DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: NPDI

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00233

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245620**

2.STATE VENDOR OR MEDICAID NO.
(L2) **743749800**

3. NAME AND ADDRESS OF FACILITY
(L3) **MN VETERANS HOME MINNEAPOLIS**
(L4) **5101 MINNEHAHA AVENUE SOUTH**
(L5) **MINNEAPOLIS, MN** (L6) **55417**

4. TYPE OF ACTION: **7** (L8)

1. Initial
2. Recertification
3. Termination
4. CHOW
5. Validation
6. Complaint
7. On-Site Visit
9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/03/2016** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
06/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **502** (L18)

13.Total Certified Beds **200** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	200			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Lisa Hakanson, HFE NEII 10/05/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 11/18/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
01/06/2014
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/12/2016
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24 5620

At the time of the July 28, 2016 standard survey the facility was not in substantial compliance with Federal participation requirements. The facility has been given an opportunity to correct before remedies would be imposed. The most serious deficiency is a widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections are required. In addition, at the time of the standard survey an investigation of complaint number H5620012 was conducted and found to not be substantiated.

Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245620

November 18, 2016

Mr. Cory Glad, Administrator
Mn Veterans Home Minneapolis
5101 Minnehaha Avenue South
Minneapolis, Minnesota 55417

Dear Mr. Glad:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective September 20, 2016 the above facility is certified for:

200 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 200 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
October 5, 2016

Mr. Cory Glad, Administrator
Mn Veterans Home Minneapolis
5101 Minnehaha Avenue South
Minneapolis, Minnesota 55417

RE: Project Number S5620005

Dear Mr. Glad:

On August 16, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 28, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On October 3, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on September 20, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 28, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 15, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 28, 2016, effective September 20, 2016 and therefore remedies outlined in our letter to you dated August 16, 2016, will not be imposed.

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
245620		10/3/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME MINNEAPOLIS	5101 MINNEHAHA AVENUE SOUTH MINNEAPOLIS, MN 55417

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0287 Reg. # 483.20(f) LSC	Correction Completed 09/15/2016	ID Prefix F0441 Reg. # 483.65 LSC	Correction Completed 09/15/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY [x]	REVIEWED BY (INITIALS) GL/mm	DATE 10/05/2016	SIGNATURE OF SURVEYOR 28230	DATE 10/03/2016
REVIEWED BY CMS RO [ ]	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
7/28/2016	[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245620	A. Building 02 - BUILDING 21 B. Wing	9/20/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME MINNEAPOLIS	5101 MINNEHAHA AVENUE SOUTH MINNEAPOLIS, MN 55417

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0160	Correction Completed 09/20/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY [X]	**REVIEWED BY (INITIALS)** GL/mm	**DATE** 10/05/2016	**SIGNATURE OF SURVEYOR** 37009	**DATE** 09/20/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 7/26/2016	[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] **YES** [ ] **NO**			

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
October 5, 2016

Mr. Cory Glad, Administrator
MN Veterans Home Minneapolis
5101 Minnehaha Avenue South
Minneapolis, Minnesota 55417

Re: Enclosed Reinspection Results - Project Number S5620005

Dear Mr. Glad:

On October 3, 2016 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 28, 2016. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT
00233 Y1	Y2	10/3/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME MINNEAPOLIS	5101 MINNEHAHA AVENUE SOUTH MINNEAPOLIS, MN 55417

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 30910 Reg. # MN Rule 4655.5200 Subp. 4 LSC	Correction Completed 10/03/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY [X]	REVIEWED BY (INITIALS) GL/mm	DATE 10/05/2016	SIGNATURE OF SURVEYOR 28230	DATE 10/03/2016
REVIEWED BY CMS RO [ ]	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 7/28/2016

[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] **YES** [ ] **NO**

 EVENT ID: NPDI12

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00233 Y1	A. Building B. Wing Y2	10/3/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME MINNEAPOLIS	5101 MINNEHAHA AVENUE SOUTH MINNEAPOLIS, MN 55417

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

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	20430	Correction	ID Prefix	20435	Correction	ID Prefix	20565	Correction
Reg. #	MN Rule 4658.0210 Subp. 1	Completed	Reg. #	MN Rule 4658.0210 Subp. 2 A.B.	Completed	Reg. #	MN Rule 4658.0405 Subp. 3	Completed
LSC		10/03/2016	LSC		10/03/2016	LSC		10/03/2016
ID Prefix	20830	Correction	ID Prefix	21375	Correction	ID Prefix	21880	Correction
Reg. #	MN Rule 4658.0520 Subp. 1	Completed	Reg. #	MN Rule 4658.0800 Subp. 1	Completed	Reg. #	MN St. Statute 144.651 Subd. 20	Completed
LSC		10/03/2016	LSC		09/15/2016	LSC		10/03/2016
ID Prefix	21995	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	MN St. Statute 626.557 Subd. 4a	Completed	Reg. #		Completed	Reg. #		Completed
LSC		10/03/2016	LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	GL/mm	10/05/2016	28230	10/03/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
7/28/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: NPDI

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00233

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245620**
2.STATE VENDOR OR MEDICAID NO.
(L2) **743749800**

3. NAME AND ADDRESS OF FACILITY
(L3) **MN VETERANS HOME MINNEAPOLIS**
(L4) **5101 MINNEHAHA AVENUE SOUTH**
(L5) **MINNEAPOLIS, MN** (L6) **55417**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/28/2016** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
06/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **502** (L18)
13.Total Certified Beds **200** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	200			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Lisa Hakaanson, HFE NEII 09/06/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 09/09/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION **01/06/2014** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
03001 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24 5620

At the time of the July 28, 2016 standard survey the facility was not in substantial compliance with Federal participation requirements. The facility has been given an opportunity to correct before remedies would be imposed. The most serious deficiency is a widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections are required. In addition, at the time of the standard survey an investigation of complaint number H5620012 was conducted and found to not be substantiated.

Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
August 16, 2016

Mr. Cory Glad, Administrator
MN Veterans Home Minneapolis
5101 Minnehaha Avenue South
Minneapolis, MN 55417

RE: Project Number S5620005

Dear Mr. Glad:

On July 28, 2016, a standard 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the July 28, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5620012 that was found to be unsubstantiated.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

> **<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be**

contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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

DEPARTMENT CONTACT

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

Gayle Lantto, Unit Supervisor
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0970
Telephone: (651) 201-3794
Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 6, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 6, 2016 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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. 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, 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 28, 2016 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 28, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245620	A. BUILDING _____ B. WING _____	07/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME MINNEAPOLIS	5101 MINNEHAHA AVENUE SOUTH MINNEAPOLIS, MN 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
F 000	INITIAL COMMENTS 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. Complaint H5620012 was also investigated at the time of the recertification and was found unsubstantiated.	F 000		
F 287 SS=B	483.20(f) ENCODING/TRANSMITTING RESIDENT ASSESSMENT (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. (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	F 287		9/15/16

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

Electronically Signed | 08/26/2016

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F 287	Continued From page 1 the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. (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 a resident that does not have an admission assessment. (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 encode or transmit Minimum Data Set (MDS) data to the Centers for Medicare/Medicaid (CMS) systems for 100 of 200 residents residing in certified beds. Findings include:	F 287	The MDS's for the certified residents affected have been transmitted to the Centers for Medicare and Medicaid Services and an ongoing process is in place. Compliance for correct submissions of the MDS's to CMS will be audited monthly by	

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F 287	Continued From page 2 During review of resident information during the sampling for the recertification survey, MDS information was not available for any residents residing on Unit 21. On 7/28/16, at 10:30 a.m. the director of nursing (DON) was interviewed and stated the facility had requested to expand their certified beds from 100 to 200. Upon further discussion with Minnesota Department of Health (MDH) staff, it was learned MDH had received notice from CMS approving certification for the additional beds in March 2016, and had sent a letter via US Postal service to notify the provider. However, the provider alleged they had not received the notice from MDH indicating the additional 100 beds had been approved for certification. Consequently, the provider had not submitted any MDS data to CMS for the expanded 100 certified beds. During the interview with the DON, she verified that although they had not submitted the MDS data to CMS, the facility had been completing MDS assessments on all residents at admission, quarterly, annually and whenever a resident experienced a significant change in condition.	F 287	the MDS nurse. Results of the MDS audits will be presented to the QA committee and continued until the QA committee suspends due to substantial compliance. DON or designee is responsible.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control	F 441		9/15/16

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F 441	Continued From page 3 Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to utilize proper hand hygiene between glove changes for 1 of 5 residents (R1) whose cares were observed. Findings include: R1 was assisted with morning cares on 7/28/16,	F 441	R1 residents' cares are being done utilizing proper hand hygiene and glove use. All other residents' cares are being done utilizing proper hand hygiene and glove use. Nursing staff will be educated on the Hand Hygiene policy regarding hand washing and glove use. Random weekly observational audits will	

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F 441	Continued From page 4 at 7:10 a.m. two human service technicians (HST)-G and HST-I. Both HSTs washed their hands and donned gloves, and then washed the resident's feet and legs and applied lotion. HST-I washed R1's groin and perineal area, removed her gloves and left R1's room without washing or otherwise sanitizing her hands. At 7:17 a.m. HST-I returned to R1's room with incontinence briefs. HST-I confirmed she had not wash nor sanitize her hands after removing her gloves after performing perineal care. R1's Diagnosis Report included diagnoses of Alzheimer's disease and dementia. R1's quarterly review minimum data set (MDS) dated 6/4/16, indicated R1 needed extensive assistance with transfers, dressing, toileting and personal hygiene. R1's care plan directed two staff extensive assist with bathing, grooming and dressing. On 7/28/16, at 10:12 a.m. registered nurse (RN)-D stated it was the facility's expectation that staff will always wash hands before and after donning gloves during cares. The facility's 7/30/10, Hand Hygiene policy directed staff to wear gloves when contact with potentially infectious materials could occur and to decontaminate hands after removing gloves.	F 441	be done to ensure proper hand washing and glove use. DON or designee will be responsible. Audit results will be presented to the QA Committee and continued until the QA Committee suspends them due to substantial compliance.	

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted
August 16, 2016

Mr. Cory Glad, Administrator
MN Veterans Home Minneapolis
5101 Minnehaha Avenue South
Minneapolis, MN 55417

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5620005 & H5620012

Dear Mr. Glad:

The above facility was surveyed on July 25, 2016 through July 28, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5620012 that was found to be unsubstantiated. 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 that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 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 deficiency 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 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. 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 after the statement, "This Rule 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 Gayle Lantto, Unit Supervisor at (651) 201-3794.

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

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

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00233	A. BUILDING: _____ B. WING _____	07/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME MINNEAPOLIS	5101 MINNEHAHA AVENUE SOUTH MINNEAPOLIS, MN 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) COMPLETE DATE
3 000	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: 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 <http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm> The State licensing orders are	3 000	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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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3 000	Continued From page 1 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. On July 25, 26, 27, 28, 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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.	3 000	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. 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.	
3 910	MN Rule 4655.5200 Subp. 4 Activities Program; Supervision of Program Subp. 4. Supervision of program. The activities program shall be supervised by a person employed on the basis of two-thirds hour per bed per week which is equal to 40 hours per week for 60 beds, who is trained and/or experienced in the supervision of such a program. This MN Requirement is not met as evidenced	3 910		9/6/16

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3 910	Continued From page 2 by: Based on interview, and document review, the facility failed to ensure the activities supervisor worked the required two-thirds hours per bed per week. This practice had the potential to affect all 44 residents who resided in the Domiciliary (DOMS). Findings include: The Minnesota Rule required the activities program be supervised by an employee based on two-thirds hour per bed per week. For a facility with 44 residents, this would equal 29.5 hours for the activities supervisor each week (0.67 multiplied 44). The DOMS facility is boarding care. R1 stated in an interview on 7/26/16, at 9:45 a.m. that the administrator had informed them the residents they could be fit into activities in the nursing home. R2 reported on 7/27/16, at 10:30 a.m. activities were a "big issue" with only one or two outings a month. R2 stated, "We used to go to Walmart twice a month." R2 further stated the residents enjoyed going to movies and it gave them an opportunity to socialize with others who resided in the DOMS in a different environment. "We don't do the group things" except for golf outings, as that was the preference of the staff person in charge of activities. During an interview on 7/26/16, at 4:00 p.m. the licensed social worker (LSW) explained that the DOMS recreational therapist had left last fall and the position was not retained. The LSW stated, "Recreational therapist position went to the nursing home--the money went there." The LSW	3 910	MN Rule 4655.5200 Subp. 4 Activities Program; Supervision of Program Designated Staff person has been assigned to supervision of program and employed at 2/3 hour/bed/week. 1. Review and update PD as needed 2. Hours audited for compliance until Quality Assurance team determines substantial compliance Completion Date: 9/06/2016 Responsible party: Administrator or designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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3 910	Continued From page 3 said the residents in the DOMS could structure their own leisure time. They also had access to Twins baseball and State Fair tickets, and one movie ticket would be reimbursed. The residents, however, were responsible for arranging their own transportation. The LSW stated, "They are welcomed and encouraged to go out on outings when the nursing home goes." When interviewed on 7/28/16, at 9:40 a.m. the therapeutic recreation director (TRD) verified activities were supervised by the vocational work service employee. Five to six hours a week were dedicated to activities and care conferences. The TRD was unaware a supervisor was needed for the activities program and that the director's time was adequate. The TRD verified the residents residing in the DOMS were younger, and some had jobs and were working to transition back into the community. When interviewed on 7/27/16, at 2:35 p.m. the administrator explained that when the full time activities supervisor resigned last fall, it was decided they would opt to go with campus wide activities, designating one activities staff per nursing unit. Activities in the DOMS would then be supplemented using those same staff. The administrator was unaware of the requirement for the scheduling of the activities supervisor for two-thirds hour per bed per week. The 7/16 activity schedule revealed most activities were scheduled on the main nursing home campus. Activities in the DOMS included a special breakfast (7/7), shopping (7/10), Blackjack card game (7/18 and 7/15), golf outing (7/21), and darts game (7/26). The 8/16 activity schedule included leisure time Monday-Friday at 5:00 a.m., 10:00 a.m. and 7:00 p.m., Blackjack	3 910		

