File

MINNESOTA
MDH
DEPARTMENT of HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

September 29, 2013

Mr. Jon Skillingstad, Administrator
Minnesota Veterans Home Fergus Falls
1821 North Park
Fergus Falls, Minnesota 56537

Re: Enclosed Reinspection Results - Project Number SL00531020

Dear Mr. Skillingstad:

On August 6, 2013 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 15, 2013, with orders received by you on June 7, 2013. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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

Please feel free to call me with any questions.

Sincerely,

Shellae Dietrich

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

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00531	A. Building B. Wing	8/6/2013

Name of Facility	Street Address, City, State, Zip Code
MN VETERANS HOME FERGUS FALLS	1821 NORTH PARK FERGUS FALLS, MN 56537

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix 20565 Reg. # MN Rule 4658.0405 Subp. 3 LSC	Correction Completed 08/06/2013	ID Prefix 20905 Reg. # MN Rule 4658.0525 Subp. 4 LSC	Correction Completed 08/06/2013	ID Prefix 21375 Reg. # MN Rule 4658.0800 Subp. 1 LSC	Correction Completed 08/06/2013
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GA/sd	09/29/13	31222	08/06/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 5/15/2013

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 2982

June 4, 2013

Mr. Jon Skillingstad, Administrator
Minnesota Veterans Home Fergus Falls
1821 North Park
Fergus Falls, Minnesota 56537

Re: Enclosed State Supervised Living Facility Licensing Orders - Project Number SL00531020

Dear Mr. Skillingstad:

The above facility was surveyed on May 13, 2013 through May 15, 2013 for the purpose of assessing compliance with Minnesota Department of Health Supervised Living Facility Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144.56. 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.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Supervised Living Facilities.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings is the Time Period For Correction.

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

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

When all orders are corrected, the first page of the order form should be signed and returned to this office at Minnesota Department of Health, P.O. Box 64900, St. Paul, Minnesota 55164-0900. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact at . A written plan for correction of licensing orders is not required.

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

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

Feel free to contact me with any questions related to this letter.

Sincerely,

Colleen Leach

Colleen Leach, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
PO Box 64900
Saint Paul, Minnesota 55164-0900

Telephone: (651)201-4117 Fax: (651)215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00531	A. BUILDING: _____ B. WING _____	05/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME FERGUS FALLS	1821 NORTH PARK FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments	2 000		

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

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

INITIAL COMMENTS:
On May 13 to May 15, 2013, surveyors of this Department's staff, visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00531	A. BUILDING: _____ B. WING _____	05/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME FERGUS FALLS	1821 NORTH PARK FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 Certification Program; 1505 Pebble lake Road, Suite 300, Fergus Falls, MN	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the plan of care (POC) for 2 of 5 residents (R2, R1) in the sample who required assistance with repositioning. Findings include: R2 and R1 did not receive assistance with repositioning according to the POC. R2's diagnoses included multiple sclerosis (MS), quadriplegia, neurogenic bladder, indwelling Foley catheter, and peripheral vascular disease. R2's current POC, dated 5/19/13, included, "physical immobility due to advanced MS" and directed staff to reposition every 2 hours in chair and bed. R2 was continuously observed on 5/13/13, from 5:30 p.m. to 7:45 a.m. sitting in her wheel chair without being turned and repositioned. At 5:30 p.m., R2 was sitting in a reclining wheel chair in the dining room being assisted with her meal until 6:00 p.m. when she was taken to her room. R2	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00531	A. BUILDING: _____ B. WING _____	05/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME FERGUS FALLS	1821 NORTH PARK FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 2 remained in her room, seated in her wheel chair without being repositioned, until 7:45 p.m. when she was transferred via a mechanical lift onto her bed. R2 was turned to her left side and was observed to be incontinent of bowel. R2's buttock appeared to be bright red and had creases present on the skin. NA-B and NA-C confirmed R2's buttock was very red with creases present on the skin and added R2 had last been repositioned at 2:00 p.m. (5 hours, 45 minutes earlier.) During an interview with the infection control registered nurse (RN) on 5/14/13, at 2:30 p.m. it was verified that R2 was at risk for the development of pressure ulcers, and should have been repositioned every 2 hours as directed by the POC. During an interview with the director of nursing (DON) on 5/15/13, at 9:30 a.m. she stated NA-B, who was a new employee, said R2 had refused to be repositioned at 4:00 p.m. on 5/13/13, but there was no documentation to verify the refusal had occurred or that R2 had been educated about the risk/benefit of not being repositioned. The DON stated NA-B and NA-C did not report R2's refusal to be repositioned until they were questioned about R2's repositioning (by the DON) on 5/15/13. R1's diagnoses included diabetes mellitus, alzheimer's dementia, congestive heart failure, and a history of falls. R1's current POC, dated 5/14/13, included "skin integrity" and directed staff to reposition every 2 hours while sitting and lying.	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00531	A. BUILDING: _____ B. WING _____	05/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME FERGUS FALLS	1821 NORTH PARK FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 3 R1 was continuously observed on 5/13/13, from 5:30 p.m. to 7:35 p.m. sitting in his wheel chair without being turned and repositioned. At 5:30 p.m., R1 was sitting in a wheel chair in the dining room being assisted with his meal until 6:15 p.m. when he was taken to the west lounge. At 7:17 p.m. R1 was taken to his room and NA-D assisted with oral hygiene while R1 was still seated in the wheel chair. At 7:35 p.m. R1 was transferred via a mechanical lift into the bathroom. When R1's brief was removed, it was noted he was incontinent of urine and R1's buttock appeared to be bright red with creases present on the skin. NA-D and NA-E confirmed R1's buttock was very red with creases present, and added R1 had last been repositioned at 4:30 p.m. (3 hours, 5 minutes earlier.) During an interview with the infection control RN on 5/14/13, at 2:30 p.m. it was verified R1 was at risk for the development of pressure ulcers, and should have been repositioned every 2 hours as directed by the POC. A facility policy, titled Skin Integrity: Assessment and Management, dated 5/15/12, included under Procedure: "3. Care plan will reflect present treatment regime."	2 565		
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning 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.	2 905		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00531	A. BUILDING: _____ B. WING _____	05/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME FERGUS FALLS	1821 NORTH PARK FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 905	Continued From page 4	2 905		

