Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 12, 2024

Administrator
MN Veterans Home - Luverne
1300 North Kniss Avenue
Luverne, MN 56156

RE: CCN: 245631
Cycle Start Date: December 4, 2024

Dear Administrator:

On December 4, 2024, 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:

Nicole Dahl, RN, Regional Operations Supervisor
Marshall District Office
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

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 March 4, 2025 (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 June 4, 2025 (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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245631	A. BUILDING _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME - LUVERNE	1300 NORTH KNISS AVENUE LUVERNE, MN 56156

(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
E 000	Initial Comments On 12/2/24 through 12/4/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 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.	E 000		
F 000	INITIAL COMMENTS On 12/2/24 through 12/4/24, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 755 SS=F	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services	F 755		12/27/24

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

Electronically Signed — 12/18/2024

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 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.

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F 755	Continued From page 1 The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure 1 of 1 narcotic emergency kit (E-Kit) was replaced prior to the pharmacy date of expiration documented on top of kit. This had the potential to affect all residents. Findings include:	F 755	F755 Pharmacy Procedures 1. The narcotic emergency kit was replaced on 12/5/24. 2. All Resident s have the potential to be affected. 3. The narcotic EKit will be examined at each shift change to ensure the narcotic	

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F 755	Continued From page 2 Observation on 12/3/24 at 4:40 p.m. with registered nurse (RN)-A of the Green Wing medication room, identified the narcotic E-Kit, with a red numbered tag lock, and a bright green pharmacy sticker which listed the expiration date of 10/29/24. The label directed to notify pharmacy 7 days prior to this date for replacement. Interview on 12/3/24 at 4:42 p.m. with RN-A reported the narcotic E-Kit was checked during each shift narcotic count, but there was no individual log signed that the E-kit had been checked and verified the medication had not expired. She reported the only documentation that the count was accurate was in the narcotic book that was signed by both the on-coming and off-going staff members. RN-A reported the expiration sticker should have been noted and the pharmacy notified of the need to provide a new E-Kit as directed on the sticker dated 10/29/24. Observation and interview with the director of nursing (DON) identified the narcotic E-Kit contained two outdated medications: Morphine Sulfate 20 milligrams/milliliter (mg/ml) (pain medication) 15 ml bottle with the pharmacy label identifying an expiration date of 4/30/24, Lorazepam 1 mg tablets (6) with expiration dates of 10/29/24 (anti-anxiety medication). The DON reported her expectation was for staff to observe the label on the outside of the E-Kit when it was checked with each narcotic count. She was unaware of how the label noting an expiration date of 10/29/24 was not caught between the multiple shift narcotic counts that had taken place between 10/22/24 and 12/3/24. The DON reported the consultant pharmacist was in the facility monthly, but she was not aware of how	F 755	count is correct. An additional column will be added to the narcotic book for staff to note the expiration date for the EKit. When the EKit is within 7 days of expiration date, the nursing staff will notify the pharmacy by communicating the expiration date and ordering a new EKit. The pharmacy consultant will also monitor the EKit monthly at the routine site visit as an additional check. The licensed nurses will be educated on this process by 12/27/24. 4. Audits will be conducted weekly for 4 weeks and monthly for 3 months to ensure compliance by the Director of Nursing or Designee. Audit results will be reported to the Quality Assurance Committee for review at the next Quality Assurance meeting. 5. 12/27/24	

