Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 7, 2026

Administrator
Minnesota Veterans Home - Silver Bay
56 Outer Drive
Silver Bay, MN 55614

RE: CCN: 245628
Cycle Start Date: April 16, 2026

Dear Administrator:

On April 16, 2026, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Alex Warren, Regional Operations Supervisor
Duluth District Office
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082
Email: Alex.Warren@state.mn.us
Office: 218-302-6186 Mobile: 651-279-5375

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued, and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by July 16, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by October 16, 2026 (six months after the identification of noncompliance), your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245628	A. BUILDING B. WING	04/16/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments On 4/13/26 to 4/16/24, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		05/13/2026
F0000	INITIAL COMMENTS On 4/13/26 to 4/16/26, a standard recertification survey was conducted at your facility. Complaint investigations were also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed without citation: H#: 56283300C 2706457 H#: 56289520C 2745142 H#: 56284344C 1184176 MN#:00112943 H#: 56286807C 1184181 MN#:00113725 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F0000		05/19/2026

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245628	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2026

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F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to ensure medications weren't left at a resident bedside when the resident was assessed to be unable to self-administer medications. This affected 1 of 1 resident (R41) reviewed for self-administration of medications. Findings include: R41's quarterly Minimum Data Set (MDS) dated 1/27/26 indicated R41 was cognitively intact. Diagnoses included renal insufficiency, anxiety, and depression R41's Provider Order Summary Report undated, lacked orders to keep medications at bedside. R41's care plan undated, lacked information related to self-administration of medications. R41's Self Administration of Medications &/or Treatments (SAM) dated 3/20/26 indicated R41 did not want to self-administer medications. The SAM also indicated R41 was no longer able to self administration. During an observation on 4/13/26 at 3:45 p.m., two white pills what R41 stated were nicotine throat lozenges were on the bedside table. There were no staff in the room at that time. During an observation on 4/14/26 at 11:10 a.m., two nicotine throat lozenges were again observed on the bedside table and there were no staff present in the room. During an interview on 4/14/26 at 11:12 a.m., trained medication assistant (TMA)-A stated she very rarely leaves medications at bedside. I am not sure what all needs to be in place to be able to keep medications at bedside when staff are not present. TMA-A confirmed R41 had medication left at beside and confirmed they were nicotine throat lozenges. During an interview on 4/14/26 at 11:16 a.m., registered nurse (RN)-A state a SAM assessment and order needed to be in place before medications could be left at bedside so the resident could self-administer.During an interview on 4/16/26 at 7:58 a.m., the director of nursing (DON) stated the SAM assessment needed to be in place and indicate the resident wants to self-administer and is able to self-administer before medications could be left at bedside. An expectation was for staff to confirm the appropriate information was confirmed before medications were left at bedside. Facility policy Self Administration of	F0554	F554 Resident Self-Admin Meds-Clinically Appropriate What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practices: Resident R41-A new comprehensive Self Administration of Medication (SAM) assessment completed with resident regarding nicotine throat lozenges. Policy reviewed. Orders were clarified with the provider, and excessive lozenges removed from resident room. All medications are signed in the Medication Administration Record at the time of administration. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents that are approved for SAM have the potential to be affected by the same alleged deficient practice. What measures will be put in place or what systemic changes will be made to ensure that the deficient practices does not recur: Licensed nurses re-educated on: Completing SAM for a residents' self-administration. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place: DON/designee will audit residents on SAM's ordered medications 2 times per week for the first month, then weekly for 2 months to ensure physicians orders are followed and proper documentation in the medical record. DON/designee will present a summary of the audits to the Quality Assurance Performance Improvement (QAPI) committee monthly for three months. Thereafter, if determined by the QAPI, auditing and monitoring will be done quarterly and present quarterly at the QAPI meeting.	05/19/2026

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F0554 SS = D	Continued from page 2 Medications-Skilled Nursing last revised 2/27/25, indicated a comprehensive assessment would be completed to make sure the resident wanted to, and had the capability to self-administer medications and keep medications at bedside.	F0554		05/19/2026
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to report an allegation of staff on resident physical abuse within two hours to the State Agency (SA) for 1 of 4 residents (R54) reviewed for abuse. Findings include: Facility incident report dated 6/7/25, identified on the evening of 6/6/25 at approximately 8:00 p.m., R54 was handled roughly by a staff member, coming in contact with R54's left hand causing injury and pain.	F0609	F609-Reporting Alleged Violations What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. All residents involved in any episodes of suspected abuse will have the incident reported with two hours of the occurrence being identified. All staff have reviewed the abuse policy and its reporting requirements. Abuse reporting will be a topic at Town Halls. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: IDT Team reviewed policy: Vulnerable Adult-Resident Protection Plan. Any allegation involving abuse, reportable injury, neglect, exploitation, or mistreatment will be reported within 2 hours. Staff re-education on reporting requirements completed. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place: Staff will be randomly audited for reporting requirements for three months. All allegations of abuse, neglect, exploitation or mistreatment will be reviewed by the clinical leadership team and reported according to the policy: Vulnerable Adult - Resident Protection Plan. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present	05/19/2026

