Facial hair is absent (except for beards/mustaches)								
Hair is neatly combed								
*Repositioning {every 2 hours} of residents have occurred and documented on HST assignment list.								
*The incontinent resident is dry and odor free								
*Treatment plan has been followed regarding incontinent residents. Check and changed q 2 hours.								
*Resident has been offered fluids within the past 2 hours. Note: res that require thickened liquids								
Hearing Aids are in and on								
Glasses are clean and worn								
*Splints / therapeutic appliances are on as ordered								
Residents clothes are clean and worn in a dignified manner								
Proper foot attire is being worn.								
Ward Order								
Bed has been made. Room is neat, no personal belongings on floor.								
Fresh Water and **cup** is at bedside. (n/a on 6-3) **NOTE: Exception those that require thickened liquids**								
*Gloves are readily available and worn according to MVH policy								
*No Incontinent pads on the floor								
*No linen on the floor								
*No food containers or incontinent pads in the waste basket in the room								
When assisting with meals staff is sitting with resident. {Not standing}								

Use back of form to document actions taken.

- NOCs

MN Veterans Homes Minneapolis
Internal Monitor
August / September 2005

Thank you for agreeing to be the shift monitor.

The purpose of the monitor is to validate that care standards are being met and if the care standards are not being met, what was the obstacle to having the care standards met.

Here is the procedure I would like you to follow:

1. Introduce yourself to the units and let them know your purpose.
2. Select 2 or more residents per NCU unit that are dependent on staff for cares such as toileting, repositioning, restraint release, oral cares, hydration, etc.
3. Don't share who the residents are initially.
4. You may note the time and positioning of a resident, or if the resident does not object, mark the incontinent pad with a time.
5. Come back after two hours have passed and see if the cares have been provided.
6. If the cares have not been provided, gather the nurse and the HST assigned to the resident. Ask them:
   A. What were the obstacles or barriers that kept you from providing the required care - ask them to be as specific as possible?
   B. What would help remove those barriers?
   C. Let them know that we are "friendly fire" looking for solutions from versus criticism of staff.
7. Also, select random room ensuring the water pitcher liner date is today's date, denture cups are dated within the month, oxygen tubing is no older than 1 week, toiletries are not in shared bathrooms.
8. Do a spot check of oral care being performed.
9. Also, monitor glove use.
10. Check that med / tx carts are locked and confidential information is not left open.
11. Check that in between med passes the juices / applesauces are dated, covered, and placed in the refrigerator.
12. Ensure charts are not left unattended on the floor.

It's a big job, but it is necessary now as we rebuild the structure of the nursing department and restore quality care as we "Serve Those Who Have Served".

Please leave your findings in the nursing supervisor office with at note, "for Diane Vaughn".

Thank you!

Minnesota Veterans Home-Minneapolis
Resident Care Audit

Date / Shift of Audit: _____ / _____ Unit: _____
Auditor: _____
Instructions: Record resident's name, complete the audit with yes or no answers. If the answer is no, contact RNM before leaving the unit. Return completed audit form to RNM..

Standard / Resident	Name	Name	Name	Name	Name	Name	Name	Name
Resident appears well groomed.								
*Oral hygiene has been done								
Fingernail are clean and trimmed								
Facial hair is absent (except for beards/mustaches)								
Hair is neatly combed								
*Repositioning {every 2 hours} of residents have occurred and documented on HST assignment list.								
*The incontinent resident is dry and odor free								
*Treatment plan has been followed regarding incontinent residents. Check and changed q 2 hours.								
*Resident has been offered fluids within the past 2 hours. Note: res that require thickened liquids								
Hearing Aids are in and on								
Glasses are clean and worn								
*Splints / therapeutic appliances are on as ordered								
Residents clothes are clean and worn in a dignified manner								
Proper foot attire is being worn.								
Ward Order								
Bed has been made. Room is neat, no personal belongings on floor.								
Fresh Water and **cup** is at bedside. (n/a on 6-3) **NOTE: Exception those that require thickened liquids**								
*Gloves are readily available and worn according to MVH policy								
*No Incontinent pads on the floor								
*No linen on the floor								
No food containers or incontinent pads in the waste basket in the room								
When assisting with meals staff is sitting with resident. {Not standing}								

Use back of form to document actions taken.