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3 910	Continued From page 4 on Mondays, Legion lunch outing (8/3), shopping (8/5), and golf outing (8/25). No activities were scheduled on the weekends for July or August, however, church and BINGO were scheduled at the nursing home. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	3 910		

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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: 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 <http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm> The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 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. On July 25, 26, 27, 28, 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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. 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		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. Complaint H5620012 was also investigated at the time of the recertification and was found unsubstantiated.	2 000		
2 430	MN Rule 4658.0210 Subp. 1 Room Assignments Subpart 1. Room assignments and furnishings. A nursing home must attempt to accommodate a resident's preferences on room assignments, roommates, and furnishings whenever possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to accommodate a room change request for 1 of 1 resident (R4) whose family representative requested a room change. Findings include: R4's family member (F)-A reported on 7/26/16, at 9:50 a.m. alarm sounds bothered the resident. F-A explained that R4's roommate utilized a personal alarm, and when it sounded, R4 associated the noise with war sirens. F-A had reportedly requested a room change for R4, but was told, "no." During interview on 7/26/16, at 1:00 p.m. family friend (FF)-A stated R4's roommate caused increased agitation in the resident. FF-A explained a meeting had been held on 6/1/16, with F-A, the administrator, licensed social	2 430	R4 room change request has been re-reviewed. All residents who request room changes will have the requests documented on grievance forms. When appropriate, room changes are accommodated. Leadership team members, nursing management and social workers will be educated that all room change requests will be addressed on a Grievance form. Random weekly audits of Grievances regarding documentation and resolution of room change requests will be done. Social Services Director will be responsible. Audit results will be presented to the QA committee and continued until the QA committee suspends due to substantial compliance.	9/6/16

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2 430	Continued From page 3	2 430		

worker, director of nursing, physician, and several others. During the meeting F-A was allegedly told the staff did not think R4 needed a room change, as it would have been detrimental to his health to be alone in his room all day, and changing R4's staff was not advised. The following day at 9:00 a.m.

During interview on 7/27/16, at 9:00 a.m. FF-A first requested a room change at a care conference in 7/15, because R4 had a new roommate whose alarms frequently sounded. Because of this, R4 became uncomfortable with new roommate. FF-A began to push for a room change at the 4/4/16 care conference.

R4's Admission Record 4/15, indicated the resident had diagnoses including anoxic brain damage, paranoid schizophrenia, post-traumatic stress disorder, and depression. A significant change Minimum Data Set (MDS) dated 6/23/16, revealed the resident was cognitively impaired and was totally dependent on staff for cares. R4 displayed mood indicators, hallucinations, physical and verbal behaviors, and rejected care.

Registered nurse (RN)-A was interviewed on 7/26/16, 5:50 p.m. RN-A said R4 displayed behaviors of yelling and grabbing staff during cares since his admission to the facility, and was prescribed scheduled pain medicaiton. RN-A reported visitors were known to increase the resident's agitation. Although R4 did not utilize a personal alarm, his roommate did.

During interview on 7/26/16, at 6:30 p.m. licensed practical nurse (LPN)-C described R4 as mostly quiet when in his own rooms watching perferred television programs.

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2 430	Continued From page 4 A licensed social worker (LSW)-B stated she was aware of R4's family request for a room change in an interview on 7/27/16, at 12:20 p.m. The LSWs did not assist with room changes, and instead they were referred to the Room Utilization Review Committee. On 7/27/16, at 2:30 RN-A was reportedly unaware of a room change request for R4 until a grievance was filed on 6/14/16. RN-A referred the grievance to the interdisciplinary team administrator for a decision. RN-A verified R4's roommate's alarms did sound. LSW-A was interviewed on 7/27/16, at 3:00 p.m. and reported she was first aware of a room change request in 5/16. LSW-A stated the interdisciplinary team met with the family on 5/25/16 and on 6/1/16, to help them understand why R4's room would not be changed to another building, due to his complex care needs. LSW-A verified R4 displayed behavioral issues, as did residents in other buildings on the campus. LSW-A was aware R4's family requested a roommmate change and better environment for the resident, and she had informed them she would look for a room change within the same building, with the same team of staff. During interview on 7/28/16, at 7:36 a.m. nursing assistant (NA)-B stated R4 displayed behavioral issues, and the staff utilized interventions such as stepping back and trying again at a later time. A social services progress note dated 4/21/16, indiated the interdisciplinary team met to review a recent doctor note recommending a private room due to the resident's agitation. The interdisciplinary team determined a room with reduced stimulation would be beneficial for R4,	2 430		

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2 430	Continued From page 5 and the family had recently made request for a room change at a care conference. R4's family was okay with a different double room, and reported a change in environment had been helpful in the past when R4 resided at another facility. The note indicated R4 had "an ongoing aversion to alarms/noises," and the resident resided in a room close to the nursing station and his roommate had a sensor alarm that sounded. It was indicated a private room would result in a benefit to R4 and lessen the impact of R4's behaviors, as it had been observed the resident was more calm in a relaxed situation with minimal stimulation. Care conference progress notes revealed R4's family inquired about private room on 4/22/15, 7/14/15, and 4/4/16. A policy for room changes/assignments and mechanism for addressing and resolving complaints. The corporate director stated in an interview on 7/28/16, at 11:00 a.m. that the facility's 10/23/12, Resident Concern/Grievance Procedure and Notice of Proposed Room or Bed Change policy was the policy regarding room change requests. The policy indicated, "A resident has a right to voice grievances without discrimination or reprisal," and verbal or written concerns could be brought to any staff person. The supervisor would then report the resolution to the complainant within two working days of receipt of the concern. If the concern can not be resolved, a grievance form will be provided. Within seven working days the responder was to meet with the complainant and review and provide a written response. The policy included other State agencies names and telephone numbers to contact with concerns. The facility's Notice of Proposed Room or Bed Change was used when the facility chose to change a resident's room.	2 430		

