Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 17, 2023

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

RE: CCN: 245631
Cycle Start Date: October 4, 2023

Dear Administrator:

On October 4, 2023, 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), 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 Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
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 January 4, 2024 (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 April 4, 2024 (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) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

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
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
travis.ahrens@state.mn.us
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

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October 17, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: 9BCW11

Dear Administrator:

The above facility was surveyed on October 2, 2023 through October 4, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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:

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
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

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.

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 _____	C 10/04/2023

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 10/2/23 through 10/4/23, 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.	E 000		
F 000	INITIAL COMMENTS On 10/2/23 through 10/4/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H56315902C (MN91206), H56315903C (MN94464), H56315904C (MN94472), H56315905 (MN94470), H56915906C (MN94465), HL004115907C (MN91468), and H56315909C (MN94474). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/24/2023

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 000	Continued From page 1 regulations has been attained.	F 000		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the county (designated State Mental Health Authority) for 1 of 1 resident (R49) with new onset of mental illness. Findings include: R49's 4/5/23, Initial Pre-Admission Screening (PAS), did not identify a diagnosis of mental illness and did not indicate the need for a Level II PASARR to be completed. R49's 4/12/23, admission Minimum Data Set	F 644	F644 □ Coordination of PASARR and Assessments 1. A level II OBRA screening request was made to the local contact agency on 10/3/2023 for resident R49. By 11/30/2023 all residents will be audited to determine if a level II OBRA screening is needed for any resident and if needed, ensure the referral for a level II OBRA screening is made to the local contact agency. 2. All Residents have the potential to be affected. 3. Administrator and Social Worker	11/30/23

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F 644	Continued From page 2 (MDS) assessment identified R49 was admitted on April 2023. R49's cognition was intact with diagnoses of anxiety, depression and Post Traumatic Stress Disorder. R49 had disorganized thinking, felt tired and having little energy, feeling bad about himself or feeling like he let his family down, and had trouble concentrating during the 14-day assessment period. Additionally, R49's 7/13/23, quarterly MDS identified R49 continued to have disorganized thinking, had little interest or pleasure in doing things, feeling down, depressed or hopeless, thought he would be better off dead, or of hurting himself in someway during the 14-day assessment period. R49's 4/12/23, progress note identified social services had assessed R49 following a conversation he had with the therapist that day. The mental help provider had been contacted and R49 had a crisis assessment completed to determine a need for crisis counseling or if a session could wait until Monday. R49's 4/17/23, Mental Health Consult note identified R49 had been seen and had a history of working with a psychiatrist in the past related to suicidal thoughts. R49 plan to continue to work with the Mental Health provider here at the facility. R49's undated, Medical Diagnoses identified upon admission he had diagnoses of anxiety, depression, obsessive-compulsive personality disorder. On 5/11/23 a new diagnosis of suicidal ideation was noted. Interview on 10/3/23 at 11:38 a.m., with licensed social worker (LSW)-A identified if a resident was to receive a new mental health diagnosis, she	F 644	reviewed the policy titled Preadmission Screening and Annual Resident Review (PASARR) on 10/18/2023. On 10/18/2023 Administrator provided training to Social Worker regarding the Screening and Annual Resident Review (PASARR) policy and expectations for timely completion of level II PASARRs in coordination with the local contact agency. 4. Audits will be conducted weekly for 4 weeks by the Social Worker or Designee for 5 randomly selected residents to determine if a level II PASARR is needed for the resident and if so, ensure the level II PASARR was completed. Audit results will be reported to the Quality Assurance Committee for review at the next Quality Assurance meeting. 5. 11/30/2023	