- NOCs

Minnesota Veteran me - Mpls
Resident Care W ksheet

Date: ____________________ Unit/Team _____/_____

Resident	Oral Care		Circle Hour Resident Repositioned / Toileted																									Comments
Repositioned (R) / Toileted (T)	AM	PM																										
			R	23	24	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	
			T	23	24	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	
			R	23	24	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	
			T	23	24	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	
			R	23	24	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	
			T	23	24	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	
			R	23	24	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	
			T	23	24	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	
			R	23	24	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	
			T	23	24	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	
			R	23	24	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	
			T	23	24	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	
			R	23	24	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	
			T	23	24	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	
			R	23	24	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	
			T	23	24	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	
			R	23	24	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	
			T	23	24	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	
			R	23	24	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	
			T	23	24	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	

1. Circle the time you complete positioning and toileting on each resident
2. Initial when oral cares are completed
3. Return this document to the staff nurse at the end of your shift

Night shift: HST: ____________________ Nurse Review: ____________________
Day shift: HST: ____________________ Nurse Review: ____________________
Evening Shift: HST: ____________________ Nurse Review: ____________________
RNM: ____________________

Thank you for "Serving Those Who Have Served."

Minnesota Veterans Home- Minneapolis -DRAFT#1

GUIDELINES FOR GLOVE USE

Health care workers wear gloves to:

- Reduce the risk of acquiring infections
- Prevent health care worker flora from being transmitted to residents
- Reduce the transmission of flora from resident to resident via the health care worker.
- Prevent the transmission of hepatitis B, hepatitis C and HIV.

Did you know?

Gloves do not provide complete protection against hand contamination.
Wearing gloves does not provide complete protection against acquisition of infections caused by hepatitis B virus and herpes simplex.
Failure to change gloves between residents may contribute to the transmission of organisms.
Weather the wearing of rings results in greater transmission of pathogens remains unknown, further research is indicated.

Gloves are worn when:

- Personal care is provided to residents.
- There is a possibility of having contact with blood or body fluids.
- Contact with mucous membranes or non-intact skin.
- Personal protection is indicated.

Change gloves during resident care if moving from a contaminated body site to a clean body site.
Hands must be washed immediately after gloves are removed.

Source: Guideline for Hand Hygiene in Health-Care Settings: MMWR. October 25, 2003/51{RR16}:1-44

"Serving Those Who Have Served"

MN Veterans Homes – Minneapolis
Quality of Care Standards – Nursing Care Units

Nursing care and services are performed to:

- maximize the residents' current abilities
- preserve and/or restore functional status
- support residents' freedom of choice
- provide for resident privacy and ensure a safe environment.
- follow the residents' plan of care
- provide for and maintain resident dignity and right to confidentiality
- perform tasks within the scope of the employee's training and ability
- administer care which promotes dignity and respect.
- communicate significant resident information to appropriate care team members
- comply with MVH policies/procedures
- comply with MDH and VA regulations

Promote a resident-centered environment:

- primary focus is physical, mental and emotional well-being of each resident
- supports an environment of trust dignity and caring.
- maximize the comfort level of the residents through pain management. Pain assessment is the 5th vital sign.

Comprehensive Resident Assessment and Care Planning:

- all residents receive a comprehensive assessment through the RAI/MDS process.
- RAPS are completed
- items of concern are communicated on the resident focused care plan
- goal attainment is measured during the quarterly process and when a significant change in status is identified
- all nursing staff are aware of the contents of individual residents in their care.

Personal Cares :

- Bathing:
  1. Each resident receives a bathe or shower a minimum of one time per week and as needed and as desired.
  2. Provide for resident privacy throughout the procedure including to and from the tub room
  3. The safety belt is applied to and worn by all residents in the tub throughout the bath.
  4. Observe and report skin conditions to licensed staff

  Note: NCU residents are not to be unsupervised in tub/shower rooms.

- Dressing:
  1. Clothing is changed daily and as needed
  2. Residents are dressed appropriately for weather, activity level, social acceptability and to maintain privacy / dignity.
  3. Clothing protectors are applied as needed while dining and are removed before the resident leaves the dining area.
  4. Footwear is appropriate to the resident mobility status.
  5. Privacy and dignity are maintained throughout the process of dressing.
  6. Clothing items are labeled with the resident's name.

