

# PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS NOTICE OF CORRECTION OF ORDERS FOR NURSING HOMES

Electronically Delivered February 21, 2016

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

RE: Project Number S5620002

Dear Mr. Glad:

On February 21, 2016, a Notice of Assessment for Noncompliance with Correction Orders was issued to the above facility. That Notice, which was received by the facility on 11/30/2015, did not impose a daily fine. However, the notice required correction violations.

On December 18, 2015, an acknowledgement was electronically received by the Department stating that the violation(s) had been corrected. A reinspection was held on December 22, 2015 and it was determined that compliance with the licensing rules was attained. A copy of the State Form: Revisit Report from this visit is being delivered electronically.

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 Email: mark.meath@state.mn.us Telephone: (651) 201-4118 Fax: (651) 215-9697

cc: Program Assurance Unit Penalty Assessment Deposit Staff

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#### STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT			
IDENTIFICATION NUMBER	A. Building					
00233 <sub>Y1</sub>	B. Wing	Y2	12/22/2015	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).

ITE	М	DATE	ITEM		DATE	ITEM		DATE
Y4		Y5	Y4		Y5	Y4		Y5
ID Prefix	21565	Correction	ID Prefix 23	3010	Correction	ID Prefix		Correction
Reg. #	MN Rule 4658.13 Subp. 4	25 Completed	Reg. #	N Rule 4658.4635 A	Completed	Reg. #		Completed
LSC		12/22/2015	LSC		12/22/2015	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		
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		
REVIEWE STATE AG		REVIEWED BY (INITIALS) GL/mm	<b>DATE</b> 01/26/2010	SIGNATURE OF S	SURVEYOR 35574			<b>date</b> 12/22/2015
REVIEWE CMS RO	D BY	REVIEWED BY (INITIALS)	DATE	TITLE	TITLE			DATE
FOLLOWUP TO SURVEY COMPLETED ON 9/17/2015		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					<b>CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>			
					AND TRANSMITTAL	ID: V6NP		
	PART I -	TO BE COMPL	LETED BY T	THE STAT	<b>FE SURVEY AGENCY</b>	Facility ID: 00233		
1. MEDICARE/MEDICAID PROVIDE (L1) 245620	R NO.	3. NAME AND AD (L3) <b>MN VETER</b>	ANS HOME N	MINNEAP		4. TYPE OF ACTION: <u>7 (</u> L8) 1. Initial 2. Recertification		
2.STATE VENDOR OR MEDICAID NO (L2) 743749800	0.	(L4) 5101 MINNEHAHA AVENUE SOUT (L5) MINNEAPOLIS, MN		(L6) <b>55417</b>	3. Termination     4. CHOW       5. Validation     6. Complaint       7. On-Site Visit     9. Other			
5. EFFECTIVE DATE CHANGE OF O (L9)	WNERSHIP	7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRD			<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint		
6. DATE OF SURVEY 11/12/ 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 06/30		
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED	AS:				
From (a):		A. In Complian	nce With		And/Or Approved Waivers Of	The Following Requirements:		
To (b):			equirements e Based On:		2. Technical Personnel	—		
12.Total Facility Beds	<b>502</b> (L18)	-	cceptable POC		3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code	<ul> <li>7. Medical Director</li> <li>NF)8. Patient Room Size</li> <li>9. Beds/Room</li> </ul>		
13.Total Certified Beds	<b>100</b> (L17)	X B. Not in Com Requireme	pliance with Prog ents and/or Appli		* Code: <b>B</b> *	(L12)		
14. LTC CERTIFIED BED BREAKDOW	WN				15. FACILITY MEETS			
18 SNF 18/19 SNF 100	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMA See Attached Remarks	ARKS (IF APPLICA	ABLE SHOW LTC CA	NCELLATION I	DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:		
Elizabeth Nelson, HFE NEII 11/24/2015			(L19)	mare meath, Enforcement Specialist 01/29/2016				
PAR	T II - TO BE	COMPLETED B	BY HCFA RE	· /	L OFFICE OR SINGLE S			
19. DETERMINATION OF ELIGIBILI	TY	20. COM	PLIANCE WITH		<ul> <li>21. 1. Statement of Financial Solvency (HCFA-2572)</li> <li>2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)</li> <li>3. Both of the Above :</li> </ul>			
2. Facility is not Eligible	(L21)							
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	. LTC AGREEN	1ENT	26. TERMINATION ACTION	: (L30)		
OF PARTICIPATION <b>01/06/2014</b>	BEGINNINC	G DATE	ENDING DAT	ГЕ	<u>VOLUNTARY</u> <u>0</u> 01-Merger, Closure	DINVOLUNTARY 05-Fail to Meet Health/Safety		
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	ement 06-Fail to Meet Agreement		
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	on <u>OTHER</u>		
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change		
(L27)	B. Rescind St	uspension Date:	(L44)			00-Active		
			(L45)					
28. TERMINATION DATE:	29	9. INTERMEDIARY/	CARRIER NO.		30. REMARKS			
	03001							
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	DATE				
	(L32)	11/23/2015		(L33)	DETERMINATION APP	ROVAL		