This MN Requirement is not met as evidenced by:
Based on observation, interview and document review, the facility failed to provide timely repositioning for 2 of 5 dependent residents (R2 and R1) who were at risk for the development of pressure ulcers.

Findings include:

R2's diagnoses included multiple sclerosis (MS), quadriplegia, neurogenic bladder, indwelling Foley catheter and peripheral vascular disease. The quarterly Minimum Data Set (MDS) dated 5/14/13, indicated R2 was cognitively impaired, required total dependence of 2 staff with bed mobility, hygiene, turning/repositioning, was at risk for pressure ulcer development, was incontinent of bowel, and was on a turning and repositioning program.

R2's Braden scale for predicting pressure ulcers, dated 5/12/13, indicated a total score of 12- a high risk for developing pressure ulcers. R2's risk factors on the Braden scale included sensory perception, chairfast, mobility, friction/shear and pain.

Record review of R2's Progress Notes, dated 3/25/13, stated, "has 2 areas of pressure that have developed the past days, 1 rt (right) buttock, 1 upper rt lat (lateral) back." On 4/25/13, the Progress Notes indicated all open areas on the skin had healed.

R2's current care plan, dated 5/19/13, included, "physical immobility due to advanced MS" and directed staff to reposition every 2 hours in chair

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00531	A. BUILDING: _____ B. WING _____	05/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME FERGUS FALLS	1821 NORTH PARK FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 905	Continued From page 5 and bed. R2 was continuously observed on 5/13/13, from 5:30 p.m. to 7:45 a.m. sitting in her wheel chair without being turned and repositioned for 2 hours and 15 minutes. At 5:30 p.m. R2 was sitting in a reclining wheel chair in the dining room being assisted with her meal until 6:00 p.m. when she was taken to her room. R2 remained in her room, seated in her wheel chair without being repositioned until 7:45 p.m. when she was transferred via a mechanical lift onto her bed. R2 was turned to her left side and was observed to be incontinent of bowel. R2's buttock appeared to be bright red with creases present on the skin. NA-B and NA-C confirmed R2's buttock was very red with creases present on the skin, and added R2 had last been repositioned at 2:00 p.m. (5 hours, 45 minutes earlier.) During an interview with the infection control registered nurse (RN) on 5/14/13, at 2:30 p.m. it was verified R2 was at risk for the development of pressure ulcers, and should have been repositioned every 2 hours as directed by the care plan. During an interview with the director of nursing (DON) on 5/15/13, at 9:30 a.m. she stated NA-B, who was a new employee, said R2 had refused to be repositioned at 4:00 p.m. on 5/13/13, but there was no documentation to verify the refusal had occurred, or that R2 had been educated about the risk/benefit of not being repositioned. The DON said NA-B and NA-C did not report R2's refusal to be repositioned until they were questioned about R2's repositioning (by the DON) on 5/15/13.	2 905		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00531	A. BUILDING: _____ B. WING _____	05/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME FERGUS FALLS	1821 NORTH PARK FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 905	Continued From page 6	2 905		

