



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 27, 2026

Administrator
MN VETERANS HOME MINNEAPOLIS
5101 MINNEHAHA AVENUE SOUTH
MINNEAPOLIS, MN 55417

RE: CCN:245620
Cycle Start Date: July 9, 2026

Dear Administrator:

On July 9, 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:

Stefanie Salberg, Regional Operations Supervisor
Metro C District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: stefanie.salberg@state.mn.us
Office: 651-201-4393 Mobile: 651-279-5602

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 October 9, 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 January 9, 2027 (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,



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



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July 27, 2026

Administrator

MN VETERANS HOME MINNEAPOLIS

5101 MINNEHAHA AVENUE SOUTH

MINNEAPOLIS, MN 55417

Re: State Nursing Home Licensing Orders

Event ID: 235CCC-H1

Dear Administrator:

The above facility survey was completed on July 9, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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:

Stefanie Salberg, Regional Operations Supervisor
Metro C District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: stefanie.salberg@state.mn.us
Office: 651-201-4393 Mobile: 651-279-5602

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 feel free to call me with any questions.



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00233		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2026	
NAME OF PROVIDER OR SUPPLIER MN VETERANS HOME-MPLS				STREET ADDRESS, CITY, STATE, ZIP CODE 5101 MINNEHAHA AVENUE SOUTH , MINNEAPOLIS, Minnesota, 55417			
(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
30000	INITIAL COMMENTS *****ATTENTION***** BOARDING CARE HOME 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 7/6/26 to 7/9/26, a standard licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Minnesota Veterans Home Minneapolis (Domiciliary) was found not in compliance with the applicable MN State Licensure rules. Minnesota Department of Health (MDH) is documenting the State Licensing Correction Orders			30000			07/31/2026

Office of Primary Care and Health Systems Management

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00233		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2026	
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30000	Continued from page 1 using federal software for Minnesota Rules, Chapter 4655 for Boarding Care Homes. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.			30000			07/31/2026
30670	Resident Care Record CFR(s): MN Rule 4655.4000 Subp. 1 & 2 Subpart 1. Application. This part applies to boarding care homes only. Subp. 2. Types of information reported. The care record for each resident shall contain the resident's weight at the time of admission and at least once each month thereafter and a summary completed at least monthly by the person in charge indicating the resident's general condition, actions, attitude, changes in sleeping habits or appetite, and any complaints. A detailed incident report of any accident or injury and the action taken shall be recorded immediately. All dates and times of visits by physicians or podiatrists and visits to clinics, dentists, or hospitals shall be recorded. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure monthly nursing progress notes were completed that included the resident's general condition, actions, attitudes, changes in appetite, changes in sleep patterns, and complaints for 1 of 5 residents reviewed (R1). Findings include: R1's face sheet indicated R1 was admitted to the domiciliary home on 3/19/2020 with a primary diagnosis of alcohol abuse. R1's electronic medical record indicated the last completed monthly nursing progress note was dated 4/28/2026. There was no monthly nursing progress note completed for May 2026 or June 2026. During an interview on 7/7/2026 at 1:59 p.m., the Administrator stated there was one nurse who had been responsible for completing all of the monthly nursing progress notes. She stated the nurse retired on June 1, 2026, and had been absent for much of May, resulting in the May and June progress notes			30670	Corrected.		08/31/2026

Minnesota Department of Health

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30670	Continued from page 2 not being completed. The Administrator confirmed monthly nursing progress notes were expected to be completed for each resident and stated the responsibility had since been assigned to another nurse. She further stated she did not like relying on one nurse to complete all of the progress notes and was considering changing the process going forward. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could audit all resident records to ensure monthly progress notes were completed per regulatory requirements, review facility policy and educate staff regarding such progress notes, conduct periodic audits, and bring results to QAPI to maintain continued compliance. TIME PERIOD FOR CORRECTION: 21 days			30670			08/31/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245620		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2026	
NAME OF PROVIDER OR SUPPLIER MN VETERANS HOME-MPLS				STREET ADDRESS, CITY, STATE, ZIP CODE 5101 MINNEHAHA AVENUE SOUTH , MINNEAPOLIS, Minnesota, 55417			
(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 7/6/26 – 7/9/26, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) 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			07/31/2026
F0000	INITIAL COMMENTS On 7/6/26 – 7/9/26, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaints were reviewed with no deficiency issued: H#: H56203140C (iQies: 2629109) H#: H56203139C (iQies: 2977542) H#: H56202140C (iQies: 3007892) H#: H56202140C (iQies: 3007884) H#: H56203141C (iQies: 2605098) H#: H56201322C (iQies: 2692984) H#: H56203149C (iQies: 3066511) H#: H56203154C (iQies: 3066317) 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			F0000			07/31/2026

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
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245620		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2026	
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F0000	Continued from page 1 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.			F0000			07/31/2026
F0812 SS = F	Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained. Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to monitor dishwasher temperatures in the main kitchen. This had the potential to increase the risk of food borne illness and affect 293 residents who received food from dietary services. Findings include: The dishwasher temperature log for July of 2026, indicated the required temperatures were 160 degrees (Fahrenheit) for the wash cycle and 180 degrees for the final rinse cycle. It further indicated to report low temperatures to the supervisor immediately which was also highlighted			F0812	How will corrective action be accomplished for this resident: 1. The main kitchen high-temperature dish machine was removed from service on July 9, 2026, after temperatures failed to meet the manufacturer's required wash and final rinse temperature parameters. The contracted service provider replaced a failed steam valve on July 10, 2026. Proper operation was verified by confirming wash temperatures of at least 160°F (manufacturer requirement) and final rinse temperatures of at least 180°F before returning the machine to service. During the repair period, food preparation equipment, utensils, and cookware were washed using an alternate dish machine, and the three-compartment sink according to established cleaning and sanitizing procedures. Resident meal service was not interrupted. Other residents potentially affected: 2. Residents/Veterans consuming food that was prepared in the MVH-Minneapolis main kitchen have the potential to be affected. Measures put in place/systemic changes to ensure deficiency does not recur: 3. High-temperature dish machines used by the Dietary Department were evaluated to verify compliance with manufacturer temperature requirements. A Standard of Work will be implemented to support facility established practice of temperature verification before each meal period using a waterproof Min/Max thermometer. Dietary staff will complete competency-based education on the Standard of Work with an emphasis on meeting temperature requirements. Licensed Dietary Staff and Supervisors will be re-educated on reviewing temperature logs to verify documentation accuracy, identify temperatures outside required limits, and ensure timely notification and implementation of corrective actions.		08/31/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245620		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2026	
NAME OF PROVIDER OR SUPPLIER MN VETERANS HOME-MPLS				STREET ADDRESS, CITY, STATE, ZIP CODE 5101 MINNEHAHA AVENUE SOUTH , MINNEAPOLIS, Minnesota, 55417			
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F0812 SS = F	Continued from page 2 in yellow. The following temperatures and dates were recorded on the log and did not meet the requirements for safe dishwashing temperatures: -7/1/26 wash cycle for supper 154 degrees-7/2/26 wash cycle during lunch 157 degrees-7/4/26 final rinse cycle during dinner 173 degrees-7/5/26 wash cycle for supper 150 degrees, final rinse cycle 179 degrees-7/6/26 wash cycle during breakfast 158 degrees-7/7/26 wash cycle during lunch 159 degrees-7/8/26 wash cycle during breakfast 150 degrees and final rinse cycle 174 degrees-7/9/26 final rinse cycle for lunch 174 degrees During observation with dining supervisor and food service unit supervisor present on 7/9/26 at 10:57 a.m., the dish machine was observed to run, with wash temperature reaching 143 degrees and the final rinse at 177 degrees. The machine was run again and reached a wash temperature of 141 degrees, and the rinse temperature did not register. During interview on 7/9/26 at 11:12 a.m. the dining supervisor stated staff had not notified him regarding low dishwasher temperatures. During interview on 7/9/26 at 11:17 a.m., the food service unit supervisor verified the temperatures recorded on the log did not reach the appropriate temperature and further stated staff had not notified her about it. During interview on 7/9/26 at 11:23 a.m., food service worker (FSW)-A stated when they do the dishes, they look at the temperature for the wash cycle which should be 170 degrees and then they look at the rinse cycle (because that hotter) which should be 180 degrees. Then they record it on the log. If the temperature for the wash and rinse cycle didn't reach 170 and 180 degrees, they would let the supervisor know. During interview on 7/9/26 at 11:27 a.m., FSW-B stated when they are doing the dishes, they watch to see how hot the temperature gets for the wash and rinse cycles and then they record it on a log. DA- further stated the wash cycle should be between 164-167 degrees, and the rinse cycle should be between 182-187 degrees. If it's not, they would let their supervisor know. During interview on 7/9/26 at 12:07 p.m., the administrator stated the food service staff should be writing the dishwasher temperatures on a log which is located on the dishwashers. It should be checked daily to ensure the temperatures are in within range (written on the log). If the temperatures are out of range, they should be notifying the supervisor. The facility policy regarding dishwasher temperatures dated 11/9/24, indicated the following: The dish machine temperatures (wash, dual wash,			F0812	Continued from page 2 How corrective action will be monitored: 4. Dietary supervisors will perform and document one direct observation audit of the complete dish machine temperature verification process each day for three months using the Dish Machine Temperature Verification Audit Tool. The Nutrition Program Director, or designee, will review completed temperature logs and supervisor audits for completeness, accuracy, and compliance. Aggregate audit results and trends will be reported to the QAPI Committee monthly for three months, with recommendations for continuation, reduction, or discontinuation of monitoring based on sustained compliance. Responsibility: The Nutrition Program Director, or designee, is responsible.		08/31/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245620		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/09/2026	
NAME OF PROVIDER OR SUPPLIER MN VETERANS HOME-MPLS				STREET ADDRESS, CITY, STATE, ZIP CODE 5101 MINNEHAHA AVENUE SOUTH , MINNEAPOLIS, Minnesota, 55417			
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F0812 SS = F	Continued from page 3 and final rinse) will be monitored and recorded three times daily. The employee responsible must record the temperatures and initial the log to confirm completion. If any recorded temperatures do not meet the manufacturer's specifications, the issue must be reported immediately to a supervisor, Director, or Administrator. The contracted service vendor will be contacted to address the malfunction. The supervisor or person in charge will decide whether the dish machine can continue to be used or if manual dishwashing is required. If a low-temperature chemical sanitizer is available, the machine may still be used, as the product is designed to sanitize at lower temperatures. Once the contracted vendor has completed the repairs, they will notify staff when the dish machine is ready for use, allowing a return to normal operation from manual handwashing if needed.			F0812			08/31/2026
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any			F0605	How will corrective action be accomplished for this resident: 1. R279's medical provider was updated on 7/7/26 with PRN antipsychotic order modified with a stop date. Other residents potentially affected: 2. Residents/Veterans with an order for PRN antipsychotic medication at MVH-Minneapolis have the potential to be affected. Measures put in place/systemic changes to ensure deficiency does not recur: 3. Residents currently ordered PRN antipsychotic medication were reviewed for appropriate stop/review dates and appropriate documentation if order was extended beyond 14 days. Consultant Pharmacist will mark future PRN antipsychotic medication reviews to be addressed within 1 week and will send providers a notification email of PRNs needing to be addressed. Re-education on the Psychotropic Medication Use Standard of Work with an emphasis on PRN antipsychotic usage and on checking for in progress pharmacy medication reviews will be provided to Licensed Nurses, Health Unit Coordinators, and		08/31/2026