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES** MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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

On October 23, 2015, the Minnesota Department of Health, Office of Health Facility Complaints completed a Post Certification Revisit (PCR) and on November 12, 2015, the Minnesota Department of Health, Licensing and Certification Program completed a PCR to verify that the facility had achieved and maintained compliance with federal certification deficiencies. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 11, 2015. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to the abbreviated standard survey (complaint investigation number H5620010 and the standard survey completed September 17, 2015, effective October 11, 2015.

As a result of the revisit findings, the Category 1 remedy of state monitoring is discontinued as of October 11, 2015.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in our letter of October 1, 2015:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective December 1, 2015, be rescinded. (42 CFR 488.417 (b))

Since denial of payment did not go into effect the facility would not be subject to a two year loss of NATCEP which was to begin December 1, 2015. Refer to the CMS 2567b form.

Effective October 11, 2015, the facility is certified for 100 skilled nursing facility beds.

ID: V6NP

Facility ID: 00233



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245620

January 29, 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 October 11, 2015 the above facility is certified for:

100 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 100 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 meeth

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

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# **REVISED LETTER**

Electronically delivered January 29, 2016

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

RE: Project Number H5620010 and S5620002

Dear Mr. Glad:

Please Note: This revised letter supercedes the previous letter dated November 24, 2015. Specifically, deficiency cited at F463 during the September 17, 2015 standard survey, was determined to be corrected at the time of the November 12, 2015 Post Certification Revisit (PCR).

On October 1, 2015, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective October 6, 2015. (42 CFR 488.422)

On October 1, 2015, the Department recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedy be imposed:

• Mandatory denial of payment for new Medicare and Medicaid admissions effective December 1, 2015. (42 CFR 488.417 (b))

Also, the Department notified you in their letter of October 1, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from December 1, 2015.

This was based on the deficiencies cited by this Department for an abbreviated standard survey completed September 1, 2015 and a standard survey completed on September 17, 2015, and lack of verification of compliance at the time of our October 1, 2015 notice. The most serious deficiencies were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On October 23, 2015, the Minnesota Department of Health, Office of Health Facility Complaints completed a Post Certification Revisit (PCR) and on November 12, 2015, the Minnesota Department of Health, Licensing and Certification Program completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an abbreviated standard survey completed September 1, 2015 and a standard survey completed September 17, 2015. We

Mn Veterans Home Minneapolis January 29, 2016 Page 2

presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 11, 2015. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to the abbreviated standard survey completed September 1, 2015 and the standard survey completed September 17, 2015, effective October 11, 2015. As a result of the revisit findings, the Category 1 remedy of state monitoring is discontinued as of October 11, 2015.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective October 11, 2015.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of October 1, 2015 The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective December 1, 2015, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective December 1, 2015, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective December 1, 2015, is to be rescinded.