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F0609 SS = D	Continued from page 3 R54's progress note dated 6/6/25 at 10:39 p.m., identified staff called to room to assist with resident. Resident complained a nurse assistant (NA) in a "not gentle manner" grabbed the left hand and caused pain and injury. During an interview on 4/15/26 at 2:18 p.m., registered nurse (RN)-C stated R54 reported to her on 6/6/25 around 8:00 p.m., an NA had grabbed his left hand roughly and had caused pain and possible new bruising to the left hand. RN-C could not remember if she notified anybody right away about the concern of abuse. During an interview on 4/16/26 at 7:30 a.m., the infection preventionist (IP) stated she was working as the charge nurse on day shift on 6/7/25. The day nurse had made her aware of the complaint around 10:15 a.m., and that is when it was reported to the SA. Facility policy Vulnerable Adult-Resident Protection Plan dated 6/22/23, indicated all allegations of abuse, neglect, exploitation or mistreatment would be reported no later than two hours after the allegation was made.	F0609	Continued from page 3 quarterly at the QAPI meeting.	05/19/2026
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to follow provider orders and administer medications as ordered for 1 of 2 residents (R41) reviewed for quality of care. Findings include: R41's quarterly Minimum Data Set (MDS) dated 1/27/26, identified R41 was cognitively intact. Diagnoses included renal insufficiency, anxiety, and depression	F0684	F684 Quality of Care What corrective action(s) will be accomplished for those residents found to have been affected. Resident R41- a new comprehensive SAM completed with resident regarding nicotine throat lozenges. Orders were clarified with the provider, and excessive lozenges removed from resident room. All medications are signed in Medication Administration Record at the time of administration. Resident noted to use a lozenge and put back in cup and revisit lozenge later; lozenges will be administered per provider order. How the facility will identify other residents having the protentional to be affected by the same deficient practice and corrective action will be taken: All residents have the potential to be affected by the same alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Coach and educate TMA who administered lozenges	05/19/2026

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F0684 SS = D	Continued from page 4 R41's Provider Order Summary Report undated, identified an order for nicotine throat lozenge 4 milligrams (mg), give one lozenge by mouth every hour as needed. During an observation on 4/13/26 at 3:45 p.m., two white pills what R41 stated were nicotine throat lozenges were on the bedside table. During an observation on 4/14/26 at 11:10 a.m., R41 stopped registered nurse (RN)-A and requested two nicotine throat lozenges. Trained medication aide (TMA)-A walked into the room at the same time with a medication cup with two nicotine throat lozenges in the cup and gave them to R41. During an interview on 4/14/26 at 11:12 a.m., TMA-A stated medications should only be administered to the resident based on the provider's order and the only way more could be administered is if the provider changed the order. TMA-A confirmed she had given R41 two nicotine throat lozenges, and confirmed the order was only to receive one at a time every hour as needed. TMA-A stated all staff had been giving R41 two lozenges at a time and that is why she did it. During an interview on 4/14/26 at 11:16 a.m., RN-A stated medications should only be administered as per provider orders. During an interview on 4/16/26 at 7:58 a.m., the director of nursing (DON) stated an expectation staff only administered medications as ordered by the provider.Facility policy Medication Administration, last revised 12/4/24, indicated staff would ensure the correct medication and the correct dose was only administered based on the provider	F0684	Continued from page 4 outside of order. Sitewide re-education to all licensed nurses and TMA's for proper medication storage and administration. Clarity on order following 5 rights of medication administration. How the corrective action(s) will be monitored to ensure the deficient practice will not occur, i.e., what quality assurance programs will be put into place: DON/designee will audit with room rounds for residents on SAM's ordered medications 2 times per week for the first month, then weekly for 2 months to ensure provider orders are followed and proper documentation in the medical record. DON/designee will present a summary of the audits to the Quality Assurance committee monthly for 3 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done and presented at quarterly QAPI meetings.	05/19/2026
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by:	F0689	F689 Free of Accident Hazards/Supervision/Devices What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Nursing and Dietary reviewed R1's care plan: order and documentation in "eating" section to ensure updated on HST tablets for dietary needs entered by RD and back up for orders completed by provider. Communication on 24-hr board, MDS, Med Nurse, and HST binder. How the facility will identify other residents having the potential to be affected by the same deficient	05/19/2026