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2 430	Continued From page 6 During interview on 7/28/16, at 9:00 a.m. the director of nursing (DON) stated an awareness of R4's family request for a room change due to alarm noise. The facility was monitoring how frequently the alarms sounded. The DON said staff on R4's unit had been trained to care for R4 and it was felt a change in the care team would have been detrimental to the resident's health. R4 could have moved within the same building and continued with the same care team, but if moved to another building, it would have involved re-training staff. SUGGESTED METHOD OF CORRECTION: The administrator and director of nursing could review and revise facility policies to include a mechanism for informal dispute resolution of room assignment and roommate concerns and a procedure for documenting the complaint and resolution. The administrator and director of nursing could develop a system to attempt to accomodate room change requests. The director of nursing could educate all staff on the system and monitor staff compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 430		
2 435	MN Rule 4658.0210 Subp. 2 A.B. Room Assignments Room assignment complaints. A nursing home must develop and implement written policies and procedures for addressing resident complaints, including complaints regarding room assignments and roommates. At a minimum, the policies and procedures must include the following:	2 435		9/6/16

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2 435	Continued From page 7 A. a mechanism for informal dispute resolution of room assignment and roommate complaints; and B. a procedure for documenting the complaint and its resolution. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop and implement written policies and procedures addressing room and roommate concerns, potentially affecting all residents residing in the facility, including 1 of 1 resident (R4) whose family filed a grievance regarding a room change request. Findings include: The facility's 10/23/12, Resident Concern/Grievance Procedure and Notice of Proposed Room or Bed Change policy revealed, persons could bring verbal or written concerns to any staff, and the supervisor would report the resolution to the concern within two working days. If the concern could not be resolved, a grievance form was to be provided. Within seven days of receipt, the responder was to meet with the complainant and provide a written response. The policy included other State agencies names and telephone numbers to contact with concerns. However, the policy did not include a mechanism for informal dispute resolution of room assignment and roommate concerns and a procedure for documenting the complaint and resolution as required.	2 435	R4 room change request has been re-reviewed. All residents who request room changes will have the requests documented on grievance forms. When appropriate, room changes are accommodated. Leadership team members, nursing management and social workers will be educated that all room change requests will be addressed on a Grievance form. Random weekly audits of Grievances regarding documentation and resolution of room change requests will be done. Social Services Director will be responsible. Audit results will be presented to the QA committee and continued until the QA committee suspends due to substantial compliance.	

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2 435	Continued From page 8 R4's family member (F)-A reported on 7/26/16, at 9:50 a.m. alarm sounds bothered the resident. F-A explained that R4's roommate utilized a personal alarm, and when it sounded, R4 associated the noise with war sirens. F-A had reportedly requested a room change for R4, but was told, "no." On 7/27/16, at 2:30 registered nurse (RN)-A was reportedly unaware of a room change request for R4 until a grievance was filed on 6/14/16. RN-A referred the grievance to the interdisciplinary team administrator for a decision. A policy for room changes/assignments and mechanism for addressing and resolving complaints. The corporate director stated in an interview on 7/28/16, at 11:00 a.m. that the facility's 10/23/12, Resident Concern/Grievance Procedure and Notice of Proposed Room or Bed Change policy was the policy regarding room change requests. SUGGESTED METHOD OF CORRECTION: The administrator and licensed social workers could review and revise facility policies to include a mechanism for informal dispute resolution of room assignment and roommate concerns and procedure for documenting the complaint and resolution. Appropriate staff could be educated on the policy and audits of related grievances could be conducted and brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 435		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use	2 565		8/30/16

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2 565	Continued From page 9 Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to follow provide adaptive equipment according to the care plan for 1 of 1 resident (R3) reviewed for activities of daily living. Findings include: R3's current care plan and nutritional assessment dated 5/25/16, indicated the resident utilized the following adaptive equipment: fork, teaspoon, soup spoon, small nosey cup, scoop plate, and a non-skid placemat at mealtimes and for fluid intake. R3 was observed at mealtime on 7/25/16, at 12:22 p.m. and 7/27/16, at 1:03 p.m. At both meals no non-skid placement or nosey cups were provided, and instead regular drinking glasses with straws. On 7/27/16, at 12:35 p.m. no non-skid placemat was provided. On 7/27/16, at 12:38 p.m. registered nurse (RN)-A verified R3 had not been provided the adaptive equipment according to his assessed need and care plan. RN-A stated she would have expected R3 be provided the necessary adaptive equipment at mealtime, and for staff to follow the care plan. On 7/27/16, at 3:34 p.m. the dietary manger	2 565	Dietary staff will ensure the correct adaptive eating equipment is provided for the resident per the meal ticket. The meal ticket and care plan will reflect the adaptive equipment necessary for the meal. The staff member who serves the resident will ensure the correct adaptive eating equipment is present. At any time the correct adaptive eating equipment is missing, this will be corrected immediately by doing one of the following: Ask the dietary server for the correct piece of adaptive equipment. contact the kitchen to have the correct item brought to the nursing unit. Should a resident no longer want or need a piece of adaptive eating equipment, the item(s) will be removed from the meal ticket and the care plan along with a progress note entered. Random audits will be completed weekly to ensure compliance. Audit results will be presented to the QA committee and continued until the QA committee suspends due to substantial compliance. The Dietary Manager or designee will be responsible.	