In our letter of October 1, 2015, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 1, 2015, due to denial of payment for new admissions. Since your facility attained substantial compliance on October 11, 2015, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

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

# **POST-CERTIFICATION REVISIT REPORT**

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	-
IDENTIFICATION NUMBER	A. Building			
245620 <sub>Y1</sub>	B. Wing	Y2	11/12/2015	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 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).

ITE	ITEM DATE		ITEM		DATE	ITEM			DATE
Y4		Y5	Y4		Y5	Y4			Y5
ID Prefix Reg. # LSC	F0225 483.13(c)(1)(ii)-(iii - (4)	Correction ), (c)(2) Completed 10/11/2015	ID Prefix F0226 Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC	F0463 483.70(f)		Correction Completed 10/11/2015
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
REVIEWE STATE AG REVIEWE CMS RO FOLLOWI 9/17/2013	BENCY	REVIEWED BY (INITIALS) GL/mm REVIEWED BY (INITIALS)		SIGNATURE OF S	13603			DATE 11/12 DATE	2/2015

DEPARTMENT OF HEALTH AND HUMAN SERVICES					<b>CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>			
					AND TRANSMITTAL	ID: V6NP		
	PART I -	TO BE COMPI	LETED BY T	THE STAT	ΓE SURVEY AGENCY	Facility ID: 00233		
1. MEDICARE/MEDICAID PROVIDE (L1) 245620	R NO.	3. NAME AND AD (L3) <b>MN VETER</b>	ANS HOME N	MINNEAP		<ol> <li>TYPE OF ACTION: <u>7 (L8)</u></li> <li>Initial</li> <li>Recertification</li> </ol>		
2.STATE VENDOR OR MEDICAID NO (L2) 743749800	Э.	(L4) 5101 MINNEHAHA AVENUE SOUT (L5) MINNEAPOLIS, MN		(L6) <b>55417</b>	3. Termination     4. CHOW       5. Validation     6. Complaint       7. On-Site Visit     9. Other			
5. EFFECTIVE DATE CHANGE OF O (L9)	WNERSHIP	7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRD			<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint		
6. DATE OF SURVEY 11/12/ 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 06/30		
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED	AS:				
From (a):		A. In Complian	nce With		And/Or Approved Waivers Of	The Following Requirements:		
To (b):			equirements e Based On:		2. Technical Personnel			
12.Total Facility Beds	<b>502</b> (L18)	-	cceptable POC		3. 24 Hour RN 4. 7-Day RN (Rural SM 5. Life Safety Code	<ul> <li>7. Medical Director</li> <li>NF)8. Patient Room Size</li> <li>9. Beds/Room</li> </ul>		
13. Total Certified Beds	<b>100</b> (L17)	X B. Not in Com Requireme	pliance with Prog ents and/or Appli		* Code: <b>B</b> *	(L12)		
14. LTC CERTIFIED BED BREAKDOW	VN	-			15. FACILITY MEETS			
18 SNF 18/19 SNF 100	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMA See Attached Remarks	RKS (IF APPLICA	ABLE SHOW LTC CA	NCELLATION I	DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:		
Elizabeth Nelson, HFE NEII 11/24/2015			(L19)	) Enforcement Specialist 01/05/2016				
PAR	T II - TO BE	COMPLETED H	BY HCFA RE	· · /	L OFFICE OR SINGLE S			
19. DETERMINATION OF ELIGIBILI _X1. Facility is Eligible to Pa	TY	20. COM	IPLIANCE WITH		<ul> <li>21. 1. Statement of Financial Solvency (HCFA-2572)</li> <li>2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)</li> <li>3. Both of the Above :</li> </ul>			
2. Facility is not Eligible	(L21)							
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	/IENT	26. TERMINATION ACTION	: (L30)		
OF PARTICIPATION 01/06/2014	BEGINNINC	G DATE	ENDING DAT	ГЕ	<u>VOLUNTARY</u> <u>0</u> 01-Merger, Closure	0 INVOLUNTARY 05-Fail to Meet Health/Safety		
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	sement 06-Fail to Meet Agreement		
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	OTHER		
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-1 Tovider Status Change		
(L27)	B. Rescind St	uspension Date:	(L44)			00-Active		
			(L45)					
28. TERMINATION DATE:	29	9. INTERMEDIARY/	CARRIER NO.		30. REMARKS			
		03001						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	DATE				
	(L32)	11/23/2015		(L33)	DETERMINATION APP	ROVAL		