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NAME OF PROVIDER OR SUPPLIER MN VETERANS HOME-MPLS				STREET ADDRESS, CITY, STATE, ZIP CODE 5101 MINNEHAHA AVENUE SOUTH , MINNEAPOLIS, Minnesota, 55417			
(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
F0605 SS = D	Continued from page 4 physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that--			F0605	Continued from page 4 Medical Providers. How corrective action will be monitored: 4. Designee will conduct audits on PRN antipsychotics having appropriate stop/review dates for each resident unit; audits will be conducted weekly for 3 months. Findings will be reported at upcoming Quality Assurance and Performance Improvement (QAPI) meetings monthly for 3 months and then will be reduced/eliminated per the QAPI committee recommendation based on substantial compliance being met. Responsibility: The DON is responsible.		08/31/2026

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F0605 SS = D	Continued from page 5 §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure as-needed (PRN) psychotropic medication orders had a defined stop date and were limited to 14 days without a documented rationale for extension for 1 of 5 residents (R279) reviewed for unnecessary medications. Findings include: R279's quarterly Minimum Data Set (MDS) dated 5/12/26, indicated R279 was severely cognitively impaired, and had diagnoses of non-traumatic brain dysfunction, Alzheimer's disease, non-Alzheimer's dementia, anxiety, and depression. R279 had verbal behavioral symptoms (such as threatening or screaming) directed toward others, behavioral symptoms not directed at others (such as disruptive sounds, pacing, ect.), and wandering. R237 used a wheelchair for			F0605			08/31/2026

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F0605 SS = D	Continued from page 6 mobility. R279's Mood/Behavior care plan focus revised 6/11/26, directed staff to administer prescribed medications per MD/NP orders, monitor for side effects of medications, notify provider with concerns, and refer to behavioral services as needed. R279's Order Review History Report dated 7/7/26, included Haloperidol (an antipsychotic) Oral Tablet 1 milligram (mg), give 1 tablet by mouth every 4 hours as needed for 14 days starting 4/28/2026. The order lacked an order end date. R279's Haloperidol Order Details dated 4/28/26, identified the end date as "Indefinite". R279's Medication Administration Record (MAR) dated 6/1/26 - 6/30/26, indicated R279 received PRN Haloperidol 16 times during the month. R279's MAR dated 7/1/26 - 7/7/26, indicated R279 received PRN Haloperidol one time during the first six days of the month. During interview on 7/7/26 at 3:02 p.m., nursing assistant (NA)-C stated sometimes R279 became violent with staff during cares and sometimes they needed to call the nurse to help with de-escalation. During interview on 7/7/26 at 3:10 p.m., licensed practical nurse (LPN)-B stated staff tried to redirect and distract R279 with coloring or other things to do when he demonstrated behaviors, and gave him PRN Haloperidol if the redirection did not work and when the behaviors were disturbing other residents. LPN-B stated it was "not very often, one or two times a shift". Upon review of R279's medical record, LPN-B verified the order for Haloperidol was for 14 days, however, was entered as "indefinite" and had been mistakenly given far beyond the 14-day end date. During interview on 7/7/26 at 3:19 p.m., unit manager registered nurse (RN)-H stated PRN psychotropic medications should have an end date and were limited to 14 days. If PRN psychotropic medications were being used on a frequent or regular basis, they would ask the provider to have them scheduled. Upon review of R279's medical record, RN-H confirmed R279's Haloperidol order did not have an end date and had been given many times after the order should have been discontinued. During interview on 7/7/26 at 5:15 p.m., the director of nursing (DON) stated PRN psychotropic medications should have an end date and were expected to be re-evaluated by a provider after 14 days. The provider could then continue, discontinue, or change the order based on the resident's needs. The facility Psychotropic Medications policy dated 4/11/25, indicated PRN orders for psychotropic and antipsychotic medication are limited to 14 days. 1. If the prescriber believes it appropriate to extend the order for the psychotropic medication, excluding antipsychotics, the provider must document the clinical rationale for the extended period in the			F0605			08/31/2026

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F0605 SS = D	Continued from page 7 resident's medical record.			F0605			08/31/2026
F0684 SS = D	2. PRN orders for antipsychotic medications are only effective for 14 days. If the provider wants to write a new or another order, they must first evaluate the resident to determine if the new order for the PRN antipsychotic medication is appropriate and document the evaluation in the resident's medical record. 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 doctor's orders for 1 of 1 resident (R87) reviewed who required daily weights. In addition, the facility failed to ensure services were coordinated with the hospice agency for 1 of 1 resident (R265) reviewed who received hospice services. Finding include: R87's significant change Minimum Data Set (MDS) dated 6/29/26, indicated severely impaired cognition and diagnoses of congestive heart failure (CHF), chronic kidney disease, and dementia. R87's physician's orders dated 5/18/26, indicated daily weight for CHF, in the morning and to update the provider if the resident gains +2 pounds (lbs.) per day or +5 lbs. per week R87's treatment administration record (TAR) indicated the following weights: -6/1/26 229.5 lbs. -6/2/26 236.2 lbs. R87 gained 6.7 lbs. between 6/1/26 and 6/2/26.			F0684	How will corrective action be accomplished for this resident: 1. R87's provider was updated on the resident's weight changes on 6/10/26. R265's missing hospice documentation was received on 7/7/26 with the resident's plan of care updated. Other residents potentially affected: 2. Residents/Veterans with a diagnosis of heart failure and orders for weight parameters that require a provider be updated or residents receiving hospice services at MVH-Minneapolis have the potential to be affected. Measures put in place/systemic changes to ensure deficiency does not recur: 3. Residents with a diagnosis of heart failure and with current orders for weight parameters that require a provider be updated had their weights reviewed and verified that providers had been updated based on resident specific parameters. Residents currently receiving hospice services were reviewed to verify hospice service plans were available in each resident's electronic medical record, hospice calendars were available in each resident's hospice binder on the nursing units, and that care plans referencing these services were in place. Resident Weights Standard of Work was updated with an emphasis on requiring nurses review weights for residents with weight orders above the standard facility protocol. Re-education will be provided to Licensed Nurses on these changes and required documentation when updating providers. Education provided to specify the storage location of hospice service plans and calendars as well as when facility staff will verify updated forms are obtained from hospice. Re-education will be provided to Registered Nurse Seniors (RNS), Registered Nurse		08/31/2026