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2 565	Continued From page 10 explained adaptive equipment was placed on trays by the food service workers and a resident's adaptive equipment needs were noted on their dietary slips used for tray preparation. A policy and procedure was requested for following a resident care plan and was not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing and dietary manager could review who should have adaptive equipment and mealtime. Procedures could be developed to ensure equipment will be provided and appropriate staff trained. Audits could be conducted to determine compliance and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 565		
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 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.	2 830		9/6/16

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2 830	Continued From page 11 This MN Requirement is not met as evidenced by: Based on observation, and interview, the facility failed to ensure appropriate wheelchair positioning was provided for 1 of 2 residents (R3) reviewed for positioning. Findings include: R3 was observed in his wheelchair (w/c) in his room on 7/26/16, at 6:32 p.m. The resident was leaning to the left and was watching television. The following morning at 9:20 a.m. R3 was again in his wheelchair and leaning to the left as he watched television. On 7/27/16, at 9:42 a.m. during an observation of cares in R3's room, health services technicians (HST)-A and HST-E both verified R3 was leaning to the left in his wheelchair. HST-E reported it was usual for the resident to lean to the left while seated in his wheelchair. On 7/27/16, at 12:27 p.m. R3 was observed in the dining room. He was leaning to the left with his left elbow positioned on the armrest of the w/c. Registered nurse (RN)-A verified the resident's poor positioning at 12:38 p.m. RN-A said she planned to make a referral to occupational therapy staff for w/c positioning. RN-A stated she had been unaware of any positioning concerns and she had not received a report of positioning concerns regarding R3. On 7/27/16, at 2:59 p.m. HST-F stated, "We can't help [R3] with wheelchair positioning. We can sit him straight in the wheelchair and he would lean to the left. We try to reposition him in the wheelchair so he is not leaning, but when we	2 830	R 3 has been evaluated by Occupational Therapy for wheelchair positioning. Residents who use wheelchairs for mobility, will be observed by the RN Unit Managers, RN Seniors or RN's to observe for issues with their wheelchair positioning. If there is an issue noted with a resident's wheelchair positioning the RN Unit Manager or RN Senior will contact OT and request a screen. New admissions who use a wheelchair for mobility will be screened by OT to ensure wheelchair is appropriate. Random weekly audits of wheelchair positioning will be completed by OT staff members. Random audits will be presented to the QA Committee. Audits will be discontinued when the committee feels there is substantial compliance. The Rehab Director or designee is responsible.	

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2 830	Continued From page 12 come back [R3] is leaning to the left." HST-F stated she had not reported any concerns related to R3's positioning, but they did discuss issues as a team. On 7/28/16, at 8:26 a.m. R3 was observed in the dining room, and was again leaning to the left in his w/c. At 8:44 a.m. occupational therapist/registered (OTR)-D verified R3 was leaning in his w/c, and said he had always excessively leaned while seated. She reported she had just received an order that morning for a positioning assessment. OTR-D stated to her knowledge there had been no other referrals since the resident was screened in 12/15. OTR-A explained R3 had poor trunk and neck strength, which was anticipated based on his disease process. W/c positioning concerns were usually brought up in a interdisciplinary team meetings, which therapists attended weekly. OTR-A also stated staff was also able to obtain a physician's order for w/c positioning and make a referral to therapists as needed. On 7/28/16, at 9:11 a.m. OTR-A stated she had completed a therapy screen to determine R3's positioning needs. She planned to order a different w/c back and a different head rest to trial. OTR-A stated being able to eat independently was important for R3, as this is the only activity of daily living he was able to do for himself. OTR-A stated the plan was to try to achieve appropriate positioning that would allow him to maintain his current level of independence with self-feeding. SUGGESTED METHOD OF CORRECTION: The director of nursing and occupational therapists could evaluate persons in wheelchairs to determine whether their current wheelchair meets	2 830		

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2 830	Continued From page 13 the resident's need, or whether proper positioning could be maintained with other adaptive devices/positioning. Audits could be conducted to determine whether residents appear comfortable, and results could be brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to utilize proper hand hygiene between glove changes for 1 of 5 residents (R1) whose cares were observed. Findings include: R1 was assisted with morning cares on 7/28/16, at 7:10 a.m. two human service technicians (HST)-G and HST-I. Both HSTs washed their hands and donned gloves, and then washed the resident's feet and legs and applied lotion. HST-I washed R1's groin and perineal area, removed her gloves and left R1's room without washing or otherwise sanitizing her hands. At 7:17 a.m. HST-I returned to R1's room with incontinence briefs. HST-I confirmed she had not wash nor sanitize her hands after removing her gloves after	21375	R1 residents' cares are being done utilizing proper hand hygiene and glove use. All other residents' cares are being done utilizing proper hand hygiene and glove use. Nursing staff will be educated on the Hand Hygiene policy regarding hand washing and glove use. Random weekly observational audits will be done to ensure proper hand washing and glove use. DON or designee will be responsible. Audit results will be presented to the QA Committee and continued until the QA Committee suspends them due to substantial compliance.	8/30/16

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21375	Continued From page 14 performing perineal care. R1's Diagnosis Report included diagnoses of Alzheimer's disease and dementia. R1's quarterly review minimum data set (MDS) dated 6/4/16, indicated R1 needed extensive assistance with transfers, dressing, toileting and personal hygiene. R1's care plan directed two staff extensive assist with bathing, grooming and dressing. On 7/28/16, at 10:12 a.m. registered nurse (RN)-D stated it was the facility's expectation that staff will always wash hands before and after donning gloves during cares. The facility's 7/30/10, Hand Hygiene policy directed staff to wear gloves when contact with potentially infectious materials could occur and to decontaminate hands after removing gloves. SUGGESTED METHOD OF CORRECTION: The director of nursing and infection control nurse could ensure all staff have been trained and are following policies. Audits could be conducted to ensure staff are able to demonstrate understanding of proper hand hygiene. The results of the audits could be brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21375		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment,	21880		9/6/16

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21880	Continued From page 15 to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure.	21880		

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21880	Continued From page 16 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to address grievances for 1 of 1 resident (R4) reviewed for room accommodations, 1 of 5 residents (R16, R18) whose formal grievances were reviewed. Findings include: R4 had grievances filed on his behalf, however, the persons who filed the concerns reported they had not been informed of the facility's efforts toward resolution. During an interview on 7/26/16, at 9:50 a.m. family member (F)-A reported filing and presenting written grievances to facility staff. Later, at 1:00 p.m. family friend (FF)-A reported submitting grievances, as well. Although registered nurse (RN)-A had called with responses, a written response was not received. The following day at 9:00 a.m. FF-A reported submitting three grievances on R4's behalf, handing them the Officer of the Day (OD), however, written responses had not been received. FF-A summarized the three grievances: 1) Staffs' continued reports that R4's behaviors are causing staff injury. FF-A stated the family feels badly but cannot do anything about the resident's behavioral issues. 2) Poor wheelchair positioning causes R4 increased agitation. 3) R4 had an episode of agitation, crying, and vomiting; family requested more medication oversight. During interview on 7/27/16, at 12:25 p.m. licensed social worker (LSW)-B reported finding one undated grievance for R4 in the social services office. She explained the facility had seven business days to respond to a grievance in	21880	R4 room change request has been re-reviewed. All residents who request room changes will have the requests documented on grievance forms. When appropriate, room changes are accommodated. Leadership team members, nursing management and social workers will be educated that all room change requests will be addressed on a Grievance form. Random weekly audits of Grievances regarding documentation and resolution of room change requests will be done. Social Services Director will be responsible. Audit results will be presented to the QA committee and continued until the QA committee suspends due to substantial compliance.	