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: V6NP Facility ID: 00233

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

On October 23, 2015, the Minnesota Department of Health, Office of Health Facility Complaints completed a Post Certification Revisit (PCR) and on November 12, 2015, the Minnesota Department of Health, Licensing and Certification Program completed a PCR to verify that the facility had achieved and maintained compliance with federal certification deficiencies. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 11, 2015. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to the abbreviated standard survey (complaint investigation number H5620010. However your facility has not obtained substantial compliance with the deficiencies issued pursuant to the standard survey completed on September 17, 2015. The deficiency not correct is as follows:

- F0463 -- S/S: D -- 483.70(f) -- Resident Call System - Rooms/toilet/bath

The most serious deficiency in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of the revisit findings, the Category 1 remedy of state monitoring will remain in effect. In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in our letter of October 1, 2015:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective December 1, 2015, remain in effect. (42 CFR 488.417 (b))

If DPNA goes into effect, the facility, would be subject to a two year losso NATCEP.

Refer to the CMS 2567b forms for the results of this vists. Post Certification Revisit to follwo.



Electronically delivered November 24, 2015

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

RE: Project Number H5620010 and S5620002

Dear Mr. Glad:

On October 1, 2015, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective October 6, 2015. (42 CFR 488.422)

On October 1, 2015, the Department recommeded to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedy be imposed:

• Mandatory denial of payment for new Medicare and Medicaid admissions effective December 1, 2015. (42 CFR 488.417 (b))

Also, the Department notified you in their letter of October 1, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from December 1, 2015.

This was based on the deficiencies cited by this Department for an abbreviated standard survey completed September 1, 2015 and a standard survey survey completed on September 17, 2015, and lack of verification of compliance at the time of our October 1, 2015 notice. The most serious deficiencies were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On October 23, 2015, the Minnesota Department of Health, Office of Health Facility Complaints completed a Post Certification Revisit (PCR) and on November 12, 2015, the Minnesota Department of Health, Licensing and Certification Program completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 11, 2015. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to the abbreviated standard survey. However your facility has not obtained substantial compliance with the deficiencies issued pursuant to the standard survey completed on September 17, 2015. The deficiency not correct is as follows:

MN Veterans Home Minneapolis November 24, 2015 Page 2

F0463 -- S/S: D -- 483.70(f) -- Resident Call System - Rooms/toilet/bath

The most serious deficiency in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of the revisit findings, the Category 1 remedy of state monitoring will remain in effect.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in our letter of October 1, 2015:

• Mandatory denial of payment for new Medicare and Medicaid admissions effective December 1, 2015, remain in effect. (42 CFR 488.417 (b))

As we notified you in our letter of October 1, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from December 1, 2015.

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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 Metro D Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: gayle.lantto@state.mn.us

Phone: (651) 201-3794 Fax: (651) 215-9697

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# 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..

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

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

- 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.

MN Veterans Home Minneapolis November 24, 2015 Page 4

# PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

# VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC and CMS Region V Office approval, a revisit of your facility may be conducted to verify that substantial compliance with the regulations has been attained. The revisit would 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the third revisit.

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

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 March 1, 2016 (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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</a>

MN Veterans Home Minneapolis November 24, 2015 Page 5

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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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.