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F 644	Continued From page 3 would contact Senior Linkage to see if a Level II Preadmission Screening and Annual Resident Review (PASARR) would need to be completed. The LSW noted R49's suicidal statements were to be taken seriously, and the facility completed a suicidal risk assessment and made a referral to a mental health provider. She confirmed R49 had received a new diagnosis of suicidal ideation on 5/11/23, and she had not notified senior linkage of the new diagnosis for a Level II screening for additional services that may be needed. Review of 1/20/23, (PASARR) Policy identified a mental disorder was often associated with significant distress or disability. A resident with a new possible serious mental disorder or related condition should be referred for a level II screening to Senior Linkage.	F 644		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure nursing assistant (NA) staff correctly transferred 1 of 1 resident (R47) resident with use of 2 staff during a mechanical sit to stand lift transfer to ensure his safety.	F 689	F689 □ Free of Accident Hazards/Supervision/Devices 1. On 10/17/2023 it was confirmed that the MDS completed on 8/3/2023 identified resident R47 required extensive assistance from two staff for transfers. On 10/17/2023 it was confirmed that care	11/30/23

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F 689	Continued From page 4 Findings included: On 10/2/23 at 1:52 p.m., R47 stated that he needs two staff to assist him with transferring, with the mechanical lift, when he gets in and out of recliner. On 10/2/23 at 2:31 p.m., nursing assistant (NA)-A brought a mechanical lift into R47's room and assisted R47 with transferring from recliner to wheelchair with one staff. R47's annual Minimum Data Set (MDS) dated 8/3/23, identified R47 was cognitively intact and required extensive assistance from two staff for transfers. R47's diagnoses included Parkinson's disease (condition that affects the brain and causes problems with movement, balance, and coordination), myasthenia gravis (neuromuscular disorder that leads to weakness of skeletal muscles) and dependence on other enabling machines and devices. R47's care plan dated 8/11/23, identified R47 needed assistance of two staff with a stand-aid lift (mechanical sit to stand lift) for transfers. On 10/4/23 at 10:22 a.m., NA-B stated R47 utilizes a mechanical lift with assistance of two staff at all times for transfers. On 10/4/23 at 10:41 a.m., registered nurse (RN)-C stated that R47 is an assist of two staff with the mechanical lift for all transfers. On 10/4/23 at 11:28 a.m., director of nursing (DON) stated that staff are aware of what type of assistance a resident need from the care plan. DON confirmed that R47's care plan indicated	F 689	plan for R47 dated 8/11/2023 identified R47 needed assistance of two staff with a stand-aid lift for transfers. On 10/17/2023 it was confirmed that resident R47 continued to require extensive assistance from two staff members for transfers. All resident□s care plans will be audited by 11/30/2023 to ensure resident□s need for assistance during transfers is identified and accurate in the resident□s care plan for all residents. 2. All Residents have the potential to be affected. 3. Administrator and DON reviewed policy titled Transfers on 10/24/2023. Nursing staff will be educated by the DON or designee on the Transfers policy by 11/30/2023. Specifically, nursing staff will be educated regarding the importance of following the care plan regarding level of assistance needed for transferring residents using a mechanical lift. 4. Audits will be conducted weekly for 4 weeks by the DON or designee for 5 randomly selected residents to ensure care plan identifies resident□s level of need for assistance during transfers. Audits will be conducted weekly for 4 weeks by the DON or designee for 5 randomly selected nursing staff to ensure they understand where to find care plan information for residents need for assistance during transfers. Audit results will be reported to the Quality Assurance Committee for review at the next Quality Assurance meeting. 5. 11/30/2023	

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F 689	Continued From page 5 that R47 needs two staff for transfers with the mechanical lift. The DON stated it is important to ensure staff are following the care plan for resident's safety. The Transfers policy dated 5/4/23, indicated residents will be prepared for a transfer and complete the transfer by referring to the resident's care plan for specific transfer directions.	F 689		
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure side rails were	F 700	F700 □ Bedrails 1. Residents R9, R16, R30 and R31 will	11/30/23