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21880	Continued From page 17 writing, and was unsure whether the family had been given a written response to the grievance. Registered nurse (RN)-A verified on 7/27/16, at 2:30 p.m. having all three grievance forms for R4, all dated 6/14/16. RN-A reported having called the family with responses to all three grievances. Resolutions were documented as 1) Resolution--staff education, 2) Resolution--consult nurse practitioner and occupational therapy evaluation, 3) Resolution--seen by nurse practitioner, RN-A spoke with family, antidepressant medication decreased per family request. During interview on 7/27/16, at 3:00 p.m. LSW-A reported being unaware of any grievances filed for R4. LSW-A stated the process for grievances was to follow up with the complainant verbally, and written responses were not required. In a follow up interview with RN-A on 7/28/16, at 7:15 a.m. she stated she had telephoned R4's family with verbal responses to the grievances, and was unaware a written response was required. The director of nursing verified on 7/28/16, at 9:00 a.m. awareness of grievances on R4's behalf. The DON stated the facility's process was to provide a written response on the grievance form, but it was not an expectation to provide a written response to the complainant. The DON verified facility policy directed written response provided to the complainant within seven working days. R16's family (F-C and F-D) brought a concern regarding personal safety of the resident to the surveyor on 7/27/16, at 11:00 a.m. The concern	21880		

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21880	Continued From page 18 was related to a friend from outside the facility taking R16 out in her car and without signing him out per facility procedure. Because R16 had cognitive decline, poor decision making skills, and a history of poor anger management skill, they were afraid R16 may try to drive the vehicle and/or would not wear his seat belt. Another concern was that the friend provided R16 with food against the resident's care plan related to a previous choking incident. F-C and F-D reported having multiple conversations with the friend requesting she not take R16 out of the facility. The friend had admitted to the family members she was unable to control R16 when he made requests to leave the building or obtain food. F-C and F-D stated they had been told by staff R16 may need to move to another facility if he did not refrain from leaving the building. The family felt R16 should not have been punished for the actions of the friend, and produced a copy of a 6/28/16, email letter to the administrator outlining their concerns. Progress notes were as follows: 1) 6/25/16, R16 left without signing out--security guard reported seeing him dropped off by a woman and getting out of a car 2) 5/4/16, getting into a car with a female friend; when asked if he had signed out he reported he had not and the friend reported she did not know. Staff requested they return and sign out, and were told the police would be notified if R16 was missing and not signed out. 3) 5/4/16, R16 attempted to leave the facility with a woman but was stopped; staff spoke to the woman who reportedly seemed to acknowledge she should not take the resident out of the facility. "She has been asked not to do this in the past, but still continues to do the opposite."	21880		

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21880	Continued From page 19 A Determination of Ability to Make health Care Decisions form for R16 was signed by a physician on 6/4/15. The form indicated R16 was no longer able to make health care decisions due to chronic cognitive impairment (dementia) of significant severity. A neurological assessment completed 7/7/15, indicated R16 was not safe to make his own medical and financial decisions for himself and was a vulnerable adult. The administrator was interviewed on 7/27/16, at 4:30 p.m. The administrator acknowledged receipt of the letter of concern dated 6/28/16, and said he was planning, but had not yet scheduled a meeting. The administrator was aware R16's friend understood she was not to take the resident off campus, but was "becoming more covert about it." He was unaware of the friend providing food for R16 against his care plan. The administrator stated R16 was his own guardian, therefore they could not prohibit the relationship. He had advised the family to pursue guardianship and a restraining order. LSW-D was interviewed on 7/28/16, at 9:00 a.m. and said she had attended several meetings with R16's family and had met privately with R16's friend. The plan was for the friend to visit within the facility, and not to leave the campus. When she recently was found returning with R16 in her car, she explained R16 had followed her to her car and she did not know how to handle the situation. LSW-D said she was aware the administrator planned to meet with R16's family, and was "anxiously" awaiting further direction. R18's nursing notes, dated 6/5/16 indicated F-A had reported removing the resident's jacket to find a large bleeding skin tear on the resident's arm.	21880		

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21880	Continued From page 20 An incident report dated 6/5/16 indicated R18 had been noted with a large skin tear on his arm noted by F-A when she removed his jacket, which was reported to the OD, nurse manager and the nurse practitioner. R18's nursing progress notes dated 6/15/16, indicated F-A had met with a LSW and nurse manager related to the concerns on 6/5/16. F-A then provided pictures of R18's jacket and stated she wanted the incident and discussion to be "on record." Follow-up was noted as F-A chose not to file a grievance, as her concern regarding the skin tear was resolved. During interview on 7/27/16, at 9:55 a.m. F-A stated she outlined her concerns regarding finding R18 with a large, bleeding skin tear, and blood on his pillow, quilt, and jacket in a letter to administration. She had submitted the letter "several weeks ago" but had not received any feedback. F-A provided a letter dated 6/5/16, to the Commissioner of Veterans Affairs. F-A reported she had initially reported her concern to the LSW and nurse manager at the time of the incident and expressed concern it could have been abuse. F-A alleged she was "discouraged" from filing a formal grievance. During interview on 7/27/16, at 2:26 p.m. LSW-C reported being the LSW on R18's unit and said she would have reported potential abuse to her supervisor. LSW-C verified learning of R18's skin tear approximately a month prior, which she and the nurse manager discussed with F-A. LSW-C stated it was her impression F-A was satisfied with the outcome of the discussion. The administrator reported on 7/28/16, at 11:40	21880		

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21880	Continued From page 21 a.m. he was unaware of the incident on 6/5/16, involving R18, nor had he seen the letter that same date addressed to the Commissioner, nor had he followed up with F-A. The director of nursing stated on 7/28/16, at 11:47 a.m. she had also not seen the photos or letter F-A sent to the Commissioner, and had not followed up with F-A. Document review of facility Resident Concern/Grievance Procedure dated 10/23/12, revealed "A resident has a right to voice grievances without discrimination or reprisal." The procedure included bringing a concern to any staff, verbal or written, the supervisor will report the resolution to resident or person who initiated the concern within two working days of receipt of the concern. If the concern can not be resolved, a grievance form will be provided. Within seven working days of receipt of the grievance, the responder will meet with the grievance and review and give written response to the grievance. The policy included other State agencies names and telephone numbers to contact with concerns. SUGGESTED METHOD OF CORRECTION: The administrator and director of nursing could review and revise facility policies to ensure a system to include written resolution to grievances be provided to the grievance. The director of nursing could educate all staff on the grievance process and monitor staff compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21880		
21995	MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults	21995		9/6/16