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPRC							
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		OMB 1	NO. 0938-0391		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
		245620	B. WING _		R 11/12/2015		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	11/12/2013		
MN VETERANS HOME MINNEAPOLIS				5101 MINNEHAHA AVENUE SOUTH MINNEAPOLIS, MN 55417			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC 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 COMMENT	rs	{F 00	0}			
	completed on [date tags that were corre CMS2567B. Also th found corrected and	ification revisit (PCR) was of survey]. The certification ected can be found on the here are tag/s that were not d/or new tags were issued at CR which are located on the					
	signature is not req page of the CMS-2	nrolled in ePOC, your uired at the bottom of the first 567 form. Your electronic POC will be used as liance.					
{F 463} SS=D	on-site revisit of you validate that substa		{F 46	3}	12/4/15		
	resident calls through	must be equipped to receive gh a communication system s; and toilet and bathing					
	by: Based on observat review the facility fa available and funct	NT is not met as evidenced tion, interview and document tiled to ensure a call light was tioning for 1 of 1 resident environmental concerns.		During survey R72 call cord was place Care plan was reviewed at the time of survey and residents cognitive inability use call light. All residents that have room changes have the potential to be affected.			
	ically Signed	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE 12/04/2015		
	loany olgricu				12/04/2013		

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

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program participation.

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

PRINTED: 01/05/2016

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		TIPLE CONSTRUCTION		E SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG		PLETED <b>R</b>
		245620	B. WING _			` 12/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		
MN VETI	ERANS HOME MINNE	EAPOLIS		5101 MINNEHAHA AVENUE SOUTI MINNEAPOLIS, MN 55417	1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
{F 463}	Continued From pa	age 1	{F 46	3}		
	p.m. There was no	oserved on 11/12/15, at 9:58 call light available in the room. s attached to the wall, but a call sing.		All resident rooms checked cords are present.	d to endure call	
	A licensed practical nurse (LPN)-A working with R72 was interviewed on 11/12/15, at 10:05 a.m. LPN-A verified that there was no call light available in R72's room. LPN-A stated that R72			Random audits will be con by nursing.Findings will be committee until QA determ compliance.	reported to QA	
	"just moved into th 4th floor." LPN-A s cord in R72's room sure when that was safety issue and th to have a working times." LPN-A state notify person in cha	e room two weeks ago from tated that she saw a call light n "sometime" back but wasn't s. LPN-A stated that it was a hat all residents were supposed accessible call light "at all ed that staff was supposed to arge if there were any concerns and a place a maintenance		ED, DON, ADON responsi	ble.	
	11/12/15, at 10:10 light "is a safety pro- "must" have a func- irrespective of whe not. RN-A stated th staff reported any r "immediately" to th stated that all staff sure call light are fu	(RN)-A was interviewed on a.m. RN-A stated that a call otocol" and that all residents stioning call light in their rooms other they were able to use it or hat her expectation was that non-functioning call light e person in charge. RN-A were responsible of making unctioning "properly" and within d any knowledge of call light				
	R72 was interview HST-A verified that the room. HST-A s in his room this mo	echnician (HST)-A working with ed on 11/12/15, at 10:15 a.m. t R72 did not have a call light in tated "There was no call light orning, and there wasn't any n him on Monday." HST-A				

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		AND HUMAN SERVICES				FORM	01/05/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245620	B. WING			R 11/12/2015	
NAME OF	PROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MN VET	ERANS HOME MINNE	APOLIS			101 MINNEHAHA AVENUE SOUTH MINNEAPOLIS, MN 55417		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
{F 463}	stated that if a call I was supposed to re- person in charge. I- had not reported the having knowledge if that R72 was not ca "he is supposed to stated that, "I shoul guess I didn't." The assistant direct interviewed on 11/1 her expectations wa available and access stated that houseke for call light audits to they were competer ADON approached call light was now a R72's room. The AI were being educate "are being audited." The executive hous interviewed at 11:55 room get cleaned o were checked at the random call lights w housekeepers "hav The maintenance n on 11/12/15, at 1:31 audits were perform MM stated nursing placing work orders there were any issu- also stated, "I check a day, sign them of	tor of nursing (ADON) was 2/15, at 11:17 a.m. stated that as call lights would be working, stated as call lights would be working, ssible "at all times." The ADON eeping staff was responsible but was not sure how often d. Several minutes later the the surveyor and stated that a vailable and functional in DON also stated that call lights wow call lights	{F 4	63}			