- Grooming

  Monitor, encourage participation, assist and/or perform resident grooming which includes:

  1. Shaving: daily and as needed
  2. Deodorant: daily
  3. Nail Care: weekly and as needed (clean and trim)
  4. Hair care: Combed daily, washed weekly and as needed
  5. Oral Care: Twice a day and as needed

"Serving Those Who Have Served"

Nutrition and Dining:

- Nursing staff will assist resident's in completing hand hygiene prior to each meal and follow infection control policies through out the meal
- Trays are picked up and served promptly within 5-10 minutes of arrival.
- Trays are served to all residents at each dining room table before assisting individuals.
- Staff is present throughout the meal. Licensed staff is available on the unit.
- Resident focused atmosphere and conversation are maintained throughout the dining experience
- Residents receive the required (including care planned items) assistance through out the meal.
- Staff are seated while assisting residents with their meal
- Nutritional supplements are provided in the type, amount and time indicated
- Documentation of nutritional supplement consumption is completed promptly
- Fluids are offered to the residents frequently throughout the day.
- Intake report and/or record is monitored/documented as indicated.
- Fresh water {at the proper consistency} will be supplied every shift.

Positioning:

- Residents are positioned in a manner to promote comfort and allow for maximum freedom of movement.
- Turning and repositioning is done every 2 hours or as care planned through individual assessments.
- Positioners, enablers, and restrictive devices all are <u>least</u> restrictive, have a physician / NP order including medical symptom, and a plan for re-evaluation of tolerance and effectiveness.

Resident mobility:

It is the goal of the nursing department to assist the resident to maintain their highest level of functioning. All residents will be assessed and care planned for their individualized mobility plan containing:

- Transfer technique
- Plan for ambulating as assessed
- AROM / PROM as assessed
- Bed mobility

Resident / Staff Safety:

- Suspected abuse or neglect is reported immediately to the nursing supervisor, nurse manager, director of nursing or social worker
- Mechanical lifts will be used as assessed specific to type. This will be noted on the care plan
- The use of transfer belts is <u>required</u> on all physically assisted transfers.
- Nursing and housekeeping staff promptly resolves spills and wet spots on the floor.
- Equipment that is in disrepair, inoperable or unsafe is reported to the maintenance department and removed from the patient care area.

Customer Service:

- Call lights will be answered within 3-5 minutes and tub room/bathroom call lights are responded to immediately.
- Each resident will be addressed by the name they prefer and in a respectful way.
- All nursing staff are responsible for answering call lights in a timely and courteous manner.
- The call light cord is accessible for the resident's use.

Infection Control policies and guidelines will be followed and include:

- Hand hygiene
- Use of Personal Protective Equipment
- Providing nursing services in a way that minimizes the transfer of pathogens.

"Serving Those Who Have Served"

Resident and staff safety:

- Residents are monitored a minimum of every two hours and more frequently as indicated.
- Resident environment is maintained free of hazards and obstacles
- Egress paths are consistently clear of obstacles.
- Rooms and beds are labeled with resident names.
- Wrist bands are legible and on all residents.

Resident Dignity and Privacy

- Knock before entering rooms
- Always ensure privacy for conversation and cares
- Use respectful tones
- Resident medical records are not left unattended in the public view
- MAR's are closed or covered when away from the cart
- Queries into resident status by others are referred to the nurse

State of Minnesota Veterans Home – Minneapolis
NURSING POLICY AND PROCEDURES

Title: Thickened Liquids

Number: N02-151
23-26
19-043
10-057

DRAFT #2
09/02/05

Approvals: Director of Nursing
Director of Dietary
Medical Director

Date: 09/05

Page: 1 of 1

Objective: To ensure that residents at risk for aspiration receive the right consistency of liquids while attending on and off unit events.

Policy:

Procedure:

A. Following a comprehensive assessment, if a resident is found to be at risk for aspiration requiring thickened liquids, the following will occur:
   1. The speech therapist, dietitian, or nurse practitioner writing the order for non-thin liquids will notify the HIC:
      a. In person or
      b. Via the HIC Communication Board
   2. The HIC will place a blue colored insert into the identification band of the individual resident.
   3. All departments will be aware that residents with blue name band inserts may not have thin liquids being offered.
   4. Departments hosting the resident event are responsible for ensuring a current list of resident diets/consistencies are readily available and an alternative beverage at the right consistency is available.