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F 700	Continued From page 6 assessed to determine appropriateness and safety of use for 4 of 4 residents (R9, R16, R30 and R31) who was observed to have a side rails affixed to their beds. Findings include: R9's quarterly Minimum Data Set (MDS) dated 7/1/23, identified R9 was cognitively intact and required extensive assistance with bed mobility and transfers. R9's diagnoses included traumatic brain dysfunction (head injury causing damage to the brain by external force or mechanism), hemiplegia (condition that causes paralysis or weakness on one side of the body) and contracture of muscle, multiple sites. R9's care plan dated 7/7/23, included that R9 utilized bilateral assist device bars on bed to assist with bed mobility. Additionally, the care plan included that R9 needs assistance of two staff to boost up in bed. On 10/2/23 at 2:25 p.m., Observed R9's bed had 1/2 side rails affixed to the head of bed on both sides of bed. R9's medical record lacked evidence an assessment had been completed to determine necessity and whether R9 could safely use side rails. Additionally, R9's medical record lacked evidence alternatives were tried prior to installing the side rails, the resident or representative were educated on the risk of having a side rail on bed, if a consent form was completed and a order from the provider was obtained. R16's annual MDS dated 6/23/23, identified R16 had moderate cognitive impairment and required	F 700	have a new bed rail assessment completed by 11/30/2023. All residents will have new bed rail assessments completed by 11/30/2023. Residents assessed to benefit from the use of bed rails will be care planned for the appropriate use of bed rails, and a risk/benefit form will be completed with the resident and/or the resident□s representative. 2. All Residents have the potential to be affected. 3. Administrator, DON, and Physical Therapist created policy titled Bed Rails on 10/18/2023. Nursing staff will be educated by DON or Designee regarding the Bed Rails Policy by 11/30/2023. Specifically nursing staff will be educated regarding Physical Therapy□s process for assessing residents to be appropriate for the use of bed rails. 4. Audits will be conducted weekly for 4 weeks by the Physical Therapist or designee for up to 5 residents with bed rails in use to ensure that the bed rail assessment is completed, ensure that the resident□s care plan is up to date regarding the use of bed rails, and to ensure that a risk/benefit form has been completed with the resident and/or the resident□s representative. Audit results will be reported to the Quality Assurance Committee for review at the next Quality Assurance meeting. 5. 11/30/2023	

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 _____	C 10/04/2023

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
F 700	Continued From page 7 extensive assistance with bed mobility and transfers. R16's diagnoses included Alzheimer's Disease (type of brain disorder that causes problems with memory, thinking and behavior), non-Alzheimer's dementia (condition in which a person loses the ability to think, remember, learn, make decisions, and solve problems due to causes other than Alzheimer disease), anxiety disorders and repeated falls. R16's care plan dated 9/26/23, included that R16 needs assistance of two staff with bed mobility and transfers. Care plan does not indicate bed rails. On 10/2/23 at 1:59 p.m., Observed R16's bed had 1/2 side rails affixed to the head of bed on both sides of bed. R16's medical record lacked evidence an assessment had been completed to determine necessity and whether R16 could safely use side rails. Additionally, R16's medical record lacked evidence alternatives were tried prior to installing the side rails, the resident or representative were educated on the risk of having a side rail on bed, if a consent form was completed and a order from the provider was obtained. R30's quarterly MDS dated 9/8/23, identified R30 had moderate cognitive impairment and required extensive assistance with bed mobility and transfers. R30's diagnoses included stroke (occurs when the blood supply to part of the brain is interrupted or reduced, preventing brain tissue from getting oxygen and nutrients), hemiplegia affecting left side of body. R30's care plan dated 9/15/23, included that R30	F 700		

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	245631	A. BUILDING _____ B. WING _____	C 10/04/2023

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
F 700	Continued From page 8 utilized bilateral assist device bars on bed to assist with bed mobility. On 10/2/23 at 5:07 p.m., Observed R30's bed had 1/2 side rails affixed to the head of bed on both sides of bed. R30's medical record lacked evidence an assessment had been completed to determine necessity and whether R30 could safely use side rails. Additionally, R30's medical record lacked evidence alternatives were tried prior to installing the side rails, the resident or representative were educated on the risk of having a side rail on bed, if a consent form was completed and a order from the provider was obtained. R31's quarterly MDS dated 9/1/23, identified R31 was cognitively intact and required supervision with bed mobility and transfers. R31's diagnoses included chronic kidney disease. R31's care plan dated 9/11/23, included that R31 is independent with bed mobility and transfers. Care plan does not indicate bed rails. On 10/2/23 at 4:59 p.m., Observed R31's bed had 1/2 side rails affixed to the head of bed on both sides of bed. R31's medical record lacked evidence an assessment had been completed to determine necessity and whether R31 could safely use side rails. Additionally, R31's medical record lacked evidence alternatives were tried prior to installing the side rails, the resident or representative were educated on the risk of having a side rail on bed, if a consent form was completed and a order from the provider was obtained.	F 700		