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F0684 SS = D	Continued from page 8 R87's care plan dated 6/22/26, indicated R87 had CHF and indicated the following interventions: -Apply oxygen 2-5 liters per minute for desaturation, titrate to comfort via nasal cannula for CHF. Apply at bedtime per order and as needed (PRN) during waking hours for comfort. -Check breath sounds and monitor/document for labored breathing. Monitor/document for the use of accessory muscles while breathing. -Give cardiac medications as ordered. -Monitor Lab work: potassium, sodium, blood urea nitrogen (BUN), Creatinine -Monitor/document/report to medical doctor (MD) PRN any signs or symptoms of CHF: dependent edema of legs and feet, periorbital edema, shortness of breath upon exertion, cool skin, dry cough, distended neck veins, weakness, weight gain unrelated to intake, crackles and wheezes upon auscultation of the lungs, orthopnea, weakness and/or fatigue, increased heart rate (Tachycardia) lethargy and disorientation. -Monitor/document/report to MD PRN any signs/symptoms of digitalis toxicity: fatigue, muscle weakness, anorexia, nausea, yellow halos around objects. -Monitor/document/report to MD PRN any signs/symptoms of hypokalemia in residents receiving diuretic therapy: fatigue, muscle, weakness, diminished appetite, nausea and vomiting and dysrhythmias, Monitor potassium levels. R87's progress notes for the months of May and June of 2026 lacked indication the provider was notified of a weight gain between 6/1/26 and 6/2/26. During interview on 7/7/26 at 2:15 p.m., registered nurse (RN)-E verified R87 had gained 6.7 lbs. between 6/1/26 and 6/2/26 and there was no documentation the provider was notified and should have been. During interview on 7/7/26 at 2:25 p.m., RN-F stated the provider should have been notified when R87 had a weight gain of 6.7 lbs. from 6/1/26 to 6/2/26. RN-F further stated there also should have been a progress note so that other staff are aware the provider had been notified.			F0684	Continued from page 8 Managers (RNM), Minimum Data Set (MDS) Nurses, and Assistant Director of Nurses (ADON) on these changes. How corrective action will be monitored: 4. Designee will conduct audits on residents with a diagnosis of heart failure and current orders for weight parameters on updating providers, checking that appropriate updates were provided based on weight fluctuations for each nursing unit; audits will be conducted weekly for 3 months. Designee will conduct audits on each hospice resident, verifying updated hospice service plans and calendars are present; audits will be conducted monthly for 3 months. Findings will be reported at upcoming Quality Assurance and Performance Improvement (QAPI) meetings monthly for 3 months and then will be reduced/eliminated per the QAPI committee recommendation based on substantial compliance being met. Responsibility: The DON is responsible.		08/31/2026

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F0684 SS = D	Continued from page 9 During interview on 7/9/26 at RN-D stated the provider should have been notified when R87 had a weight gain of 6.7 lbs. from 6/1/26 to 2/2/26. RN-D further stated, each time R87 had a weight gain the nurses were expected to notify the provider and document in a progress note to let the other nurses know what happened, the steps they took and how they followed through. This was important because a resident with CHF requires their weight to be monitored in order to prevent a fluid imbalance/fluid overload which could then cause shortness of breath (SOB) and problems with endurance. It was also important to monitor weights and labs to ensure the medications R87 was taking were working and they were the right ones. During interview on 7/9/26 at 1:05 p.m. The director of nursing (DON) stated nurses should be following doctor's orders. A facility policy on following doctor's orders was requested but not received. R265 R265's quarterly Minimum Data Set (MDS) dated 6/26/26 identified R265 with impaired cognition, dependent on staff for all cares including eating, toileting, personal hygiene, and dressing. R265 had diagnoses of Parkinsons, dementia, and depression and was on hospice (end of life) services. During review of R265's hospice binder on nursing station on 7/7/26 at 9:10 a.m., the calendar for July 2026 identified one home health aide visit on July 1, 2026, and social services visit on July 31, 2026. July 5-30 was left blank of visit notes from nursing, home health aide, social services, chaplain services, massage therapy services, and music therapy services. In addition, the hospice plan of care (POC) dated 7/1/26 to 8/29/26 that was in the binder identified start of hospice services on 1/2/26 and included diagnoses, allergies, activity level, functional limitations, mental status, psychosocial status, safety measures, supplies, nutrition, medications, care plan goals and interventions for home health aide, chaplain, massage therapy, social services, music therapy, and nursing. The POC failed to identify visit orders for the services for nursing, home health aide, chaplain, massage therapy, social services, and music therapy. During interview with registered nurse (RN)-A on 7/7/26 at 1:21 p.m., RN-A stated she was not aware			F0684			08/31/2026

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F0684 SS = D	Continued from page 10 of when hospice visited R265 and had no knowledge of what the visit orders were. RN-A stated expectation of R265's hospice binder to have an updated calendar and visit orders. During interview with health services technician (HST)-A on 7/7/26 at 1:26 p.m., stated, “we do not know when and who comes from hospice. There is no calendar or notice to staff here on who is coming and when.” In addition, HST-A stated he was not aware of visit notes in R265's hospice binder for updates and information. HST-A stated missing calendar and visit orders was “not ideal”. During interview with RN-B on 7/7/26 at 1:39 p.m., RN-B reviewed R265's hospice binder and verified calendar for July 2026 missed visits for month from July 5-30, 2026. RN-B stated he believed the hospice nurse visited once a week and the hospice home health aide visited once per week. RN-B also verified R265's POC failed to identify visit orders for the services for nursing, home health aide, chaplain, massage therapy, social services, and music therapy. RN-B stated importance of facility and hospice services to collaborate and communicate regarding visit orders and update the calendar, so facility would be aware of what services were scheduled and when. During interview with hospice nurse RN-C on 7/7/26 at 2:31 p.m., RN-C stated she was R265's nurse case manager for hospice. RN-C verified the July 2026 calendar and POC, “are not updated at this time”. RN-C stated the home health aide was scheduled twice per week to visit R265 and nursing visits once per week. RN-C verified information facility had was “incomplete”. RN-C stated it was important for facility to have an accurate calendar of visits and updated POC with visit orders. “Staff there would not know who is coming and when by looking at an empty calendar and incomplete POC”. During interview with director of nursing (DON) on 7/9/26 at 9:03 a.m., DON stated expectation of hospice binders to include updated and accurate monthly calendars and plan of care to include visit orders for each discipline. DON reviewed R265's July 2026 calendar and POC dated 7/1/26 and verified they were both incomplete. DON stated importance of hospice and facility to collaborate and communicate regarding visit orders. Hospice contract with effective date of April 29, 2026, identified the POC to include details concerning frequency of hospice services and details regarding which provider is responsible for			F0684			08/31/2026

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F0684 SS = D	Continued from page 11 performing the services.			F0684			08/31/2026
F0880 SS = D	Facility policy titled End of life, Hospice, and Comfort Care Services, revised 12/04/2024, identified, "The hospice and MVH [Minnesota Veterans Home] will ensure that each residents' written plan of care includes the most recent hospice plan of care, intervention and services furnished". 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; (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;			F0880	How will corrective action be accomplished for this resident: 1. R11's Human Service Technician (HST) was re-educated on the use of Enhanced Barrier Precautions (EBP) on 7/9/26. Other residents potentially affected: 2. Residents/Veterans requiring EBP at MVH-Minneapolis have the potential to be affected. Measures put in place/systemic changes to ensure deficiency does not recur: 3. Re-education will be provided to Licensed Nurses and HSTs on EBP and what activities require EBP personal protective equipment (PPE) to be worn. How corrective action will be monitored: 4. Designee will conduct audits on proper EBP PPE usage during resident cares. Audits will be conducted on 2 residents per Registered Nurse Manager (RNM) unit per week; audits will continue for 3 months. Findings will be reported at upcoming Quality Assurance and Performance Improvement (QAPI) meetings monthly for 3 months and then will be reduced/eliminated per the QAPI committee recommendation based on substantial compliance being met. Responsibility: The DON is responsible.		08/31/2026

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F0880 SS = D	Continued from page 12 (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, interview and document review, the facility failed to ensure enhanced barrier precautions (EBP) were followed for 1 of 1 resident (R11) reviewed for EBP. Findings include: R11's quarterly Minimum Assessment Data (MDS) dated 6/9/26, indicated R11 had moderate cognitive impairment, was incontinent of bowel and bladder, required moderate assistance to transfer to the toilet, and was dependent on staff for toileting hygiene. R11's Clinical Diagnosis form dated 7/9/26 indicated a diagnosis of carrier of methicillin resistant staphylococcus aureus (MRSA).			F0880			08/31/2026

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NAME OF PROVIDER OR SUPPLIER MN VETERANS HOME-MPLS				STREET ADDRESS, CITY, STATE, ZIP CODE 5101 MINNEHAHA AVENUE SOUTH , MINNEAPOLIS, Minnesota, 55417			
(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 13 R11's Clinical Profile dated 7/9/26 indicated R11 was on EBP. R11's care plan dated 7/9/26, included a care plan focused on EBP. The EBP care plan indicated R11 required enhanced barrier precautions due to history/diagnosis of MRSA in nares and directed staff to wear gown and gloves when in room providing personal cares. During observation on 7/9/26 at 11:07 a.m., a sign on R11's door indicated he was on EBP. The sign directed staff to wear a gown and gloves when aiding with transfers and personal cares. R11 walked into his room followed by a health support technician (HST)-B. HST-B directed R11 to the bathroom. HST-B assisted R11 to use the toilet and changed his incontinent brief. HST-B wore gloves but did not wear a gown. During interview on 7/9/26 at 11:12 a.m., HST-B stated he was rushing and didn't have time to put on a gown. HST-B said he needed to wear gown and gloves to assist R11 with personal cares. HST-B stated R11 was on infection precautions because R11 had a skin rash before. HST-B stated he needed to wear a gown to protect his clothes from R11's urine. During interview on 7/9/26 at 11:03 a.m., licensed practical nurse (LPN)-A stated R11 was on EBP due to MRSA on the nose. LPN-A stated the sign on R11's door directed staff to wear gloves and gowns to provide personal cares. LPN-A stated the nursing staff received annual infection control training, and as needed whenever they had a new resident with an infection. During interview on 7/0/26 at 11:12 a.m., senior nurse/registered nurse RN-G stated the EBP signs were in place to alert staff of some kind of communicable disease. RN-G stated the EBP signs directed staff to wear gown and gloves when personal cares were provided to residents on EBP. RN-G stated all the staff received annual infection control training and as needed. During interview on 7/9/26 at 3:42 p.m., director of nursing (DON) stated he expected staff to follow the instructions on the signs. DON said the EBP signs had pictograms and indicated what personal protection equipment (EPP) the staff needed to wear when they were in contact with the residents. DON stated the facility provided a PPE bin containing all necessary equipment for every resident. DON added that the essence of an EBP sign is to identify residents that had an infection or were susceptible			F0880			08/31/2026