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F0689 SS = D	Continued from page 5 Based on observation, interview, and document review the facility failed to implement and follow interventions in place for a resident who needed assistance with meals. This had the potential to affect 1 of 1 resident (R1) reviewed who required assistance with feeding. Findings include: R1's quarterly Minimum Data Set (MDS) dated 3/6/26, identified R1 was cognitively intact. Diagnoses included stroke, hemiplegia and dysphagia. R1's Care plan undated, identified a current diet of regular with thin liquids. All foods needed to be cut into bite size pieces. The care plan also indicated and assist of one with meals. The facility East Dining Assistance Roster identified R1 was an assist of one for meals. R1's care conference notes dated 3/4/26 at 12:39 p.m., identified R1 had agreed to a bite size diet and assist of one with meals and the care plan was updated. During an observation on 4/14/26 at 12:34 p.m., R1 was given a plate that consisted of mashed potatoes with gravy and a piece of meatloaf. The resident then began feeding himself. The meatloaf was not cut up into bite size pieces and there were no staff with him, assisting with the meal. During an observation on 4/15/26 at 8:29 a.m., R1 received a piece of coffee cake with his breakfast. It was not cut up and again he ate it without any staff around to assist him. During an interview on 4/15/26 at 9:00 a.m., cook (CK)-A stated R1 was supposed to have his food cut up into bite size pieces and the cooks were responsible for cutting up the food. CK-A stated the coffee cake was not cut up because she felt the coffee cake was soft enough, and he could cut it himself. CK-A also stated the nurse assistants were responsible for assisting residents who needed assistance with meals. During an interview on 4/15/26 at 10:02 a.m., nursing assistant (NA)-A stated she was not aware NA-A was an assist for all meals and did not stay with him while he ate his meal. There should be somebody trained in feeding assistance with all residents that need assistance with meals.	F0689	Continued from page 5 practice and what corrective action will be taken: All residents have the potential to be affected by the deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Standard of Work identifies the person responsible for the chain of events in dietary changes. IDT educated on procedure; documentation of changes to staff listed above. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place: Full audit of residents to review assistance needs with weekly audits for 1 month and monthly audits for 2 months; audits will be reviewed during monthly QAPI meetings. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly, and presented quarterly at the QAPI meeting.	05/19/2026

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F0689 SS = D	Continued from page 6 During an interview on 4/15/26 at 10:43 a.m., registered nurse (RN)-B stated R1 had agreed to bite sized food and having assistance with meals during the last care conference. The care plan had been updated, and the staff should follow the care plan when a resident needed assistance with meals. During an interview on 4/16/26 at 7:58 a.m., the director of nursing (DON) stated an expectation the staff would follow the care plan and provide care based on the care plan. The facility policy Resident Assessment-Care Plan dated 4/22/25, indicated the care plan would be implemented to assist the residents reach the highest practical level of functionality and wellness.	F0689		05/19/2026
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F0880	F880 Infection Prevention & Control What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Skin checks completed. Resident and room cleaned on 4/15 post identification and immediate "5 moments of hand hygiene" training completed with staff. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by the deficient practice. What measure will be put in place or what systemic changes will be made to ensure the deficient practice does not recur: Staff re-education on "5 moments of and hygiene" and infection control procedures for dirty/clean. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place: An audit completed, with random audits completed weekly to ensure compliance for 3 months, audits will be reviewed during monthly QAPI meetings. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and presented quarterly at QAPI meeting.	05/19/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245628	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0880 SS = D	Continued from page 7 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to complete appropriate hand hygiene during cares for 1 of 1 resident (R1) reviewed for infection control. Findings include: R1's quarterly Minimum Data Set (MDS) dated 3/6/26, identified R1 was cognitively intact. Diagnoses included stroke and cancer. The MDS	F0880		05/19/2026