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 _____	C 10/04/2023

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
F 700	Continued From page 9 On 10/4/23 at 10:22 a.m., nursing assistant (NA)-B stated R9 is minimally able to reposition self while in bed. NA-B stated R16 is dependent on all activities of daily living (ADL's) and is not able to reposition self in bed. NA-B stated R30 is moderately able to reposition self in bed. R30 can roll to the left and is able to use side rail for turning. NA-B stated R31 is independent with all ADL's and uses the side rails to get in and out of bed. On 10/4/23 at 10:41 a.m., registered nurse (RN)-C stated that she was not sure who was responsible for assessments of the side rails and indicated that therapy may perform them. On 10/4/23 at 11:28 a.m., the director of nursing (DON) stated physical therapy are to assess for side rails. DON stated once physical therapy assesses resident and deemed it appropriate for resident to use side rail, then an assessment would be completed by the nurse. Care plan would be updated, risks/benefits would be discussed with resident and/or resident's representative and a consent form would be obtained. DON stated this is a new process and confirmed that R9, R16, R30 and R31 did not have assessments and/or risk/benefits completed. DON stated assessment of side rails is important to ensure appropriateness and safety for the resident. The Bed Inspection policy dated 5/10/18 indicated residents will be screened to determine the level a resident's independence with bed mobility. Staff were to assess the need for special equipment or accessories (e.g., positioning bar, half, or quarter rail for positioning). Assess the resident to identify	F 700		

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	245631	A. BUILDING _____ B. WING _____	C 10/04/2023

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
F 700	Continued From page 10 appropriate alternative(s) prior to installing bed rails, and assess the resident for risk of entrapment from bed rails prior to installation. The increased risk would be largely due to unsafe moving about the bed, or ill-advised attempts to exit from the bed. Additionally, untimely responses to care increased the risk of entrapment. No matter the purpose for use, bed rails and other bed accessories, although prescribed to improve functional independence with bed mobility and transfers, may increase resident safety risk. Staff were to review the risk and benefits with resident and resident representative and obtain informed consent.	F 700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00411	A. BUILDING: _____ B. WING _____	C 10/04/2023

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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 10/2/23 through 10/4/23, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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	00411	A. BUILDING: _____ B. WING _____	C 10/04/2023

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed during the survey: H56315902C (MN91206), H56315903C (MN94464), H56315904C (MN94472), H56315905 (MN94470), H56915906C (MN94465), HL004115907C (MN91468), and H56315909C (MN94474).and NO licensing orders were issued. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00411	A. BUILDING: _____ B. WING _____	C 10/04/2023

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MN VETERANS HOME - LUVERNE	1300 NORTH KNISS AVENUE LUVERNE, MN 56156

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2 000	Continued From page 2 completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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. http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and	2 830		11/30/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 830	Continued From page 3 custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure nursing assistant (NA) staff correctly transferred 1 of 1 resident (R47) resident with use of 2 staff during a mechanical sit to stand lift transfer to ensure his safety. Findings included: On 10/2/23 at 1:52 p.m., R47 stated that he needs two staff to assist him with transferring, with the mechanical lift, when he gets in and out of recliner. On 10/2/23 at 2:31 p.m., nursing assistant (NA)-A brought a mechanical lift into R47's room and assisted R47 with transferring from recliner to wheelchair with one staff. R47's annual Minimum Data Set (MDS) dated 8/3/23, identified R47 was cognitively intact and required extensive assistance from two staff for transfers. R47's diagnoses included Parkinson's disease (condition that affects the brain and causes problems with movement, balance, and	2 830	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00411	A. BUILDING: _____ B. WING _____	C 10/04/2023