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F0880 SS = D	Continued from page 14 to infections and prevent infection from being transmitted to other residents. Facility's policy titled Infection Prevention and Control Program dated 4/22/25, indicated EBP is an intervention designed to reduce transmission of multidrug-resistant organisms during high contact resident care activities in which opportunities exist for the transfer of MDROs to staff hands and clothing. EBP, in conjunction with standard precautions, includes staff use of gowns and gloves during high contact resident care activities.			F0880			08/31/2026
F0883 SS = D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization,			F0883	How will corrective action be accomplished for this resident: 1. R11 was offered and received the pneumococcal vaccine on 7/9/26. Other residents potentially affected: 2. Residents/Veterans who have not received or declined the PCV20 or PCV21 pneumococcal vaccine at MVH-Minneapolis have the potential to be affected. Measures put in place/systemic changes to ensure deficiency does not recur: 3. Residents who had not received or declined the PCV20 or PCV21 pneumococcal vaccines but were eligible were offered and administered, as appropriate based on resident preferences, the PCV21 pneumococcal vaccine. Re-education will be provided to Infection Prevention Nurse, Registered Nurse Managers, Registered Nurse Seniors, MDS Nurses, Quality Director, and Assistant Directors of Nursing on determining up-to-date pneumococcal vaccine status. How corrective action will be monitored: 4. Designee will conduct audits on new admits and current residents not yet eligible to receive the PCV20 or PCV21 pneumococcal vaccine; audits will be conducted monthly for 3 months. Findings will be reported at upcoming Quality Assurance and Performance Improvement (QAPI) meetings monthly for 3 months and then will be reduced/eliminated per the QAPI committee recommendation based on substantial compliance being met. Responsibility:		08/31/2026

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F0883 SS = D	Continued from page 15 each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure that recommended pneumococcal vaccinations were offered and/or that shared clinical decision-making regarding pneumococcal vaccinations occurred, as outlined by the Centers for Disease Control (CDC), to reduce the risk of severe disease for 1 of 5 residents (R11) reviewed for immunizations. Findings include: A CDC Pneumococcal Vaccine Timing for Adults chart dated 3/2025, included a table identifying when each (or all) of the pneumococcal vaccinations should be obtained for adults 50 years and older. The chart indicated that when a resident had received the 13-valent pneumococcal conjugate vaccine (PCV13) at any age and the pneumococcal polysaccharide vaccine 23 (PPSV23) at greater than 65 years, the resident and provider may choose to administer the 20-valent pneumococcal conjugate vaccine (PCV20) or the 21-valent pneumococcal conjugate vaccine (PCV21). R11's quarterly Minimum Data Set (MDS) dated 6/2/26, indicated R11 was 75 years old at the time of assessment, had moderately impaired cognition, and was diagnosed with kidney disease, dementia,			F0883	Continued from page 15 The DON is responsible.		08/31/2026

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F0883 SS = D	Continued from page 16 and diabetes. R11's Resident Vaccinations record dated 10/30/25, indicated R11 had received the PPSV23 on 4/15/20 (was greater than 65 years old) and the PCV13 on 4/11/19. The record indicated R11 had refused “pneumovax dose 1” on 1/10/13. R11's medical record was reviewed and did not indicate shared clinical decision-making had occurred or the PCV20/21 had been offered or administered to R11. During an interview on 7/9/26 at 8:26 a.m., the infection preventionist (IP, a registered nurse) confirmed she had reviewed R11's medical record and stated that R11 should have been offered an additional pneumococcal vaccination. The IP stated she did not see that this had occurred before the survey start. The facility Vaccine for Residents policy dated 4/22/25, indicated vaccinations would be offered to residents according to the current CDC guidance.			F0883			08/31/2026
F0640 SS = A	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts			F0640			08/31/2026

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F0640 SS = A	Continued from page 17 and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i) Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure a Death in Facility Minimum Data Set (MDS) was transmitted to the Centers for Medicare and Medicaid (CMS) in a timely manner for 1 of 1 residents (R238) reviewed for MDS accuracy. Findings include: The CMS Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated 10/2025, identified all applicable MDS along with their completion and transmission dates required. This included, "Death in Facility-tracking record" listed with a completion date of no later than "Death date +7 calendar days" and a transmission date of no later than, "Death Date + 14 calendar days."			F0640			08/31/2026

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F0640 SS = A	Continued from page 18 R238's Census listing, printed 7/7/26, indicated R238 had a status of "Stop Billing" on 1/28/26. R238's progress note dated 1/28/26 at 7:11 a.m., indicated R238 was not feeling well and progressed to increased lethargy. "Resident was transferred via stretcher and departed the unit at 0610 [6:10 a.m.] to [hospital]." R238's emergency room (ER) report dated 1/28/26 at 8:53 a.m., indicated R238 arrived at the ER minimally responsive, was on maximum oxygen therapy, with oxygen saturation in the 80s. "Shortly after arrival patient lost pulses, he lost pulses prior to getting a set of vital signs here in the ER. Given DNR [do not resuscitate] status allowed natural death. Died prior to any laboratory evaluation, EKG, in the emergency department. Time of death was called by me [ER physician] at 6:49 AM." R4's MDS listing, printed 7/7/26, indicated the last assessment completed, submitted, and transmitted to CMS was an Annual assessment on 1/8/26. During interview on 7/7/26 at 2:33 p.m., MDS registered nurse (MDS-RN) verified she was responsible for completing and submitting MDS assessments for some of the residents. MDS-RN confirmed she had not completed or submitted a death in facility assessment for R238. During interview on 7/7/26 at 3:01 p.m., director of nursing (DON) stated would expect MDS assessments completed and submitted timely per the RAI manual. During interview on 7/7/26 at 3:05 p.m., quality director (QD) who oversees MDS stated a death in facility should have been completed and submitted for R238 and would expect staff to follow the timelines in the RAI manual. A policy on MDS assessments was requested but not provided. The facility follows the RAI manual.			F0640			08/31/2026

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K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on July 7, 2026, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, MN Veterans Home Minneapolis, 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			K0000			07/31/2026

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

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K0000 Bldg. 01	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 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. Building Info: Minnesota Veterans Home Minneapolis-Building 19 is a 4-story building without a basement that was determined to be of Type II (222) construction and was built in 2012. The facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and areas open to the corridors that is monitored for automatic fire department notification. The facility is separated from other facilities by 2-hour fire-rated construction. The facility has a capacity of 300 beds and had a census of 298 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:			K0000			07/31/2026
K0311 SS = F Bldg. 01	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure			K0311	K0311 – Vertical Openings – Enclosure How will corrective action be accomplished for this resident: 1. Room 266 and 466 conduits were repaired upon		08/31/2026

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K0311 SS = F Bldg. 01	Continued from page 2 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to seal the ceiling and openings in accordance with the Life Safety Code NFPA 101 - 2012 edition (8.6, 19.3.1.1). These deficient findings could have a widespread impact on the residents within the facility. Findings Include: On 7/7/2026, at 9:30 AM, observations and staff interview revealed that there were 2 conduits in room 466 and 1 conduit in room 266 that were not sealed. Both of these rooms are storage rooms that require all penetrations to be sealed. On 7/7/2026, at 10:30 AM, observations and staff interview revealed that the soiled linen chute in room Soiled Holding Room in the basement was not properly sealed at the deck to prevent smoke or fire from transferring to other floors. An interview with the Maintenance Manager verified these deficient findings at the time of discovery.			K0311	Continued from page 2 notification. The soiled linen chute in the basement of B19 was repaired and sealed at the deck. Other residents potentially affected: 2. For others who may be affected by this practice, the Physical Plant Director or designee will conduct an audit of all other storage rooms in building 19 to verify conduits are sealed appropriately. Measures put in place/systemic changes to ensure deficiency does not recur: 3. Education will be provided by the Physical Plant Director to the General Repair Workers (GRWs) on requirements for maintaining vertical opening enclosures. How corrective action will be monitored: 4. The Physical Plant Director or designee will audit vertical openings via visual inspection monthly for three months to ensure sustained compliance. The results will be presented to the Quality Assurance and Performance Improvement (QAPI) Committee for review and further recommendations. Responsibility: The Physical Plant Director will be responsible for corrections and all audit completion.		08/31/2026
K0353 SS = F Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and			K0353	K0353 – Sprinkler System – Maintenance and Testing How will corrective action be accomplished for this resident: 1. The documentation for sprinkler system maintenance and testing was located and filed in the documentation binder. The date of the testing was 6/19/2026. Other residents potentially affected:		08/31/2026