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F0880 SS = D	Continued from page 8 indicated R1 was frequently incontinent of bladder and always incontinent of bowel. R1 needed maximum assistance with toileting needs. R1's care plan undated, identified R1 had an alteration in elimination due to incontinence of urine and bowel. interventions included to check and change brief and provide perineal care. During an observation on 4/15/26 at 8:29 a.m., nurse assistant (NA)-A entered R1's room and told R1 she was going to check to see if the brief was dirty, and if so, change his brief, clean him up, and get him dressed for the morning. NA-A washed her hands and donned gloves. NA-A gathered wipes, cream, and a new brief from the R1's closet. R1's brief was undone and NA-A confirmed R1's brief was saturated with urine. NA-A removed R1's dirty brief and washed the front of his peri area with wipes. R1 was rolled to the right side and NA-A cleaned the buttock region. The dirty brief was rolled halfway under R1, and the clean brief was rolled to the other half of the R1, coming in contact with the soiled brief. R1 was then rolled to the left, the dirty brief was removed, and the clean brief was rolled the rest of the way under R1 with the dirty disposable chuck still under R1. The disposable chuck was observed to have wet areas on the pad where the peri-area would be located. With the contaminated gloves still on, NA-A then placed the new brief on R1 and secured it in place. NA-A proceeded to transfer R1 to the wheelchair and place R1's clean clothes on him. Lastly NA-A was observed placing the peri area cleaning supplies back into R1's closet, touching several items, with the contaminated gloves still on. The gloves were removed, hands washed, and R1 was taken to the dining hall. During an interview on 4/15/26 at 10:01 a.m., NA-A stated gloves would be changed if there was visible soiling noted or any time they went from a dirty area to clean area. During an interview on 4/15/26 at 10:43 a.m., registered nurse (RN)-B stated when doing cares gloves should always be changed when going from dirty parts, such as cleaning the peri area, to clean parts such as placing a new brief or clean clothes on the resident. During an interview on 4/16/26 at 7:30 a.m., the infection preventionist (IP) stated not following appropriate hand hygiene and not changing gloves when going from dirty to clean can increase the resident's risk of getting an infection.	F0880		05/19/2026

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F0880 SS = D	Continued from page 9 During an interview on 4/16/26 at 7:58 a.m., the DON stated all staff should change gloves when doing cares anytime they change from dirty parts of the process to clean parts of the process. Facility policy Hand Hygiene last revised 9/17/24, indicated staff would only perform hand hygiene before and after resident cares.	F0880		05/19/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245628	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MN VETS HO...** B. WING	(X3) DATE SURVEY COMPLETED **04/14/2026**

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K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 04/14/2026. At the time of this survey, Minnesota Veterans Home Silver Bay was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us	K0000		05/14/2026

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245628	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MN VETS HO...** B. WING	(X3) DATE SURVEY COMPLETED **04/14/2026**

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K0000 Bldg. 01	Continued from page 1 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Minnesota Veterans Home-Silver Bay is a one story building, partial basement original year of construction 1960's, and it was converted into a nursing home in the early 1990's. The original building and additions are all Type II(111) construction. The building is fully sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a capacity of 83 beds and had a census of 80 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K0000		05/14/2026
K0712 SS = F Bldg. 01	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.	K0712	K0712 Fire Drills Corrective Actions accomplished by this alleged practice. Fire drills conducted quarterly on each shift will have varying times by more than an hour and on different days to ensure that all staff members—including rotating and night-shift employees—are fully prepared, All residents have the potential to be affected by the alleged deficient practice and being prepared for a fire at any time.	04/28/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245628	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MN VETS HO...** B. WING	(X3) DATE SURVEY COMPLETED **04/14/2026**

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K0712 SS = F Bldg. 01	Continued from page 2 19.7.1.4 through 19.7.1.7 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/14/2026, at 11:58am, it was revealed by a review of available documentation that fire drills did not meet the varying time requirement. Fire drills third shift on 02/15/2026 at 03:35am and on 05/20/2026 at 03:37am. First shift on 03/26/2026 at 1:16pm and on o6/24/2026 at 1:47pm. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K0712	Continued from page 2 The maintenance director or designee will audit to ensure times meet guidance. This will be monitored through physical audits quarterly over the next three quarters. The maintenance director will present audits at the monthly QAPI meeting to verify audits are ongoing and the deficient practice will not recur. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QAPI meeting.	04/28/2026
K0920 SS = E Bldg. 01	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5	K0920	K0920 Electrical Equipment – Power Cords and Extension Corrective Actions accomplished by this alleged practice. The Multi-plug adapter in the safety office was removed immediately on 4/14/26 from the facility. The extension cords in Office 162 were removed immediately on 4/14/26, and the light was plugged directly into the wall. All residents have the potential to be affected by the alleged deficient practice and all department managers having in-service regarding not plugging appliances into power strips or extension cords. The maintenance director or designee will audit offices to verify that there are no inappropriately used power strips and use of extension cords. This will be monitored through physical audits weekly for the first month, bi-weekly for two months. The maintenance director will present audits at the monthly QAPI meeting to verify audits are ongoing and the deficient practice will not recur. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QAPI meeting.	04/15/2026