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2 830	Continued From page 4 coordination), myasthenia gravis (neuromuscular disorder that leads to weakness of skeletal muscles) and dependence on other enabling machines and devices. R47's care plan dated 8/11/23, identified R47 needed assistance of two staff with a stand-aid lift (mechanical sit to stand lift) for transfers. On 10/4/23 at 10:22 a.m., NA-B stated R47 utilizes a mechanical lift with assistance of two staff at all times for transfers. On 10/4/23 at 10:41 a.m., registered nurse (RN)-C stated that R47 is an assist of two staff with the mechanical lift for all transfers. On 10/4/23 at 11:28 a.m., director of nursing (DON) stated that staff are aware of what type of assistance a resident need from the care plan. DON confirmed that R47's care plan indicated that R47 needs two staff for transfers with the mechanical lift. The DON stated it is important to ensure staff are following the care plan for resident's safety. The Transfers policy dated 5/4/23, indicated residents will be prepared for a transfer and complete the transfer by referring to the resident's care plan for specific transfer directions. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee should review policies and procedures, train staff, and implement measures to ensure staff are appropriately trained to operate mechanical lifts according to manufacturer's instructions. The facility should ensure lift manuals are easily accessible and staff are deemed competent to operators instructions. The director of nursing or	2 830		

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2 830	Continued From page 5 designee, should conduct audits of the delivery of care with lift use and competencies are performed. The results of those audits should be taken to QAPI to determine compliance or the need for ongoing monitoring. TIMEFRAME FOR CORRECTION: Twenty-One (21) days.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/26/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	**505 EAST 4TH STREET** **HILLS, MN 56138**

(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
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 09/26/2023. At the time of this survey, Tuff Memorial Home 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 | 10/20/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/26/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	**505 EAST 4TH STREET** **HILLS, MN 56138**

(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
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. Tuff Memorial Home was constructed as follows: The original building was constructed in 1959, is one-story, has a partial basement, is fully fire sprinkler protected and is of Type II(111) construction; The 1st Addition was constructed in 1962, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction; The 2nd Addition was constructed in 1975, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction;	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/26/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	**505 EAST 4TH STREET** **HILLS, MN 56138**

(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
K 000	Continued From page 2 The 3rd Addition was constructed in 1988, is one-story, has a full basement, is fully fire sprinkler protected and is of Type V(111) construction; The 4th Addition was constructed in 1998, is one-story, has no basement, is fully fire sprinkler protected and is of Type V(000) construction. The facility has a capacity of 48 beds and had a census of 39 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 324 SS=E	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through	K 324		10/20/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245548	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/26/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TUFF MEMORIAL HOME	**505 EAST 4TH STREET** **HILLS, MN 56138**

(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
K 324	Continued From page 3 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation or a review of available documentation and staff interview, the facility failed to inspect the kitchen fire suppression per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.5.1 through 19.3.2.5.5, and NFPA 96 (2011 Edition), Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, section number 9.2.3,. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 09/26/2023 at 11:00AM, it was revealed by a review of available documentation that inspection records could not be reviewed to indicate a timely inspection had occurred on the kitchen fire suppression system, Last inspection occurred on 02/12/2023. An interview with Facility Maintenance Director verified this deficient finding at the time of discovery.	K 324	On 9/27/23 Heimann Fire Equipment services came and inspected the kitchen fire suppression system. The inspection is now scheduled on a semi-annual basis to maintain compliance. Heimann Fire Equipment will present documentation of inspection for facility to keep on file. The next inspection is scheduled for 2/2024.	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 14, 2023

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

RE: CCN: 245631
Cycle Start Date: October 4, 2023

Dear Administrator:

On December 12, 2023, we notified you a remedy was imposed. On December 12, 2023 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of November 30, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective January 4, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of December 12, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 4, 2024 due to denial of payment for new admissions. Since your facility attained substantial compliance on November 30, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 14, 2023

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

Re: Reinspection Results
Event ID: 9BCW12

Dear Administrator:

On December 12, 2023 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 October 4, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any 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