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K0353 SS = F Bldg. 01	Continued from page 3 readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation, a review of available documentation, and staff interview the facility failed to maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 4.3, 4.4, 4.6, 4.7, 5.1.1.1, 5.2.1.1.1, 5.2.1.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/07/2026 between 9:00 AM and 2:00 PM , it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that the fire sprinkler system has been inspected annually, last inspection date was 6/19/2025. An interview with the Campus Administrator and the Safety Officers verified this deficient finding at the time of discovery.			K0353	Continued from page 3 2. For others who may be affected by this practice and audit of all sprinkler system maintenance and testing was completed to verify documentation was present and timely. The next due date will be entered into the computerized work order system (Archibus). Measures put in place/systemic changes to ensure deficiency does not recur: 3. Education will be provided for GRWs and Administrative Assistant by the Physical Plant Director on the proper maintenance and filing of preventive maintenance documentation. How corrective action will be monitored: 4. All other fire safety documentation will be audited monthly for three months and then every 6 months for a year to ensure no other sprinkler system testing documents are missing. The results will be reported to the QAPI Committee for review and further recommendations. Responsibility: The Physical Plant Director will be responsible for corrections and audit completion.		08/31/2026
K0521 SS = F Bldg. 01	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2			K0521	K0521 – HVAC How will corrective action be accomplished for this resident: 1. The fire damper inspections for Building 19 will be scheduled and completed by the Power plat staff by 8/31/2026. Other residents potentially affected: 2. For others who may be affected by this practice,		08/31/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245620		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BLDG 19 B. WING		(X3) DATE SURVEY COMPLETED 07/07/2026	
NAME OF PROVIDER OR SUPPLIER MN VETERANS HOME-MPLS				STREET ADDRESS, CITY, STATE, ZIP CODE 5101 MINNEHAHA AVENUE SOUTH , MINNEAPOLIS, Minnesota, 55417			
(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
K0521 SS = F Bldg. 01	Continued from page 4 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire dampers per NFPA 101 (2012 edition), Life Safety Code, section 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.2, 6.5.11, and 6.5.12. This deficient finding could have a widespread impact on the residents within the facility. On 07/07/2026 at 11:56 AM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide a damper inspection report for building 19. The last inspection date was 11/15/2021. An interview with the Campus Administrator and the Safety Officers verified this deficient finding at the time of discovery.			K0521	Continued from page 4 blueprints will be reviewed by the Plant Operations Director or designee to verify that all damper locations are accounted for on the Master Inventory List. Measures put in place/systemic changes to ensure deficiency does not recur: 3. Fire damper inspections will be added to the computerized work order system (Archibus) to set automatic reminders for service. Education will be provided for the Maintenance Supervisors by the Physical Plant Director on the requirements for fire damper inspections. How corrective action will be monitored: 4. Audits will be completed annually by the Plant Operations Director or designee to ensure that fire damper inspections will trigger a due date as expected. The results of the audits will be reported to the QAPI Committee for review and further recommendations. Responsibility: The Physical Plant Director will be responsible for corrections and all audit completion.		08/31/2026
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. 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			K0712	K0712 Fire Drills How will corrective action be accomplished for this resident: 1. For others who may be affected by this practice, a comprehensive review of fire drill logs for the past twelve months was completed by the Safety Officer to verify the exact dates and times of the fire drills. Other residents potentially affected: 2. A new Master Fire Drill Schedule will be created by the Safety Officer and placed in the Safety Office mapping out the shifts, dates, and variable times for the year. Measures put in place/systemic changes to ensure deficiency does not recur: 3. Education will be provided to the safety officers by the Physical Plant Director on the requirements for conducting quarterly unannounced off-shift fire drills at varying unpredictable times. How corrective action will be monitored:		08/31/2026

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NAME OF PROVIDER OR SUPPLIER MN VETERANS HOME-MPLS				STREET ADDRESS, CITY, STATE, ZIP CODE 5101 MINNEHAHA AVENUE SOUTH , MINNEAPOLIS, Minnesota, 55417			
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K0712 SS = F Bldg. 01	Continued from page 5 facility. Findings include: On 07/07/2026 at 12:18 PM, it was revealed by a review of available documentation that the fire drills were not conducted during the 2nd and 3rd shift for 1st quarter of 2026. An interview with the Campus Administrator and the Safety Officers verified this deficient finding at the time of discovery.			K0712	Continued from page 5 4. The Plant Operations Director or designee will audit the completed fire drill documentation monthly for six months to ensure sustained compliance. The results will be reported to the QAPI Committee for review and further recommendations. Responsibility: The Physical Plant Director will be responsible for corrections and all audit completion.		08/31/2026
K0761 SS = F Bldg. 01	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, sections 5.2.1 and 5.2.4.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/07/2026 at 11:57 AM, it was revealed by a review of available documentation that at the time of the survey, the inspection report that the facility			K0761	K0761- Maintenance, Inspection, & Testing – Doors How will corrective action be accomplished for this resident: 1. The documentation checklist for maintenance, inspection, and testing of doors was updated to include all eleven inspection points. Other residents potentially affected: 2. For others who may be affected by this practice, eleven-point inspections on doors will be completed by the Physical Plant Director or designee to ensure proper latching, gap compliance, and functional hardware. Any door assemblies or latches found to fail the inspection will be added to the computerized work order system for repair. Measures put in place/systemic changes to ensure deficiency does not recur: 3. Education will be provided to the locksmith and GRWs by the Physical Plant Director on the eleven-point inspection requirements for fire doors. How corrective action will be monitored: 4. Audits of door inspection logs will be completed by the Physical Plant Director or designee monthly for three months and then every six months to verify the inspections were completed accurately and timely. The results will be reported to the QAPI Committee for review and further recommendations. Responsibility: The Physical Plant Director will be responsible for corrections and audit completion.		08/31/2026

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NAME OF PROVIDER OR SUPPLIER MN VETERANS HOME-MPLS				STREET ADDRESS, CITY, STATE, ZIP CODE 5101 MINNEHAHA AVENUE SOUTH , MINNEAPOLIS, Minnesota, 55417			
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K0761 SS = F Bldg. 01	Continued from page 6 provided was missing 8 of the 11 inspection points required for the inspection. An interview with the Campus Administrator and the Safety Officers verified this deficient finding at the time of discovery.			K0761			08/31/2026
K0363 SS = D Bldg. 01	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor walls per NFPA 101 (2012			K0363	K0363 – Corridor Doors How will corrective action be accomplished for this resident: 1. The fire door latches off the elevators in the basement of Building 19 were repaired on 7/08/2026 and now latch properly. Other residents potentially affected: 2. For others who may be affected by this practice, audits were completed on all fire doors to ensure they shut and positively latch into their frames. Measures put in place/systemic changes to ensure deficiency does not recur: 3. Education will be provided to the GRWs in Building 19 by the Physical Plant Director on the requirements for fire/smoke safety rules that corridor doors must remain in good repair and able to latch into their frames. How corrective action will be monitored: 4. Door inspection logs will be audited every three months by the Physical Plant Director for twelve months to verify all eleven inspection points are addressed. The results will be reported to the QAPI Committee for review and further recommendations. Responsibility: The Physical Plant Director will be responsible for corrections and all audit completion.		08/31/2026

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K0363 SS = D Bldg. 01	Continued from page 7 edition), Life Safety Code, sections 7.2.1.7.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 7/7/2026, at 10:30 AM, it was revealed by observation that the fire doors just off the elevator in the basement of Building 19 failed to latch when tested. An interview with the Maintenance Manager verified this deficient finding at the time of discovery.			K0363			08/31/2026
K0920 SS = D 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) assemblies 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 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 70, (2011 edition), National Electrical Code, sections 400-8. This deficient finding could have an isolated impact on the residents within the facility. Findings include:			K0920	K0920 – Electrical Equipment – Power and Extension Cords How will corrective action be accomplished for this resident: 1. The power strip in the therapy room was removed upon notification on 7/07/2026. Other residents potentially affected: 2. For others who may be affected by this practice, audits will be completed by the Physical Plant Director or designee in Building 19 to ensure power strips and extension cords are not being used as a substitute for permanent fixed wiring. Measures put in place/systemic changes to ensure deficiency does not recur: 3. The staff in Building 19 will be re-educated by the Physical Plant Director or designee on the standards prohibiting the use of power strips or extension cords in lieu of permanent fixed wiring or high current appliances. How corrective action will be monitored: 4. Audits of departmental areas will be completed monthly for three months and then quarterly for one year to ensure sustained compliance. The results will be reported to the QAPI Committee for review and further recommendations. Responsibility: The Physical Plant Director will be responsible for corrections and all audit completion.		08/31/2026

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K0920 SS = D Bldg. 01	Continued from page 8 On 7/7/2026, at 9:25 AM, it was revealed by observation that a power strip was being used as an extension cord to power a refrigerator. An interview with the Maintenance Manager verified this deficient finding at the time of discovery.			K0920			08/31/2026
K0923 SS = D Bldg. 01	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			K0923	K0923 - Gas Equipment – Cylinder and Container Storage How will corrective action be accomplished for this resident: 1. In Storage Room 453 the full oxygen tanks were separated from the empty upon notification. Signs designating which areas are for full and empty storage are affixed to the walls. Other residents potentially affected: 2. For others who may be affected by this practice, all other oxygen storage rooms in Building 19 were audited to ensure empty and full cylinders are stored separately. Measures put in place/systemic changes to ensure deficiency does not recur: 3. Education will be provided to the staff who work with oxygen tanks by the Physical Plant Director or designee on the requirements for proper storage, cylinder handling, and empty tank identification/segregation protocols. How corrective action will be monitored: 4. Audits of the oxygen storage rooms will be completed monthly for three months to ensure sustained compliance. The results will be reported to the QAPI Committee for review and further recommendations. Responsibility: The Physical Plant Director will be responsible for corrections and all audit completion.		08/31/2026