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K0920 SS = E Bldg. 01	Continued from page 3 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 70, (2011 edition), National Electrical Code, sections 400-8, and UL 1363. This deficient finding could have a Patterned impact on the residents within the facility. Findings include: On 04/14/2026 at the following times, it was revealed by observation that there were several electrical appliances plugged power-strips, multi-plug adapters and/or extension cords in the following areas; 1) Multi-plug adapter in Safety Office 2) Extension cords in office 162 An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K0920		04/15/2026
K0225 SS = D Bldg. 01	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility did not properly maintain enclose stairways used for exits and smoke proof enclosures in accordance with NFPA 101 (2012), Life Safety Code, section 7.1.3.2.1. These deficient findings could an isolated impact on the residents within the facility. Findings include: On 04/14/2026 at 1:07pm, it was revealed by observation that storage materials had been placed under staircase leading down to basement warehouse area. An interview with the Director of Maintenance verified these deficient findings at the time of	K0225	K0225 Stairways and Smokeproof Enclosures Corrective Actions accomplished by this alleged practice. Items were removed immediately on 4/14/25 from under the staircase leading down to the basement. The area has tape across the open space and a sign had been posted that there is no storage in this area. All residents have the potential to be affected by the alleged deficient practice The maintenance director or designee will audit the open area under the staircase to verify that nothing is being stored. This will be monitored through physical audits weekly for the first month, bi-weekly for two months. The maintenance director will present audits at the monthly QAPI meeting to verify audits are ongoing and the deficient practice will not recur. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QAPI meeting.	04/15/2026

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K0225 SS = D Bldg. 01	Continued from page 4 discovery.	K0225		04/15/2026
K0372 SS = D Bldg. 01	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.5. These deficient findings could have an isolated impact on the residents within the facility. Findings include: On 04/14/2026 at 12:57pm, it was revealed by observation that there was a penetration running from one smoke compartment to another above doors leading to evergreen dining room. An interview with the Director of Maintenance verified these deficient findings at the time of discovery.	K0372	K0372 Subdivision of building spaces – Smoke Barriers Corrective Actions accomplished by this alleged practice. Fire caulk applied on 04/14/2026 to repair penetration from one smoke department to the other above the Evergreen dining room. A post repair/install inspection will be completed for installations or repairs by contractors in the areas that they are in. Monthly audits will be completed for smoke barriers. The maintenance director will present audits at the monthly QAPI meeting to verify audits and inspections are ongoing and the deficient practice will not recur. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QAPI meeting.	04/15/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245628	A. BUILDING B. WING	04/16/2026

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E0000	Initial Comments On 4/13/26 to 4/16/24, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		05/13/2026
F0000	INITIAL COMMENTS On 4/13/26 to 4/16/26, a standard recertification survey was conducted at your facility. Complaint investigations were also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed without citation: H#: 56283300C 2706457 H#: 56289520C 2745142 H#: 56284344C 1184176 MN#:00112943 H#: 56286807C 1184181 MN#:00113725 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F0000		05/19/2026