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If continuation sheet Page 3 of 4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING       (X3) DATE SURVEY COMPLETED         245620       B. WING       11/12/2015         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE 5101 MINNEHAHA AVENUE SOUTH MINNEAPOLIS, MN 55417       5101 MINNEHAHA AVENUE SOUTH MINNEAPOLIS, MN 55417			AND HUMAN SERVICES				FORM	APPROVED 0938-0391	
245620     B. WING     11/12/2015       NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       MN VETERANS HOME MINNEAPOLIS     STREET ADDRESS, CITY, STATE, ZIP CODE       (X4) ID     SUMMARY STATEMENT OF DEFICIENCIES     STREET MINNEAPA AVENUE SOUTH MINNEAPOLIS, MN 55417       (X4) ID     SUMMARY STATEMENT OF DEFICIENCIES     ID     PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     PREFIX     COMPLETION CROSS-REFERENCED TO THE APPROPRIATE     COMPLETION DEFICIENCY       {F 463}     Continued From page 3 order had been received for R72's missing call light.     [F 463]     F 463]     F 463]       Atter that afternoon at 1:47 p.m. the ADON approached surveyor and stated that a call light assessment "has been added" and it will "now be done on admission and quarterly."     F       R72's quarterly Minimum Data Set (MDS) dated 9/7/15, identified that R72 was severely cognitively impaired. MDS also identified that R72 required extensive assistance of two person physical assist with bed mobility, transfer, dressing and locomotion.     A Housekeeping maintenance monthly room clean inspection log dated 10/21/15, identified R72's room as having "met" the call light inspection. A review of nursing progress notes revealed R72 was transferred to his present room	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	• •				(X3) DATE SURVEY	
Image: Non-Vetteranse Home MinneaPolis       Status and a status and			245620	B. WING	i				
Image: Minimized problem         Summary statement of deficiencies         Image: Minimized problem         Minimized problem <t< td=""><td>NAME OF</td><td>PROVIDER OR SUPPLIER</td><td>-</td><td></td><td></td><td>STREET ADDRESS, CITY, STATE, ZIP CODE</td><td></td><td></td></t<>	NAME OF	PROVIDER OR SUPPLIER	-			STREET ADDRESS, CITY, STATE, ZIP CODE			
Iminearoous       Iminearoous <thiminearoous< th=""> <thiminearoous< th=""></thiminearoous<></thiminearoous<>						5101 MINNEHAHA AVENUE SOUTH			
PRÉFIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PRÉFIX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       computerion DATE         {F 463}       Continued From page 3 order had been received for R72's missing call light.       {F 463}       (F 463)         Later that afternoon at 1:47 p.m. the ADON approached surveyor and stated that a call light assessment "has been added" and it will "now be done on admission and quarterly."       {F 463}         R72's quarterly Minimum Data Set (MDS) dated 9/7/15, identified that R72 was severely cognitively impaired. MDS also identified that R72 required extensive assistance of two person physical assist with bed mobility, transfer, dressing and toilet use. MDS also identified the resident required total dependence with personal hygiene, eating and locomotion.       A Housekeeping maintenance monthly room clean inspection log dated 10/21/15, identified R72's room as having "met" the call light inspection. A review of nursing progress notes revealed R72 was transferred to his present room	MIN VETERANS HOME MINNEAPOLIS					MINNEAPOLIS, MN 55417			
order had been received for R72's missing call light.         Later that afternoon at 1:47 p.m. the ADON approached surveyor and stated that a call light assessment "has been added" and it will "now be done on admission and quarterly."         R72's quarterly Minimum Data Set (MDS) dated 9/7/15, identified that R72 was severely cognitively impaired. MDS also identified that R72 required extensive assistance of two person physical assist with bed mobility, transfer, dressing and toilet use. MDS also identified the resident required total dependence with personal hygiene, eating and locomotion.         A Housekeeping maintenance monthly room clean inspection log dated 10/21/15, identified R72's room as having "met" the call light inspection. A review of nursing progress notes revealed R72 was transferred to his present room	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	COMPLETION	
A facility's Call Light Usage policy dated 7/12, directed that, "Upon admission, the use of the call light will be explained to each new resident. The call light is easily accessible both in the bed and chair, in the shower and bathroom by the toilet. The call light is individualized to what the resident needsResidents who may not be able to utilize the standard call light; have physical barriers or cognitive barriers will be identified and their needs will be listed on their care plan."	{F 463}	order had been rec light. Later that afternoor approached survey assessment "has b done on admission R72's quarterly Min 9/7/15, identified the cognitively impaired required extensive physical assist with dressing and toilet of resident required to hygiene, eating and A Housekeeping ma clean inspection log R72's room as havi inspection. A review revealed R72 was t on 10/26/15. A facility's Call Ligh directed that, "Upor light will be explained chair, in the shower The call light is indi- needsResidents of the standard call lig cognitive barriers w	eived for R72's missing call a at 1:47 p.m. the ADON or and stated that a call light een added" and it will "now be and quarterly." imum Data Set (MDS) dated at R72 was severely d. MDS also identified that R72 assistance of two person bed mobility, transfer, use. MDS also identified the otal dependence with personal d locomotion. aintenance monthly room g dated 10/21/15, identified ing "met" the call light v of nursing progress notes transferred to his present room t Usage policy dated 7/12, n admission, the use of the call ed to each new resident. The ccessible both in the bed and r and bathroom by the toilet. vidualized to what the resident who may not be able to utilize ht; have physical barriers or vill be identified and their needs		63				