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K0923 SS = D Bldg. 01	Continued from page 9 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to construct a storage space that is of non-combustible materials in accordance with NFPA 99, 11.3.1. This deficient finding could have an isolated impact on the residents within the facility. Findings Include: On 7/7/2026, at 9:35 AM, observations and staff interview revealed that the oxygen cylinders within the storage room 453 were not properly separated between empty cylinders and full cylinders. An interview with the Maintenance Manager verified this deficient finding at the time of discovery.			K0923			08/31/2026

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NAME OF PROVIDER OR SUPPLIER MN VETERANS HOME-MPLS				STREET ADDRESS, CITY, STATE, ZIP CODE 5101 MINNEHAHA AVENUE SOUTH , MINNEAPOLIS, Minnesota, 55417			
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K0000 Bldg. 02	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on 07/07/2026, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, MN Veterans Home Minneapolis 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			K0000			07/31/2026

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

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K0000 Bldg. 02	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us 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 Minneapolis Building 21 is a 3-story building without a basement that was determined to be of Type II (222) construction and was built in 2015. The facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and areas open to the corridors that is monitored for automatic fire department notification. The facility is separated from other facilities by 2-hour fire rated construction. The facility has a capacity of 300 beds and had a census of 298 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:			K0000			07/31/2026
K0353 SS = F Bldg. 02	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101			K0353	K0353 – Sprinkler System – Maintenance and Testing How will corrective action be accomplished for this resident:		08/31/2026

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NAME OF PROVIDER OR SUPPLIER MN VETERANS HOME-MPLS				STREET ADDRESS, CITY, STATE, ZIP CODE 5101 MINNEHAHA AVENUE SOUTH , MINNEAPOLIS, Minnesota, 55417			
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K0353 SS = F Bldg. 02	Continued from page 2 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation, a review of available documentation, and staff interview the facility failed to maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 4.3, 4.4, 4.6, 4.7, 5.1.1.1, 5.2.1.1.1, 5.2.1.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/07/2026 between 9:00 AM and 2:00 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that the fire sprinkler system has been inspected annually, last inspection date was 6/19/2025. An interview with the Campus Administrator and the Safety Officers verified this deficient finding at the time of discovery.			K0353	Continued from page 2 1. The documentation for sprinkler system maintenance and testing was located and filed in the documentation binder. The date of the testing was 6/19/2026. Other residents potentially affected: 2. For others who may be affected by this practice and audit of all sprinkler system maintenance and testing was completed to verify documentation was present and timely. The next due date will be entered into the computerized work order system (Archibus). Measures put in place/systemic changes to ensure deficiency does not recur: 3. Education will be provided for GRWs and Administrative Assistant by the Physical Plant Director on the proper maintenance and filing of preventive maintenance documentation. How corrective action will be monitored: 4. All other fire safety documentation will be audited monthly for three months and then every 6 months for a year to ensure no other sprinkler system testing documents are missing. The results will be reported to the QAPI Committee for review and further recommendations. Responsibility: The Physical Plant Director will be responsible for corrections and audit completion.		08/31/2026
K0521 SS = F Bldg. 02	HVAC CFR(s): NFPA 101			K0521	K0521 – HVAC How will corrective action be accomplished for this resident:		08/31/2026

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NAME OF PROVIDER OR SUPPLIER MN VETERANS HOME-MPLS				STREET ADDRESS, CITY, STATE, ZIP CODE 5101 MINNEHAHA AVENUE SOUTH , MINNEAPOLIS, Minnesota, 55417			
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K0521 SS = F Bldg. 02	Continued from page 3 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire dampers per NFPA 101 (2012 edition), Life Safety Code, section 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.2, 6.5.11, and 6.5.12. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/07/2026 at 11:56 AM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide a damper inspection report for building 21. The last inspection date was 11/15/2021. An interview with the Campus Administrator and the Safety Officers verified this deficient finding at the time of discovery.			K0521	Continued from page 3 1. The fire damper inspections for Building 21 will be scheduled and completed by the Power Plant Staff by 8/31/2026. Other residents potentially affected: 2. For others who may be affected by this practice, blueprints will be reviewed by the Plant Operations Director or designee to verify that all damper locations are accounted for on the Master Inventory List. Measures put in place/systemic changes to ensure deficiency does not recur: 3. Fire damper inspections will be added to the computerized work order system (Archibus) to set automatic reminders for service. Education will be provided for the Maintenance Supervisors by the Physical Plant Director on the requirements for fire damper inspections. How corrective action will be monitored: 4. Audits will be completed annually by the Plant Operations Director or designee to ensure that fire damper inspections will trigger a due date as expected. The results of the audits will be reported to the QAPI Committee for review and further recommendations. Responsibility: The Physical Plant Director will be responsible for corrections and audit completion.		08/31/2026
K0712 SS = F Bldg. 02	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. 19.7.1.4 through 19.7.1.7			K0712	K0712 Fire Drills How will corrective action be accomplished for this resident: 1. For others who may be affected by this practice, a comprehensive review of fire drill logs for the past twelve months was completed by the Safety Officer to verify the exact dates and times of the fire drills. Other residents potentially affected: 2. A new Master Fire Drill Schedule will be created by the Safety Officer and placed in the Safety Office mapping out the shifts, dates, and variable times for the year. Measures put in place/systemic changes to ensure		08/31/2026

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K0712 SS = F Bldg. 02	Continued from page 4 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 07/07/2026 at 12:18 PM, it was revealed by a review of available documentation that the fire drills were not conducted during the 2nd and 3rd shift for 1st quarter of 2026. An interview with the Campus Administrator and the Safety Officers verified this deficient finding at the time of discovery.			K0712	Continued from page 4 deficiency does not recur: 3. Education will be provided to the safety officers by the Physical Plant Director on the requirements for conducting quarterly unannounced off-shift fire drills at varying unpredictable times. How corrective action will be monitored: 4. The Plant Operations Director or designee will audit the completed fire drill documentation monthly for six months to ensure sustained compliance. The results will be reported to the QAPI Committee for review and further recommendations. Responsibility: The Physical Plant Director will be responsible for corrections and all audit completion.		08/31/2026
K0761 SS = F Bldg. 02	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, sections 5.2.1 and 5.2.4.2. This deficient finding could have a			K0761	K0761- Maintenance, Inspection, & Testing – Doors How will corrective action be accomplished for this resident: 1. The documentation checklist for maintenance, inspection, and testing of doors was updated to include all eleven inspection points. Other residents potentially affected: 2. For others who may be affected by this practice, eleven-point inspections on doors will be completed by the Physical Plant Director or designee to ensure proper latching, gap compliance, and functional hardware. Any door assemblies or latches found to fail the inspection will be added to the computerized work order system for repair. Measures put in place/systemic changes to ensure deficiency does not recur: 3. Education will be provided to the locksmith and GRWs by the Physical Plant Director on the eleven-point inspection requirements for fire doors. How corrective action will be monitored: 4. Audits of door inspection logs will be completed by the Physical Plant Director or designee monthly for three months and then every six months to verify the inspections were completed accurately and timely. The results will be reported to the QAPI Committee for review and further recommendations.		08/31/2026

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K0761 SS = F Bldg. 02	Continued from page 5 widespread impact on the residents within the facility. Findings include: On 07/07/2026 at 11:57 AM, it was revealed by a review of available documentation that at the time of the survey, the inspection report that the facility provided was missing 8 of the 11 inspection points required for the inspection. An interview with the Campus Administrator and the Safety Officers verified this deficient finding at the time of discovery.			K0761	Continued from page 5 Responsibility: The Physical Plant Director will be responsible for corrections and audit completion.		08/31/2026
K0920 SS = D Bldg. 02	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) assemblies 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 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 70, (2011 edition), National Electrical Code, sections 400-8. This deficient finding could have an isolated impact on the residents within the facility. Findings Include:			K0920	K0920 – Electrical Equipment – Power and Extension Cords How will corrective action be accomplished for this resident: 1. The power strip in the therapy room was removed upon notification on 7/07/2026. Other residents potentially affected: 2. For others who may be affected by this practice, audits will be completed by the Physical Plant Director or designee in Building 21 to ensure power strips and extension cords are not being used as a substitute for permanent fixed wiring. Measures put in place/systemic changes to ensure deficiency does not recur: 3. The staff in Building 21 will be re-educated by the Physical Plant Director or designee on the standards prohibiting the use of power strips or extension cords in lieu of permanent fixed wiring or high current appliances. How corrective action will be monitored: 4. Audits of departmental areas will be completed monthly for three months and then quarterly for one year to ensure sustained compliance. The results will be reported to the QAPI Committee for review and further recommendations. Responsibility: The Physical Plant Director will be responsible for corrections and all audit completion.		08/31/2026

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K0920 SS = D Bldg. 02	Continued from page 6 On 07/07/2026, at 10:10 AM, it was revealed by observation that in the nurses corridor on the 2nd floor, a microwave and 2 refrigerators and coffee pot were plugged into a power strip. An interview with the Assistant Administrator and the Lead Plant Engineer verified this deficient finding at the time of discovery.			K0920			08/31/2026