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

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MINNESOTA VETERANS HOME - SILVER BAY	**56 OUTER DRIVE , SILVER BAY, Minnesota, 55614**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to ensure medications weren't left at a resident bedside when the resident was assessed to be unable to self-administer medications. This affected 1 of 1 resident (R41) reviewed for self-administration of medications. Findings include: R41's quarterly Minimum Data Set (MDS) dated 1/27/26 indicated R41 was cognitively intact. Diagnoses included renal insufficiency, anxiety, and depression R41's Provider Order Summary Report undated, lacked orders to keep medications at bedside. R41's care plan undated, lacked information related to self-administration of medications. R41's Self Administration of Medications &/or Treatments (SAM) dated 3/20/26 indicated R41 did not want to self-administer medications. The SAM also indicated R41 was no longer able to self administration. During an observation on 4/13/26 at 3:45 p.m., two white pills what R41 stated were nicotine throat lozenges were on the bedside table. There were no staff in the room at that time. During an observation on 4/14/26 at 11:10 a.m., two nicotine throat lozenges were again observed on the bedside table and there were no staff present in the room. During an interview on 4/14/26 at 11:12 a.m., trained medication assistant (TMA)-A stated she very rarely leaves medications at bedside. I am not sure what all needs to be in place to be able to keep medications at bedside when staff are not present. TMA-A confirmed R41 had medication left at beside and confirmed they were nicotine throat lozenges. During an interview on 4/14/26 at 11:16 a.m., registered nurse (RN)-A state a SAM assessment and order needed to be in place before medications could be left at bedside so the resident could self-administer.During an interview on 4/16/26 at 7:58 a.m., the director of nursing (DON) stated the SAM assessment needed to be in place and indicate the resident wants to self-administer and is able to self-administer before medications could be left at bedside. An expectation was for staff to confirm the appropriate information was confirmed before medications were left at bedside. Facility policy Self Administration of	F0554	F554 Resident Self-Admin Meds-Clinically Appropriate What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practices: Resident R41-A new comprehensive Self Administration of Medication (SAM) assessment completed with resident regarding nicotine throat lozenges. Policy reviewed. Orders were clarified with the provider, and excessive lozenges removed from resident room. All medications are signed in the Medication Administration Record at the time of administration. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents that are approved for SAM have the potential to be affected by the same alleged deficient practice. What measures will be put in place or what systemic changes will be made to ensure that the deficient practices does not recur: Licensed nurses re-educated on: Completing SAM for a residents' self-administration. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place: DON/designee will audit residents on SAM's ordered medications 2 times per week for the first month, then weekly for 2 months to ensure physicians orders are followed and proper documentation in the medical record. DON/designee will present a summary of the audits to the Quality Assurance Performance Improvement (QAPI) committee monthly for three months. Thereafter, if determined by the QAPI, auditing and monitoring will be done quarterly and present quarterly at the QAPI meeting.	05/19/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245628	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2026

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F0554 SS = D	Continued from page 2 Medications-Skilled Nursing last revised 2/27/25, indicated a comprehensive assessment would be completed to make sure the resident wanted to, and had the capability to self-administer medications and keep medications at bedside.	F0554		05/19/2026
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to report an allegation of staff on resident physical abuse within two hours to the State Agency (SA) for 1 of 4 residents (R54) reviewed for abuse. Findings include: Facility incident report dated 6/7/25, identified on the evening of 6/6/25 at approximately 8:00 p.m., R54 was handled roughly by a staff member, coming in contact with R54's left hand causing injury and pain.	F0609	F609-Reporting Alleged Violations What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. All residents involved in any episodes of suspected abuse will have the incident reported with two hours of the occurrence being identified. All staff have reviewed the abuse policy and its reporting requirements. Abuse reporting will be a topic at Town Halls. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: IDT Team reviewed policy: Vulnerable Adult-Resident Protection Plan. Any allegation involving abuse, reportable injury, neglect, exploitation, or mistreatment will be reported within 2 hours. Staff re-education on reporting requirements completed. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place: Staff will be randomly audited for reporting requirements for three months. All allegations of abuse, neglect, exploitation or mistreatment will be reviewed by the clinical leadership team and reported according to the policy: Vulnerable Adult - Resident Protection Plan. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present	05/19/2026

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F0609 SS = D	Continued from page 3 R54's progress note dated 6/6/25 at 10:39 p.m., identified staff called to room to assist with resident. Resident complained a nurse assistant (NA) in a "not gentle manner" grabbed the left hand and caused pain and injury. During an interview on 4/15/26 at 2:18 p.m., registered nurse (RN)-C stated R54 reported to her on 6/6/25 around 8:00 p.m., an NA had grabbed his left hand roughly and had caused pain and possible new bruising to the left hand. RN-C could not remember if she notified anybody right away about the concern of abuse. During an interview on 4/16/26 at 7:30 a.m., the infection preventionist (IP) stated she was working as the charge nurse on day shift on 6/7/25. The day nurse had made her aware of the complaint around 10:15 a.m., and that is when it was reported to the SA. Facility policy Vulnerable Adult-Resident Protection Plan dated 6/22/23, indicated all allegations of abuse, neglect, exploitation or mistreatment would be reported no later than two hours after the allegation was made.	F0609	Continued from page 3 quarterly at the QAPI meeting.	05/19/2026
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to follow provider orders and administer medications as ordered for 1 of 2 residents (R41) reviewed for quality of care. Findings include: R41's quarterly Minimum Data Set (MDS) dated 1/27/26, identified R41 was cognitively intact. Diagnoses included renal insufficiency, anxiety, and depression	F0684	F684 Quality of Care What corrective action(s) will be accomplished for those residents found to have been affected. Resident R41- a new comprehensive SAM completed with resident regarding nicotine throat lozenges. Orders were clarified with the provider, and excessive lozenges removed from resident room. All medications are signed in Medication Administration Record at the time of administration. Resident noted to use a lozenge and put back in cup and revisit lozenge later; lozenges will be administered per provider order. How the facility will identify other residents having the protentional to be affected by the same deficient practice and corrective action will be taken: All residents have the potential to be affected by the same alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Coach and educate TMA who administered lozenges	05/19/2026