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Facility ID: 00233

If continuation sheet Page 4 of 4

PRINTED: 01/05/2016

#### **Post-Certification Revisit Report**

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245620	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 11/12/2015
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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date
ID Prefix		ID Prefix	F0226	Correction Completed 10/11/2015			
	<u>483.13(c)(1)(ii)-(iii), (c)(2)</u> -	Reg. # 4			Reg. # LSC		
- <i>"</i>	Correction Completed	Reg. #		Correction Completed	Dec. #		Correction Completed
ID Prefix Reg. # LSC	Correction Completed			Correction Completed			
Reg. #	Correction Completed	Reg. #		Correction Completed			Correction Completed
Dea #	Correction Completed	D //					
Reviewed E State Agen Reviewed E CMS RO	cy GL/mm	Date: 11/24/201 Date:	5 Signature of Sur	13603		Date: 11/1 Date:	2/2015
Followup to Survey Completed on: 9/17/2015			Check for any Uncor Uncorrected Defic				NO



# Protecting, Maintaining and Improving the Health of Minnesotans NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR NURSING HOMES

Electronically delivered November 24, 2015

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

Re: Project # S5620002

Dear Mr. Glad:

On November 12, 2015, 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 September 17, 2015 with orders received by you electronically on October 1, 2015.

State licensing orders issued pursuant to the last survey completed on September 17, 2015 and found corrected at the time of this November 12, 2015 revisit, are listed on the State Form: Revisit Report Form.

State licensing orders issued pursuant to the last survey completed on September 17, 2015, found not corrected at the time of this November 12, 2015 revisit and subject to penalty assessment are as follows:

23010 -- MN Rule 4658.4635 A -- Nurse Call System; New Construction - No Fine

The details of the violations noted at the time of this revisit completed on November 12, 2015 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, electronically acknowledge and date this form and submit to the Minnesota Department of Health if there are no new orders issued.

Therefore, in accordance with Minnesota Statutes, section 144A.10, you will be assessed an amount of \$ 0.00 per day beginning on the day you receive this notice.

MN Veterans Home Minneapolis November 24, 2015 Page 2

The fines shall accumulate daily until notification from the nursing home is received by the Department stating that the orders have been corrected. This written notification shall be mailed or delivered to the Department at the address below or to , Minnesota Department of Health, Licensing and Certification Program, Health Regulation Division, Po Box 64900 St Paul Mn 55164-0900.

When the Department receives notification that the orders are corrected, a reinspection will be conducted to verify that acceptable corrections have been made. If it is determined that acceptable corrections have not been made, the daily accumulation of the fines shall resume and the amount of the fines which otherwise would have accrued during the period prior to resumption shall be added to the total assessment. The resumption of the fine can be challenged by requesting a hearing within 15 days of the receipt of the notice of the resumption of the fine.