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K0000 Bldg. 04	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on July 7th, 2026. At the time of this survey, Minnesota Veterans Home Minneapolis- Building 22 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 18 New Health Care and the 2012 edition of NFPA 99, the 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			K0000			07/31/2026

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: 245620		(X2) MULTIPLE CONSTRUCTION A. BUILDING 04 - BUILDING 2... B. WING		(X3) DATE SURVEY COMPLETED 07/07/2026	
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K0000 Bldg. 04	Continued from page 1 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us 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 Minneapolis Building 22 is a 5-story building without a basement that was determined to be of Type II (222) construction and was built in 2018. The facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and areas open to the corridors that is monitored for automatic fire department notification. The facility is separated from other facilities by 2-hour fire-rated construction. The facility has a capacity of 300 (all three buildings) beds and had a census of 298 (all three buildings) at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:			K0000			07/31/2026

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K0353 SS = F Bldg. 04	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation, a review of available documentation, and staff interview the facility failed to maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 4.3, 4.4, 4.6, 4.7, 5.1.1.1, 5.2.1.1.1, 5.2.1.1.2. This deficient finding could have a widespread impact on the residents within the facility Findings include: On 07/07/2026 between 9:00 AM and 2:00 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that the fire sprinkler system has been inspected annually, last inspection date was 6/19/2025. An interview with the Campus Administrator and the Safety Officers verified this deficient finding at the time of discovery.			K0353	K0353 – Sprinkler System – Maintenance and Testing How will corrective action be accomplished for this resident: 1. The documentation for sprinkler system maintenance and testing was located and filed in the documentation binder. The date of the testing was 6/19/2026. Other residents potentially affected: 2. For others who may be affected by this practice and audit of all sprinkler system maintenance and testing was completed to verify documentation was present and timely. The next due date will be entered into the computerized work order system (Archibus). Measures put in place/systemic changes to ensure deficiency does not recur: 3. Education will be provided for GRWs and Administrative Assistant by the Physical Plant Director on the proper maintenance and filing of preventive maintenance documentation. How corrective action will be monitored: 4. All other fire safety documentation will be audited monthly for three months and then every 6 months for a year to ensure no other sprinkler system testing documents are missing. The results will be reported to the QAPI Committee for review and further recommendations. Responsibility: The Physical Plant Director will be responsible for corrections and audit completion.		08/31/2026

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K0712 SS = F Bldg. 04	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. 18.7.1.4 through 18.7.1.7 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 per NFPA 101 (2012 edition), Life Safety Code, sections 18.7.1.4, 18.7.1.6, 18.7.1.7, 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 07/07/2026 at 12:18 PM, it was revealed by a review of available documentation that the fire drills were not conducted during the 2nd and 3rd shift for 1st quarter of 2026. An interview with the Campus Administrator and the Safety Officers verified this deficient finding at the time of discovery.			K0712	K0712 Fire Drills How will corrective action be accomplished for this resident: 1. For others who may be affected by this practice, a comprehensive review of fire drill logs for the past twelve months was completed by the Safety Officer to verify the exact dates and times of the fire drills. Other residents potentially affected: 2. A new Master Fire Drill Schedule will be created by the Safety Officer and placed in the Safety Office mapping out the shifts, dates, and variable times for the year. Measures put in place/systemic changes to ensure deficiency does not recur: 3. Education will be provided to the safety officers by the Physical Plant Director on the requirements for conducting quarterly unannounced off-shift fire drills at varying unpredictable times. How corrective action will be monitored: 4. The Plant Operations Director or designee will audit the completed fire drill documentation monthly for six months to ensure sustained compliance. The results will be reported to the QAPI Committee for review and further recommendations. Responsibility: The Physical Plant Director will be responsible for corrections and all audit completion.		08/31/2026
K0761 SS = F Bldg. 04	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability.			K0761	K0761- Maintenance, Inspection, & Testing – Doors How will corrective action be accomplished for this resident: 1. The documentation checklist for maintenance, inspection, and testing of doors was updated to include all eleven inspection points. Other residents potentially affected: 2. For others who may be affected by this practice, eleven-point inspections on doors will be completed by the Physical Plant Director or designee to ensure proper latching, gap compliance, and functional hardware. Any door assemblies or latches found to fail the inspection will be added to the computerized work order system for repair.		08/31/2026

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K0761 SS = F Bldg. 04	Continued from page 4 Written records of inspection and testing are maintained and are available for review. 18.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (NFPA 80) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire doors per NFPA 101 (2012 edition), Life Safety Code section 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, sections 5.2.1 and 5.2.4.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/07/2026 at 11:57 AM, it was revealed by a review of available documentation that at the time of the survey, the inspection report that the facility provided was missing 8 of the 11 inspection points required for the inspection. An interview with the Campus Administrator and the Safety Officers verified this deficient finding at the time of discovery.			K0761	Continued from page 4 Measures put in place/systemic changes to ensure deficiency does not recur: 3. Education will be provided to the locksmith and GRWs by the Physical Plant Director on the eleven-point inspection requirements for fire doors. How corrective action will be monitored: 4. Audits of door inspection logs will be completed by the Physical Plant Director or designee monthly for three months and then every six months to verify the inspections were completed accurately and timely. The results will be reported to the QAPI Committee for review and further recommendations. Responsibility: The Physical Plant Director will be responsible for corrections and audit completion.		08/31/2026
K0293 SS = E Bldg. 04	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 NEW Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain egress signage per NFPA 101 (2012 edition), Life Safety Code, sections 18.2.10.1, 7.10.8.3.1, and 7.10.8.3.2. This deficient finding could have a patterned impact on the residents within the facility. Findings include:			K0293	K0293 – Exit Signage How will corrective action be accomplished for this resident: 1. “Not an Exit” signs will be placed at Door 61, 63, and 64. Other residents potentially affected: 2. For others who may be affected by this practice, an audit of Building 22 doors will be completed by the Physical Plant Director or designee to verify that all doors have appropriate signage. Measures put in place/systemic changes to ensure deficiency does not recur: 3. Education will be provided for the GRWs by the Physical Plant Director on the requirements for doors that could be mistaken for an exit and the required signage. How corrective action will be monitored:		08/31/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245620		(X2) MULTIPLE CONSTRUCTION A. BUILDING 04 - BUILDING 2... B. WING		(X3) DATE SURVEY COMPLETED 07/07/2026	
NAME OF PROVIDER OR SUPPLIER MN VETERANS HOME-MPLS				STREET ADDRESS, CITY, STATE, ZIP CODE 5101 MINNEHAHA AVENUE SOUTH , MINNEAPOLIS, Minnesota, 55417			
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K0293 SS = E Bldg. 04	Continued from page 5 On 7/7/2026 at 11:02 AM, it was revealed by observation that doors 61, 63, and 64 lead to a courtyard that could be mistaken for an exit; however, the doors were not marked with "No Exit" signs. An interview with the Building Utilities Mechanic verified this deficient finding at the time of discovery.			K0293	Continued from page 5 4. The Physical Plant Director will audit the door signs quarterly for one year to ensure sustained compliance. The results will be reported to the QAPI Committee for review and further recommendations. Responsibility: The Physical Plant Director will be responsible for corrections and audit completion.		08/31/2026
K0311 SS = E Bldg. 04	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 NEW Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 2 hours connecting four or more stories. (1 hour for single story building and buildings up to three stories in height.) An atrium may be used in accordance with 8.6.7. 18.3.1 through 18.3.1.5 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain vertical openings per NFPA 101 (2012 edition), Life Safety Code, sections 18.3.1, 8.6.2, 8.6.4, and 18.5.4.1. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 7/7/2026 at 10:19 AM, it was revealed by observation that the fourth-floor trash chute door was found unlatched because the latch was sticking and did not fully extend after operation. 2. On 7/7/2026 at 10:47 AM, it was revealed by observation that the second-floor trash chute door was found unlatched because the latch was sticking and did not fully extend after operation. An interview with the Building Utilities Mechanic verified these deficient findings at the time of			K0311	K0311 – Vertical Openings – Enclosure How will corrective action be accomplished for this resident: 1. The second and fourth floor trash room latches were repaired upon notification on 7/08/2026. Other residents potentially affected: 2. For others who may be affected by this practice, the Physical Plant Director or designee will conduct an audit of all other trash room door latches to ensure they are in good repair and functional. Measures put in place/systemic changes to ensure deficiency does not recur: 3. Education will be provided by the Physical Plant Director to the General Repair Workers (GRWs) on requirements for maintaining vertical opening enclosures. How corrective action will be monitored: 4. The Physical Plant Director, or designee will audit vertical openings via visual inspection monthly for three months to ensure sustained compliance. The results will be presented to the Quality Assurance and Performance Improvement (QAPI) Committee for review and further recommendations. Responsibility: The Physical Plant Director will be responsible for corrections and audit completion.		08/31/2026