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F0684 SS = D	Continued from page 4 R41's Provider Order Summary Report undated, identified an order for nicotine throat lozenge 4 milligrams (mg), give one lozenge by mouth every hour as needed. During an observation on 4/13/26 at 3:45 p.m., two white pills what R41 stated were nicotine throat lozenges were on the bedside table. During an observation on 4/14/26 at 11:10 a.m., R41 stopped registered nurse (RN)-A and requested two nicotine throat lozenges. Trained medication aide (TMA)-A walked into the room at the same time with a medication cup with two nicotine throat lozenges in the cup and gave them to R41. During an interview on 4/14/26 at 11:12 a.m., TMA-A stated medications should only be administered to the resident based on the provider's order and the only way more could be administered is if the provider changed the order. TMA-A confirmed she had given R41 two nicotine throat lozenges, and confirmed the order was only to receive one at a time every hour as needed. TMA-A stated all staff had been giving R41 two lozenges at a time and that is why she did it. During an interview on 4/14/26 at 11:16 a.m., RN-A stated medications should only be administered as per provider orders. During an interview on 4/16/26 at 7:58 a.m., the director of nursing (DON) stated an expectation staff only administered medications as ordered by the provider.Facility policy Medication Administration, last revised 12/4/24, indicated staff would ensure the correct medication and the correct dose was only administered based on the provider	F0684	Continued from page 4 outside of order. Sitewide re-education to all licensed nurses and TMA's for proper medication storage and administration. Clarity on order following 5 rights of medication administration. How the corrective action(s) will be monitored to ensure the deficient practice will not occur, i.e., what quality assurance programs will be put into place: DON/designee will audit with room rounds for residents on SAM's ordered medications 2 times per week for the first month, then weekly for 2 months to ensure provider orders are followed and proper documentation in the medical record. DON/designee will present a summary of the audits to the Quality Assurance committee monthly for 3 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done and presented at quarterly QAPI meetings.	05/19/2026
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by:	F0689	F689 Free of Accident Hazards/Supervision/Devices What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Nursing and Dietary reviewed R1's care plan: order and documentation in "eating" section to ensure updated on HST tablets for dietary needs entered by RD and back up for orders completed by provider. Communication on 24-hr board, MDS, Med Nurse, and HST binder. How the facility will identify other residents having the potential to be affected by the same deficient	05/19/2026

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F0689 SS = D	Continued from page 5 Based on observation, interview, and document review the facility failed to implement and follow interventions in place for a resident who needed assistance with meals. This had the potential to affect 1 of 1 resident (R1) reviewed who required assistance with feeding. Findings include: R1's quarterly Minimum Data Set (MDS) dated 3/6/26, identified R1 was cognitively intact. Diagnoses included stroke, hemiplegia and dysphagia. R1's Care plan undated, identified a current diet of regular with thin liquids. All foods needed to be cut into bite size pieces. The care plan also indicated and assist of one with meals. The facility East Dining Assistance Roster identified R1 was an assist of one for meals. R1's care conference notes dated 3/4/26 at 12:39 p.m., identified R1 had agreed to a bite size diet and assist of one with meals and the care plan was updated. During an observation on 4/14/26 at 12:34 p.m., R1 was given a plate that consisted of mashed potatoes with gravy and a piece of meatloaf. The resident then began feeding himself. The meatloaf was not cut up into bite size pieces and there were no staff with him, assisting with the meal. During an observation on 4/15/26 at 8:29 a.m., R1 received a piece of coffee cake with his breakfast. It was not cut up and again he ate it without any staff around to assist him. During an interview on 4/15/26 at 9:00 a.m., cook (CK)-A stated R1 was supposed to have his food cut up into bite size pieces and the cooks were responsible for cutting up the food. CK-A stated the coffee cake was not cut up because she felt the coffee cake was soft enough, and he could cut it himself. CK-A also stated the nurse assistants were responsible for assisting residents who needed assistance with meals. During an interview on 4/15/26 at 10:02 a.m., nursing assistant (NA)-A stated she was not aware NA-A was an assist for all meals and did not stay with him while he ate his meal. There should be somebody trained in feeding assistance with all residents that need assistance with meals.	F0689	Continued from page 5 practice and what corrective action will be taken: All residents have the potential to be affected by the deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Standard of Work identifies the person responsible for the chain of events in dietary changes. IDT educated on procedure; documentation of changes to staff listed above. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place: Full audit of residents to review assistance needs with weekly audits for 1 month and monthly audits for 2 months; audits will be reviewed during monthly QAPI meetings. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly, and presented quarterly at the QAPI meeting.	05/19/2026