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21995	Continued From page 22 Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure injuries of unknown origin were thoroughly investigated and immediately reported to the administrator and designated State agency (SA) for 2 of 5 residents (R18, R22) reviewed for abuse. Findings include: R18's nursing progress notes and an incident report dated 6/5/1, indicated F-A had reported to a nurse she had discovered a large, bleeding skin tear on R18's arm upon removing his jacket. The report indicated there were no witnesses, but R18 had an unsteady gait and could have bumped up against the doorway and did not use his call light to seek help. The officer of the day (OD), nurse manager and the nurse practitioner (NP) had been notified of the incident. No further investigation was documented, however, such as interviews with staff persons who had worked with the resident, or who may have had information regarding the injury. Nursing progress notes for R18 dated 6/15/16,	21995	The incidents of alleged abuse/neglect by R18 and R22 has been reported to the designate state agency and thoroughly investigated. All incidents of alleged abuse are being reported to the designated state agency and investigated. Staff educated on the facilities policy for Vulnerable Adult/Resident Protection Plan for reporting allegations of abuse/neglect. Audits will be conducted weekly on incidents of alleged abuse/neglect for timeliness of reporting to the designated state agency. Findings will be reviewed by the QA committee. Audits will continue indefinitely until the Interdisciplinary Team determines substantial compliance. The Administrator or designee is responsible and immediately notified.	

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21995	Continued From page 23	21995		

revealed F-A had met with the unit's licensed social worker (LSW) and registered nurse (RN) related to concerns about a skin tear and soiled jacket she had observed on 6/5/16. The RN educated the F-A as to likely sources for the skin tear according to the note. F-A provided pictures of R18's jacket and stated she wanted the incident and discussion to be on record. The follow-up noted F-A chose not to file a written grievance, as her concern regarding the skin tear was resolved.

F-A was interviewed on 7/27/16, at 9:55 a.m. and reported that on 6/5/16, she arrived at the facility to find R18's jacket inside out, and he was bleeding from his right arm. Upon removing the resident's jacket, she discovered the inside was "covered" with blood and he had a large skin tear extending most of the way up his arm with a skin tear on top. F-A reportedly told the nurse and first aid was given and his arm bandaged. Family-A returned to R18's room and observed the resident's pillow and quilt were also soiled with blood. She then reported the incident to administration, and submitted a letter regarding her concerns "several weeks ago" but had not received any response. F-A produced a letter dated 6/5/16, to the Commissioner of Veterans Affairs which detailed the incident. Additionally, F-A said she reported her concern for potential abuse to the LSW and RN manager, but was allegedly discouraged from filing a formal grievance.

R18 was observed in bed and an interview was attempted on 7/27/16, at 2:00 p.m. The resident's skin appeared thin in appearance, but no large visible bruises were seen. When asked if anyone at the facility had ever hurt him he replied, "Yes." R18 said he was "hit" on the head, but was

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	00233	A. BUILDING: _____ B. WING _____	07/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME MINNEAPOLIS	5101 MINNEHAHA AVENUE SOUTH MINNEAPOLIS, MN 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) COMPLETE DATE
21995	Continued From page 24	21995		

unable to provide any further details or information regarding the incident on 6/5/16.

R18's 1/19/16, Care Area Assessment for behavior, indicated R18 experienced some confusion at times. The 7/21/16, quarterly Minimum Data Set (MDS) indicated the resident had severe cognitive impairment and had symptoms of delusions. R18 required extensive assistance of two staff members for bed mobility, transfers and dressing.

R18's 7/25/16, care plan included a mood fluctuations related to dementia, periods of anxiety and fear that he was being followed by men who wanted to hurt him. Interventions included monitoring for target behaviors, including paranoid delusions he was being attacked during the night by strangers. R18's 7/27/16, face sheet indicated diagnoses including dementia with behaviors and repeated falls.

On 7/27/16, at 1:45 p.m. licensed practical nurse (LPN)-E indicated when a skin tear was noted the nurse would assess the wound, cleanse it, measure it and provide first aid. LPN-E indicated that typically the RN in charge would next be notified of injuries or suspicions of abuse and file an incident report.

Licensed social worker (LSW)-C stated on 7/27/16, at 2:26 p.m. she would report suspicions/concerns of abuse to her supervisor. Further, LSW-C stated she generally only handled concerns related to financial exploitation and would have expected nursing to address injuries of unknown origin for potential reporting to outside agencies. LSW-C indicated she was informed by F-A approximately a month ago about the skin tear injury and bloody jacket noted

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21995	Continued From page 25 during her visit on 6/5/16, and RN-C was present during this discussion, however, was on vacation this week. LSW-C stated she did not believe the incident had been reported to the SA. LSW-C indicated RN-C had discussed with family about likely sources for the skin tear and that at that time R18 had been having increased delusions about being hurt and someone being out to hurt him. LSW-C indicated she thought F-A had been satisfied when she left her office after the meeting with the outcome. During interview on 7/27/16, at 2:37 p.m. RN-E reported he was aware of R18's skin tear injury on 6/5/16, and said F-A had been thinking it could have been either staff or just him trying to remove the jacket, although F-A did not think the resident was capable. RN-E indicated he had not been working the day of the incident, however would generally report abuse situations or injuries of unknown origin to the OD on evenings and weekends or the RN manager and begin investigation into the causes. Documentation related to the investigation should have been documented on the incident report. If there was an injury or suspected injury the doctor or nurse practitioner would be notified, but the supervisor or OD would determine if it was reportable. During interview on 7/27/16 at 2:26 p.m. licensed practical nurse (LPN)-D indicated R18 generally experienced a lot of paranoia about being assaulted/attacked and was resistive with cares, at times exhibiting physical behaviors. LPN-D indicated the skin tear of 6/5/16, may not have been considered unusual for R18 at the time. Had LPN-D been working he would have provided first aid, started an incident report and informed the OD.	21995		