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F 755	Continued From page 3 often they checked the E-Kits but there should be a system of the pharmacy being aware of when the E-Kit needed to be replaced. Interview on 12/03/24, at 4:51 p.m. with the consultant pharmacist reported she performed medication review at the facility monthly, but she had not checked the E-Kits and reported they should have been checked for expiration dates. Interview on 12/04/24 at 8:32 a.m. with the Minnesota Veterans Home Pharmacy manager reported the pharmacy supplied the E- Kits. He would expect the consultant pharmacist to monitor the E-Kits for outdates in addition to the nursing staff while performing narcotic counts on a per shift basis. He reported the pharmacy should have been notified 7 days prior to the expiration date to allow time for a replacement kit to be provided to the facility. Review of the 6/22/23 Minnesota Department of Veterans Affairs Medication Storage and Security policy identified medication storage areas were to be routinely monitored by nursing staff to prevent use of outdated or discontinued medications. Review of the 6/29/23 Operating procedure for pharmaceutical services identified both the registered pharmacist and the consulting pharmacist who provided monthly in facility medication reviews were responsible for the provision of pharmacy services. An E-Kit was supplied by the central pharmacy and scheduled II-IV medications were to be reconciled with each shift change. The consulting pharmacist was to review the E-Kit during the monthly review.	F 755		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 12/3/2024. At the time of this survey, MN Veterans Home-Luverne 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.	K 000		

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

Electronically Signed | 12/18/2024

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 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.

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us 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 in Luverne was constructed as follows: The original building was constructed in 1990, it is one story in height, has a partial basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; The 2009 Addition is one story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction. The 2011 Addition is a one story in height has no basement, is fully fire sprinkler protected and was	K 000		

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K 000	Continued From page 2 determined to be of Type II(111) construction. The facility has a capacity of 64 beds and had a census of 62 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain that the means of egress is continuously maintained free of all obstructions to full use in case of emergency, per NFPA 101 (2012 edition), Life Safety Code or NFPA 99 (2012 edition), Health Care Facilities Code, sections 19.2.1, and 7.1.10.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 12/3/2024 at 10:15AM, it was revealed by observation that that a wooden clamp had been placed on the Green Wing emergency exit door and door frame to prevent the door from being blown open by the wind. An interview with the Safety Officer verified this	K 211	K211 Means of Egress 1. The wooden clamp was immediately removed from the emergency exit door on 12/3/24. 2. All Residents have the potential to be affected. 3. The administrator and Safety Officer reviewed the policy for Means of Egress in the Life Safety Code and the Health Care Code on 12/16/24. All staff will be educated on this policy and on ensuring emergency exits are obstruction free at all times by 12/27/24. 4. Audits will be conducted daily for 4 weeks and then weekly for 4 weeks by the Safety Officer or Designee. Audit results will be reported to the Quality Assurance Committee for review at the next Quality	12/27/24

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K 211	Continued From page 3 deficient finding at the time of discovery.	K 211	Assurance meeting. 5. 12/27/24	
K 923 SS=D	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	K 923		12/27/24

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K 923	Continued From page 4 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) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper storage of oxygen cylinders per NFPA 99 (2012 edition), Health Care Facilities Code, sections11.3.1, 11.3.2, 11.3.3, 11.3.4, and 11.6.5. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 12/3/2024 at 10:30AM, it was revealed by observation that oxygen cylinders were being stored in both of the Nurse Report Rooms without being identified by full or empty signs. An interview with the Safety Officer verified these deficient findings at the time of discovery.	K 923	K923 Gas Equipment Storage 1. The signs identifying full or empty for oxygen cylinders at both nurse report rooms were installed on 12/17/24. 2. All Residents have the potential to be affected. 3. The administrator and Safety Officer reviewed the policy for gas equipment-Cylinder and Container Storage on 12/16/24. Nursing staff will be educated on properly storing oxygen cylinders under the correct signage by 12/27/24. 4. Audits will be conducted weekly for 4 weeks and monthly for 3 months to ensure compliance by the Administrator or Designee. Audit results will be reported to the Quality Assurance Committee for review at the next Quality Assurance meeting. 5. 12/27/24	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 15, 2025

Administrator
MN Veterans Home - Luverne
1300 North Kniss Avenue
Luverne, MN 56156

RE: CCN: 245631
Cycle Start Date: December 4, 2024

Dear Administrator:

On January 13, 2025, 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.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
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Minnesota Department of Health
Health Regulation Division
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