B. At special events, staff will note name band. If blue insert, will verify fluid consistency on current listing before serving the beverage.

C. During medication passes, the resident is to receive the ordered consistency of fluid. For current products available:
   1. Water is available in all consistencies
   2. Nectar level fluids for medication passes or between meals include:
      a. health shakes
      b. pudding,
      c. applesauce,
      d. ice cream,
      e. magic cups
   3. Honey level fluids for medication passes or between meals include:
      a. pudding,
      b. applesauce,
      c. magic cups

Minnesota Veterans Home- Minneapolis [redacted]
GUIDELINES FOR GLOVE USE

Health care workers wear gloves to:

- Reduce the risk of acquiring infections
- Prevent health care worker flora from being transmitted to residents
- Reduce the transmission of flora from resident to resident via the health care worker.
- Prevent the transmission of hepatitis B, hepatitis C and HIV.

Did you know?

Gloves do not provide complete protection against hand contamination.
Wearing gloves does not provide complete protection against acquisition of infections caused by hepatitis B virus and herpes simplex.
Failure to change gloves between residents may contribute to the transmission of organisms.
Weather the wearing of rings results in greater transmission of pathogens remains unknown, further research is indicated.

Gloves are worn when:

- Personal care is provided to residents.
- There is a possibility of having contact with blood or body fluids.
- Contact with mucous membranes or non-intact skin.
- Personal protection is indicated.

Change gloves during resident care if moving from a contaminated body site to a clean body site.
Hands must be washed immediately after gloves are removed.

Source: Guideline for Hand Hygiene in Health-Care Settings: MMWR. October 25; 2003/51{RR16}:1-44

Cart Number	Locked	Unlocked	Nurse Present	Meds out on Cart	MAR Confidential
Med Cart 1					
Med Cart 2					
Med Cart 3					
Tx 1					
Tx 2					
Tx 3					
Comments:					

Unit ID:

Tech/RPh ID:

Date:

Time:

State of Minnesota Veterans Home – Minneapolis
NURSING POLICY AND PROCEDURES

Title: Urinary Incontinence Management #1 DRAFT 9-2-05 Number: N02-150

Approvals: DON/Medical Director Date: 09/05

Objective: To identify the type of urinary incontinence as resident has, so appropriate interventions may be initiated.

Policy:

Procedure:

A. Upon admission and PRN, resident that are incontinent of urine will be assessed as follows:
   1. A 3 day voiding assessment will be completed by the nursing unit during the initial MDS assessment period.
   2. The nurse practitioner/physician will order a bladder scan to determine the post void residual (PVR).
   3. The results of the MMSE, BRADEN Scale, Functional Abilities, PVR, and 3 day voiding assessment will be reviewed by the nurse practitioner or physician. (See Momentus form).
   4. The nurse practitioner or physician will determine the type/types of urinary incontinence the resident has.
   5. Based on the type of UI identified, appropriate interventions will be ordered and care planned. (See house protocol in policy appendix).
   6. Upon new incidence of UI, this process may be initiated at anytime. (i.e., significant change in status).

Appendix (draft-needs further review)
Toileting Programs

Bladder Retraining

A. Individualized Bladder Retraining

This is for a resident who is able to learn and retain new information and has the physical ability and desire to retrain the bladder to treat incontinence. Each program will be individually set up based on the resident's needs and etiology of incontinence.

B. Prompted Voiding

1. From an individualized schedule determined by the resident's 3 day voiding assessment or
2. From the facility schedule:
   a. Upon rising from bed.
   b. Before laying down in bed.
   c. Before leaving the floor for meals.
   d. Upon return to the floor from meals.

*"Upon" is defined as within 30-60 minutes.

Scheduled Toileting

Residents who are unable to identify or communicate to staff regarding toileting needs. They will be toileted with hands on assistance from staff:

A. Based on an individualized schedule determined by the resident's 3 day voiding assessment or
B. From the facility schedule:
    1. Upon rising from bed.
    2. Before laying down in bed.
    3. Before leaving the floor for meals.
    4. Upon return to the floor from meals.