R1's diagnoses included diabetes mellitus, alzheimer's dementia, congestive heart failure, and a history of falls. The quarterly MDS dated 5/14/13, indicated R1 was cognitively impaired, required total dependence of 1 staff with bed mobility, hygiene, turning/repositioning, was at risk for pressure ulcer development, was incontinent of bladder/bowel, and was on a turning and repositioning program.

R1's Braden scale for predicting pressure ulcers, dated 4/23/13, indicated a total score of 14- a moderate risk for developing pressure ulcers. R1's risk factors on the Braden scale included bowel/bladder incontinence, chairfast, mobility, friction/shear, and psychotropic drug use.

Record review of R1's Progress Notes, dated 5/2/13, indicated a nutritional risk due to weight loss of 25 pounds in the last 180 days, even with nutritional interventions in place.

R1's current care plan, dated 5/14/13, included "skin integrity" and directed staff to reposition every 2 hours while sitting and lying.

R1 was continuously observed on 5/13/13, from 5:30 p.m. to 7:35 p.m. sitting in his wheel chair without being turned and/or repositioned. At 5:30 p.m., R1 was sitting in a wheel chair in the dining room being assisted with his meal until 6:15 p.m. when he was taken to the west lounge. At 7:17 p.m. R1 was taken to his room, and NA-D assisted with oral hygiene while R1 was still seated in the wheel chair. At 7:35 p.m. R1 was transferred via a mechanical lift into the bathroom. When R1's brief was removed, it was noted he was incontinent of urine and R1's buttock appeared to be bright red with creases present on the skin. NA-D and NA-E confirmed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00531	A. BUILDING: _____ B. WING _____	05/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME FERGUS FALLS	1821 NORTH PARK FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 905	Continued From page 7 R1's buttock was very red with creases present and added R1 had last been repositioned at 4:30 p.m. (3 hours, 5 minutes earlier.) During an interview with the infection control RN on 5/14/13, at 2:30 p.m. it was confirmed R1 was at risk for the development of pressure ulcers, and should have been repositioned every 2 hours as directed by the care plan. A facility policy, titled Skin Integrity: Assessment and Management, dated 5/15/12, included under Procedure: "3. Care Plan will reflect present treatment regime." Staff did not follow the policy/procedure.	2 905		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure staff utilized disposable gloves appropriately for 1 of 4 residents (R2) observed during personal cares. Findings include: During an observation on 5/13/13, at 7:45 p.m. nursing assistant (NA)-C was observed to apply gloves and roll R2 onto her left side on her bed. R2 was incontinent of bowel, and NA-C was observed to perform perineal cares with both gloved hands. With the same soiled gloves still	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00531	A. BUILDING: _____ B. WING _____	05/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME FERGUS FALLS	1821 NORTH PARK FERGUS FALLS, MN 56537

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 8 on, NA-C was observed to reach for a jar of Udder cream from the top of the night stand, held the jar in both soiled, gloved hands, unscrewed the cap and immediately applied the cream on R2's red buttock. Following this, NA-C removed her soiled gloves and placed them inside the soiled brief, rolled the brief up, then disposed of the soiled gloves/brief into the garbage. During an interview on 5/14/13, at 2:30 p.m. the registered nurse (RN) infection control coordinator verified the soiled gloves should have been removed after performing R2's personal cares, prior to touching the clean Udder cream jar. Review of the facility's policy titled Gloving procedure, revised 4/23/07, indicated, "Disposable (single use) gloves must be replaced after a dirty procedure and before a clean procedure..." Staff did not follow the above policy.	21375		

SENDER: *COMPLETE THIS SECTION*

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Mr. Jon Skillingstad, Administrator
Minnesota Veterans Home Fergus Fall
1821 North Park
Fergus Falls, Minnesota 56537

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Heidi Nygaard ☐ Agent ☐ Addressee

B. Received by (Printed Name) Heidi Nygaard
C. Date of Delivery 6/7/13

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☒ No

3. Service Type
☒ Certified Mail ☐ Express Mail

Please Return Within 5 Days
MDH L&C 3201

7011 2000 0002 5148 2982

SL00531020 LS

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540