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F0689 SS = D	Continued from page 6 During an interview on 4/15/26 at 10:43 a.m., registered nurse (RN)-B stated R1 had agreed to bite sized food and having assistance with meals during the last care conference. The care plan had been updated, and the staff should follow the care plan when a resident needed assistance with meals. During an interview on 4/16/26 at 7:58 a.m., the director of nursing (DON) stated an expectation the staff would follow the care plan and provide care based on the care plan. The facility policy Resident Assessment-Care Plan dated 4/22/25, indicated the care plan would be implemented to assist the residents reach the highest practical level of functionality and wellness.	F0689		05/19/2026
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F0880	F880 Infection Prevention & Control What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Skin checks completed. Resident and room cleaned on 4/15 post identification and immediate "5 moments of hand hygiene" training completed with staff. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by the deficient practice. What measure will be put in place or what systemic changes will be made to ensure the deficient practice does not recur: Staff re-education on "5 moments of and hygiene" and infection control procedures for dirty/clean. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place: An audit completed, with random audits completed weekly to ensure compliance for 3 months, audits will be reviewed during monthly QAPI meetings. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and presented quarterly at QAPI meeting.	05/19/2026

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F0880 SS = D	Continued from page 7 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to complete appropriate hand hygiene during cares for 1 of 1 resident (R1) reviewed for infection control. Findings include: R1's quarterly Minimum Data Set (MDS) dated 3/6/26, identified R1 was cognitively intact. Diagnoses included stroke and cancer. The MDS	F0880		05/19/2026

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F0880 SS = D	Continued from page 8 indicated R1 was frequently incontinent of bladder and always incontinent of bowel. R1 needed maximum assistance with toileting needs. R1's care plan undated, identified R1 had an alteration in elimination due to incontinence of urine and bowel. interventions included to check and change brief and provide perineal care. During an observation on 4/15/26 at 8:29 a.m., nurse assistant (NA)-A entered R1's room and told R1 she was going to check to see if the brief was dirty, and if so, change his brief, clean him up, and get him dressed for the morning. NA-A washed her hands and donned gloves. NA-A gathered wipes, cream, and a new brief from the R1's closet. R1's brief was undone and NA-A confirmed R1's brief was saturated with urine. NA-A removed R1's dirty brief and washed the front of his peri area with wipes. R1 was rolled to the right side and NA-A cleaned the buttock region. The dirty brief was rolled halfway under R1, and the clean brief was rolled to the other half of the R1, coming in contact with the soiled brief. R1 was then rolled to the left, the dirty brief was removed, and the clean brief was rolled the rest of the way under R1 with the dirty disposable chuck still under R1. The disposable chuck was observed to have wet areas on the pad where the peri-area would be located. With the contaminated gloves still on, NA-A then placed the new brief on R1 and secured it in place. NA-A proceeded to transfer R1 to the wheelchair and place R1's clean clothes on him. Lastly NA-A was observed placing the peri area cleaning supplies back into R1's closet, touching several items, with the contaminated gloves still on. The gloves were removed, hands washed, and R1 was taken to the dining hall. During an interview on 4/15/26 at 10:01 a.m., NA-A stated gloves would be changed if there was visible soiling noted or any time they went from a dirty area to clean area. During an interview on 4/15/26 at 10:43 a.m., registered nurse (RN)-B stated when doing cares gloves should always be changed when going from dirty parts, such as cleaning the peri area, to clean parts such as placing a new brief or clean clothes on the resident. During an interview on 4/16/26 at 7:30 a.m., the infection preventionist (IP) stated not following appropriate hand hygiene and not changing gloves when going from dirty to clean can increase the resident's risk of getting an infection.	F0880		05/19/2026

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F0880 SS = D	Continued from page 9 During an interview on 4/16/26 at 7:58 a.m., the DON stated all staff should change gloves when doing cares anytime they change from dirty parts of the process to clean parts of the process. Facility policy Hand Hygiene last revised 9/17/24, indicated staff would only perform hand hygiene before and after resident cares.	F0880		05/19/2026

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
July 8, 2026

Administrator
MINNESOTA VETERANS HOME - SILVER BAY
56 OUTER DRIVE
SILVER BAY, MN 55614

RE: CCN: 245628
Cycle Start Date: April 16, 2026

Dear Administrator:

On June 2, 2026, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

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