*"Upon" is defined as within 30-60 minutes.

Check and Change

Residents who are either physically unable to be toileted comfortably or who are extremely agitated by the toileting process. These residents will be checked for wetness, changed and cleaned if wet on the following schedule:

A. Based on an individualized schedule determined by the resident's 3 day voiding assessment or
B. From the facility schedule:
    a. Upon rising from bed.
    b. Before laying down in bed.
    c. Before leaving the floor for meals.
    d. Upon return to the floor from meals.

*"Upon" is defined as within 30-60 minutes.

Some residents may be on scheduled toileting during the day and on check and change at night, based on individual resident assessment.

MN Veterans Home – Minneapolis
Urinary Incontinence Assessment

Goal: To define the type of urinary incontinence a resident has and individualized interventions.

Relevant Data:

Assessment Type / Date	Outcome	Comment
MSE		
BRADEN		
Functional Status review or Case Mix Score		
Post Void Residual		
3 – Day Voiding Assessment		

Type(s) of Incontinence and Interventions

Check Type(s)	AHRQ Incontinence Types	Select Interventions
	Transient Acute	❑ Further medical evaluation – see physician order section ❑ Individualized bladder retraining to be evaluated / treated by occupational therapy ❑
	Chronic Urge	❑ The resident may be toileted at intervals consistent with their assessed voiding pattern utilizing the facility toileting protocols ❑ ❑ ❑
	Chronic Stress	❑ The resident may be toileted at intervals consistent with their assessed voiding pattern utilizing the facility toileting protocols ❑ Toileting intervals may be up to three hours ❑ ❑
	Chronic Overflow	❑ The resident may be toileted at intervals consistent with their assessed voiding pattern utilizing the facility toileting protocols ❑ Toileting intervals may be up to three hours ❑ ❑
	Chronic Functional	❑ Prompted voiding ❑ Scheduled toileting ❑ Check and Change Program ❑ Toileting intervals may be up to three hours ❑
	Intractable	❑ Prompted voiding ❑ Scheduled toileting ❑ Check and Change Program ❑ Toileting intervals may be up to three hours ❑

Date: _____ MD/NP Signature: _____

Resident: _____ Medical Record #_____ Unit: _____

MN Veterans Home – Minneapolis
3 Day Voiding Assessment

Check resident every hour and mark the appropriate column(s)

Day 1 Date: _____ Time	Dry	Wet	BM	Self Toilet	Staff Assisted	Type of Assist
7 AM						
8 AM						
9 AM						
10 AM						
11 AM						
12 Noon						
1 PM						
2 PM						
3 PM						
4 PM						
5 PM						
6 PM						
7 PM						
8 PM						
9 PM						
10 PM						
11 PM						
12 Midnight						
1 AM						
2 AM						
3 AM						
4 AM						
5 AM						
6 AM						

Resident: _____ Medical Record # _____ Room# _____

MN Veterans Home – Minneapolis
3 Day Voiding Assessment

Check resident every hour and mark the appropriate column(s)

Day 2 Date: _____ Time	Dry	Wet	Self Toilet	Staff Assisted	Type of Assist
7 AM					
8 AM					
9 AM					
10 AM					
11 AM					
12 Noon					
1 PM					
2 PM					
3 PM					
4 PM					
5 PM					
6 PM					
7 PM					
8 PM					
9 PM					
10 PM					
11 PM					
12 Midnight					
1 AM					
2 AM					
3 AM					
4 AM					
5 AM					
6 AM					

Resident: _____ Medical Record # _____ Room# _____

MN Veterans Home – Minneapolis
3 Day Voiding Assessment

Check resident every hour and mark the appropriate column(s)

Day 3 Date: _____ Time	Dry	Wet	Self Toilet	Staff Assisted	Type of Assist
7 AM					
8 AM					
9 AM					
10 AM					
11 AM					
12 Noon					
1 PM					
2 PM					
3 PM					
4 PM					
5 PM					
6 PM					
7 PM					
8 PM					
9 PM					
10 PM					
11 PM					
12 Midnight					
1 AM					
2 AM					
3 AM					
4 AM					
5 AM					
6 AM					

Resident: _____ Medical Record # _____ Room# _____