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21995	Continued From page 26 During an interview on 7/28/16, at 10:00 a.m. RN-D indicated she often functioned as the OD on weekends and if there was a suspected abuse incident she would begin investigating and immediately inform the SA and administrator. The administrator reported being unaware of R18's incident of 6/5/16, when interviewed on 7/28/16, at 11:40 a.m. nor had he seen a letter written to the Commissioner regarding the incident. During interview on 7/28/16, at 11:47 a.m. the director of nursing (DON) indicated she had not seen the photos or letter F-A sent to the Commissioner on 6/5/16, but said the situation should have been immediately investigated and reported to the SA and administrator. The DON stated it would be "reported today." A health services technician reported on 7/28/16, at 8:51 a.m. that R22 informed him "A girl on the night shift 'yanks' him around." He stated he had informed RN-C immediately, but had also suggested R22 report the allegation himself, "because sometimes it has more weight coming from a resident." HST-G continued, "I saw [R22] two days ago and he said the girl still working with him. I didn't see her for two days so I thought she was reprimanded, but I asked him, "Was she nicer?" and he replied, "'No.'" On 7/28/16, at 10:06 a.m. R22 was interviewed and said every night the HST worked with him she was rushing and said, "She stays about two minutes--nearly pulls my arms out of their sockets. My shoulders don't have any cartilage in them," and his joints were bone on bone from many hard landings as a paratrooper. "I gotta be	21995		

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21995	Continued From page 27	21995		

careful with them, but she jerks them hard...She's got no time for my handicap. She pushes me down on the bed and then walks out of the room." He said he RN-C and said, "She just listened. That was three days ago and I haven't heard anything." R22 sighed and added, "I served for years in the service and now I can't help myself...I just need a little help."

R22's health record included diagnoses of Parkinson's disease (causing shaking and loss of strength) and impingement syndrome of left shoulder (causing pain and limitation of movement). The Minimum Data Set assessment dated 5/14/16, indicated R22 was unsteady and needed extensive assistance with transfers and walking in the room. Additionally the MDS pain assessment indicated R22 had near-constant severe pain which limited his activities and made it hard to sleep. R22's current care plan included a pain in both shoulders, Parkinson's disease that included poor balance and medication side effects of dizziness. It was also noted R22 had chronic pain and needed extensive assist with all transfers, to rise to standing and to stay steady while standing.

On 7/28/16, at 11:16 a.m. the assistant director of nursing (ADON) was interviewed and indicated no report had been filed with the SA for R22. "I would do that and I just found out about it this morning. I sent an email to the night supervisor to speak with the HST and the resident to follow up...I would have expected [RN-C] to speak to the resident, get names, follow up with the HST, and possibly take the HST off duty if we determined there was an abuse allegation." She indicated she would now look for documentation of the reports to RN-C, adding "I can't say if the reporting is timely without knowing the facts."

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21995	Continued From page 28 When asked what her expectations were for this situation she said, "I, myself would follow up immediately as soon as I find out. If we feel it's abuse or if a resident reports as abuse, we would report to the Common Entry Point [CEP, the designated State agency] within 24 hours at the most, but usually would do that on the shift where we found out about it." Later, at 1:27 p.m. in a meeting with the DON, the ADON reported, "I could not find any documentation of the situation from [RN-C]. Incidents like this are usually brought to my attention, then reported to the CEP if they are reportable. The DON followed up: "We WILL be reporting that today. In this case, because it was an allegation of abuse we would report it either way." The facility's 10/28/13, Resident Protection Plan policy indicated upon receiving a complaint of alleged maltreatment, the OD would immediately notify the administrator and DON. The OD would coordinate with the ADON and DON to coordinate and investigation. Additionally, the policy indicated the OD would immediately report all suspected maltreatment to the administrator, and the ADON on call, and interdisciplinary team members as delegated and to other officials in accordance with State law. SUGGESTED METHOD OF CORRECTION: The administrator and director of nursing could ensure all staff were trained in reporting immediately to the administrator and SA. The director of nursing could educate all staff on the grievance process and monitor staff compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21995		

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	245620	A. BUILDING **01 - BLDG 19** B. WING _____	**07/26/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on July 26, 2016. At the time of this survey, Minnesota Veterans Home Minneapolis, Building 19, was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. This 4 story, Type II (222) construction without a basement and was constructed in 2012. The facility is fully fire sprinkler protected with smoke detection in the corridors and areas open to the corridors which are monitored for automatic fire department notification. The facility is attached to non-Medicare receiving facilities and is separated by 2-hour fire walls with 90-minute doors. There is no parking within the facility, is a smoke-free facility and all cooking for the residents is conducted in a separated building. The facility has a capacity of 100 beds and had a census of 91 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/26/2016

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
	245620	A. BUILDING **02 - BUILDING 21** B. WING _____	**07/26/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME MINNEAPOLIS	**5101 MINNEHAHA AVENUE SOUTH MINNEAPOLIS, MN 55417**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on July 26, 2016. At the time of this survey, Minnesota Veterans Home Minneapolis, Building 21, was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/26/2016

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
	245620	A. BUILDING **02 - BUILDING 21** B. WING _____	**07/26/2016**

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K 000	Continued From page 1 prevent a reoccurrence of the deficiency. Minnesota Veterans Home Building 21 is a 3-story building with partial basement the construction Type II(222) construction. This building is attached to a Nursing Home built in 2012 with a 2 hour separation, this facility will be surveyed as 1 building. The facility is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection, resident rooms and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 100 beds and had a census of 89 beds at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 160 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in A17.1, Safety Code for Elevators and Escalators. Fire Fighter's Service is operated monthly with a written record. New elevators conform to ASME/ANSI A17.1, Safety Code for Elevators and Escalators, including Fire Fighter's Service Requirements. 9.4.2, 9.4.3, 18.5.3 (Includes firefighters service phase I key recall and smoke detector automatic recall, firefighters service phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain elevators in accordance with NFPA 101 "The Life Safety Code" (2000	K 160	The facility will provide a HVAC system capable of keeping the two elevator rooms in Building 21 within the	9/15/16

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	245620	A. BUILDING **02 - BUILDING 21** B. WING _____	**07/26/2016**

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

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K 160	Continued From page 2 edition) section 9.4.5. This deficient practice could effect all 89 residents. Findings include: On a facility tour between the hours of 10:00 AM and 03:00 PM on July 26, 2016, observation revealed that the elevator machine room did not have an HVAC system capable of keeping the room at the manufacturers recommended 60 to 80 degrees Fahrenheit. This deficient practice was verified by the Physical Plant Director at the time of inspection.	K 160	manufacturers recommended 60 to 80 degrees Fahrenheit. The correction will be accomplished by the installation of new air conditioning equipment in the two elevator rooms. Subsequent to installation, room temperature audits of the two elevator rooms will be conducted to monitor the performance of the HVAC system. HVAC system adjustments will be made as needed to ensure the recommended room temperatures are maintained. Room temperature audit reports will be submitted the organizations Quality Council for review. Physical Plant Director or designee is responsible.	