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K0311 SS = E Bldg. 04	Continued from page 6 discovery.			K0311			08/31/2026
K0321 SS = E Bldg. 04	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure 2012 New Hazardous areas are protected in accordance with 18.3.2.1. The areas shall be enclosed with a 1-hour fire-rated barrier, with a 3/4-hour fire-rated door without windows (in accordance with 8.7.1.1). Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8. Hazardous areas are protected by a sprinkler system in accordance with 9.7, 18.3.2.1, and 8.4. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 18.3.2.1, 7.2.1.8, 8.4, 8.7, 9.7 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 and less than 100 square feet) g. Combustible Storage Rooms/Spaces (over 100 square feet) h. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous rooms per NFPA 101			K0321	K0321 – Hazardous Areas / Fire Barrier How will corrective action be accomplished for this resident: 1. Maintenance adjusted the hydraulic door closer, lubricated the latch bolt, and aligned the strike plate so the door now closes and positively latches into the door frame. Other residents potentially affected: 2. For others who may be affected by this practice, maintenance inspected all other fire rated doors and self-closing doors in hazardous areas of Building 22. Any findings were placed in the computerized work order system for repair. Measures put in place/systemic changes to ensure deficiency does not recur: 3. Education will be provided to the GRWs by the Physical Plant Director or designee on the requirements for fire and smoke barrier door operations. How corrective action will be monitored: 4. An audit will be completed monthly for three months by the Physical Plant Director to verify that all doors are in proper working order. The results will be reported to the QAPI Committee for review and further recommendations. Responsibility: The Physical Plant Director will be responsible for corrections and audit completion.		08/31/2026

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K0321 SS = E Bldg. 04	Continued from page 7 (2012 edition), Life Safety Code, sections 18.3.2.1, 8.7.1.3, and 7.2.1.8.1. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 7/7/2026 at 9:52 AM, it was revealed by observation that the door to Soiled Utility Room 526 on the fifth floor did not fully close and latch when testing the self-closing device. An interview with the Building Utilities Mechanic verified this deficient finding at the time of discovery.			K0321			08/31/2026
K0355 SS = E Bldg. 04	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain fire extinguishers per NFPA 101 (2012 edition), Life Safety Code sections 18.3.5.12 and 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, sections 6.1.3.3.1, and 7.2.1.2. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 7/7/2026 at 9:38 AM, it was revealed by observation that both fire extinguishers in the penthouse mechanical room were missing the monthly inspections for February, March and April 2026. 2. On 7/7/2026 at 9:59 AM, it was revealed by observation that the fire extinguisher on the fifth floor near spa 536 was blocked by a walker. 3. On 7/7/2026 at 10:14 AM, it was revealed by			K0355	K0355 – Portable Fire Extinguishers How will corrective action be accomplished for this resident: 1. The following fire extinguishers were inspected, signed and dated in Building 22: Two extinguishers in the penthouse mechanical room, Fifth Floor near the spa, the walker was removed from the area, near the Spa Room 409, near the Clean Linen Room 424, near the Spa Room 309, near the Spa Room 236, near the Clean Utility Room 127, near the Mechanical Room 025, near the Elevator Equipment Room 012, and near the Elevator Equipment Room 001. Other residents potentially affected: 2. For others who may be affected by this practice, an audit of all fire extinguishers in Building 22 was completed by the Physical Plant Director or designee to ensure that they were all current on all monthly initial/date entries. Measures put in place/systemic changes to ensure deficiency does not recur: 3. Education will be provided to the GRWs by the Physical Plant Director or designee on the requirements on monthly visual inspections of fire extinguishers. How corrective action will be monitored: 4. Audits of the computerized work order system will be completed monthly for six months by the physical plant director to verify the inspections were		08/31/2026

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K0355 SS = E Bldg. 04	Continued from page 8 observation that the fire extinguisher near spa 409 was missing the monthly inspection for January 2026. 4. On 7/7/2026 at 10:16 AM, it was revealed by observation that the fire extinguisher near clean linen 424 was missing the monthly inspection for January 2026. 5. On 7/7/2026 at 10:29 AM, it was revealed by observation that the fire extinguisher near spa 309 was missing the monthly inspection for February 2026. 6. On 7/7/2026 at 10:49 AM, it was revealed by observation that the fire extinguisher near spa 236 was missing the monthly inspection for May 2026. 7. On 7/7/2026 at 11:04 AM, it was revealed by observation that the fire extinguisher near Clean Utility 127 was missing the monthly inspection for February and March of 2026. 8. On 7/7/2026 at 11:16 AM, it was revealed by observation that the fire extinguisher in mechanical room 025 was missing the monthly inspection for February, March, and June of 2026. 9. On 7/7/2026 at 11:18 AM, it was revealed by observation that the fire extinguisher in elevator equipment room 012 was missing the monthly inspection for February, March, and June of 2026. 10. On 7/7/2026 at 11:20 AM, it was revealed by observation that the fire extinguisher in elevator equipment room 001 was missing the monthly inspection for February, March, and June of 2026 An interview with the Building Utilities Mechanic verified these deficient findings at the time of discovery.			K0355	Continued from page 8 completed. The results will be reported to the QAPI Committee for review and further recommendations. Responsibility: The Physical Plant Director will be responsible for corrections and audit completion.		08/31/2026
K0363 SS = E Bldg. 04	Corridor - Doors CFR(s): NFPA 101 Doors protecting corridor openings shall be constructed to resist the passage of smoke. Corridor			K0363	K0363 – Corridor Doors How will corrective action be accomplished for this resident: 1. The trash can was removed from the doorway of		08/31/2026

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K0363 SS = E Bldg. 04	Continued from page 9 doors and doors to rooms containing flammable or combustible materials have self-latching and positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 18.3.6.3.6 are permitted. 18.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatic closing devices, etc. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 18.3.6.3.10. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 7/7/2026 at 10:50 AM, it was revealed by observation that the door to resident room 256 was propped open with a trash can. An interview with the Building Utilities Mechanic verified this deficient finding at the time of discovery.			K0363	Continued from page 9 Room 256 upon notification. How will corrective action be accomplished for this resident: 2. For others who may be affected by this practice, audits were completed to ensure no other doorways were blocked by equipment or trash cans. Measures put in place/systemic changes to ensure deficiency does not recur: 3. Education will be provided to the staff in Building 22 by the Physical Plant Director or designee on the requirements for fire/smoke safety rules that corridor doors must remain unblocked and with a clear thoroughfare. How corrective action will be monitored: 4. Doorway audit logs will be audited every three months by the Physical Plant Director for twelve months to verify all fire doors are not blocked. The results will be reported to the QAPI Committee for review and further recommendations. Responsibility: The Physical Plant Director will be responsible for corrections and all audit completion.		08/31/2026
K0372 SS = E Bldg. 04	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 NEW Smoke barriers shall be constructed to provide at			K0372	K0372 – Subdivision of Building Spaces – Smoke Barrier Construction How will corrective action be accomplished for this resident: An approved fire-rated caulk was used by maintenance to seal the following areas; Laundry Room 407 around conduit, Laundry Room 434 around low voltage wiring, Laundry Room 207		08/31/2026

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K0372 SS = E Bldg. 04	Continued from page 10 least a one hour fire resistance rating and constructed in accordance with 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations of fully ducted HVAC systems. 18.3.7.3, 18.3.7.4, 18.3.7.5, 8.3 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 smoke barriers per NFPA 101 (2012 edition), Life Safety Code, sections 18.3.7.1, 18.3.7.3, 8.5.2.2, and 8.5.6.2. This deficient finding could have a patterned impact on the residents within the facility. Findings include: 1. On 7/7/2026 at 10:07 AM, it was revealed by observation that there were two penetrations in the smoke barrier near Laundry Room 407 were not properly sealed around the electrical conduit. 2. On 7/7/2026 at 10:10 AM, it was revealed by observation that there was an electrical conduit containing blue low-voltage wiring was not properly sealed where it penetrated the smoke barrier near Laundry Room 434. 3. On 7/7/2026 at 10:40 AM, it was revealed by observation that the smoke barrier near Laundry Room 207 had fire caulking that was beginning to separate from the wall, causing the smoke barrier wall to not be fully sealed. 4. On 7/7/2026 at 10:56 AM, it was revealed by observation that the smoke barrier near Mechanical Room 138 was not properly sealed because an electrical junction box was open and unsealed. An interview with the Building Utilities Mechanic verified this deficient finding at the time of discovery.			K0372	Continued from page 10 separated caulking, and Mechanical Room 138 junction box area. Other residents potentially affected: For others who may be affected by this practice, an audit was completed for all smoke barrier walls, attic spaces, and above-ceiling conduit/cable pass-throughs to identify any other unsealed penetrations. Any newly identified gaps will be sealed by maintenance. Measures put in place/systemic changes to ensure deficiency does not recur: Education will be provided to the GRWs by the Physical Plant Director or designee on the requirement to maintain integrity of smoke and fire barrier. How corrective action will be monitored: The Physical Plant Director will complete visual inspection audits of smoke and fire barriers quarterly for one year to ensure sustained compliance. The results will be reported to the QAPI Committee for review and further recommendations. Responsibility: The Physical Plant Director will be responsible for corrections and audit completion.		08/31/2026



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 8, 2026

Administrator
MN VETERANS HOME-MPLS
5101 MINNEHAHA AVENUE SOUTH
MINNEAPOLIS, MN 55417

RE: CCN: 245620

Cycle Start Date: September 2, 2026

Dear Administrator:

On September 2, 2026, the Minnesota Departments 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.

A handwritten signature in black ink, appearing to read 'M. Poepping', with a stylized, cursive script.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 8, 2026

Administrator
MN VETERANS HOME-MPLS
5101 MINNEHAHA AVENUE SOUTH
MINNEAPOLIS, MN 55417

Re: Reinspection Results
Event ID: 235CCC-H2

Dear Administrator:

On September 2, 2026 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 9, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping', with a stylized, cursive script.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us