If the accumulation of the fine is resumed, the fines will continue to accrue in the manner described above until a written notification stating that the orders have been corrected is verified by the Department.

The costs of all reinspections required to verify whether acceptable corrections have been made will be added to the total amount of the assessment.

You may request a hearing of any of the above noted penalty assessments provided that a written request is made within 15 days of the receipt of this Notice. Any request for a hearing shall be sent to Mary Henderson, Minnesota Department of Health, Licensing and Certification Program, Health Regulation Division, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

Once the penalty assessments have been verified as corrected the facility will receive a notice of the total amount of the penalty assessment including the costs of any reinspections.

Also, at the time of this reinspection completed on November 12, 2015 additional violations were cited as follows:

21565 MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin

They are delineated on the electronically delivered Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Only the ID Prefix Tag in the left hand column without brackets will identify these licensing orders. It is not necessary to develop a plan of correction, however, you will need to acknowledge when all orders will be corrected, and electronically submit.

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.

MN Veterans Home Minneapolis November 24, 2015 Page 3

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

Enclosure

cc: Licensing and Certification File Shellae Dietrich, Licensing and Certification Program Penalty Assessment Deposit Staff

Minnesc	ta Department of He	alth			1 01 101	
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00233	B. WING		F 11/1	{ 2/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MN VETI	ERANS HOME MINNE	APOLIS	NEHAHA AV OLIS, MN 5	ENUE SOUTH 5417		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
{2 000}	Initial Comments		{2 000}			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the defic herein are not correct not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.				
	electronic receipt of consistent with the Health Informationa http://www.health.st obul.htm The State delineated on the a	eed to participate in the f State licensure orders Minnesota Department of al Bulletin 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVID ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE <b>)4/2015</b>

Electronically Signed

STATE FORM

If continuation sheet 1 of 10

	IDENTIFICATION NUMBER:	A. BUILDING		SURVEY	
	00233	B. WING		R 11/12/2015	
Rovider or Supplier	APOLIS 5101 MINI	NEHAHA AV	ENUE SOUTH		
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE	
Department of Heal electronically. Althor necessary for State the word "corrected Then indicate in the process, under the date your orders wil electronically submi	Ith orders being submitted ough no plan of correction is Statutes/Rules, please enter " in the box available for text. e electronic State licensure heading completion date, the Il be corrected prior to itting to the Minnesota	{2 000}			
Medications Self Ac Subp. 4. Self-adm self-administer med resident assessmer care as required in 4658.0405 indicate is a written order fro This MN Requireme	Imin inistration. A resident may lications if the comprehensive nt and comprehensive plan of parts 4658.0400 and this practice is safe and there on the attending physician.	21565		12/4/15	
review, the facility fa (R28) who was obs medications. Findings include: R28 was observed the medication cart licensed practical ne R28 his morning me enlarged prostate) ( and then handed R2 15 ml of valproic ac	ailed to assess 1 of 1 resident erved self-administering sitting in his wheelchair next to on 11/12/15, at 10:25 a.m. A urse (LPN)-A administered edication Dutasteride (for 0.5 milligram (mg) capsule 28 a glass of orange juice with id (for seizure control) 250		have been reviewed. EMAR orders have been updated to reflect self-administration. Random weekly audits will be conducted on residents that self-administer		
F - C Iert Foel ff ercei - ker(r F Ft Feerra	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS Continued From pa Department of Hea electronically. Althor hecessary for State he word "corrected Then indicate in the process, under the date your orders will electronically subm Department of Hea MN Rule 4658.1325 Medications Self Ac Subp. 4. Self-adm self-administer med resident assessmen care as required in 4658.0405 indicate s a written order fro This MN Requireme by: Based on observati review, the facility fa R28) who was obs medications. Findings include: R28 was observed he medication cart icensed practical n R28 his morning me and then handed R 15 ml of valproic ac mg/5 ml (millimeter already added to th	Summary statement of Deficiencies (Each Deficiency MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)           Continued From page 1           Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter he word "corrected" in the box available for text. 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.           MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin           Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive process are required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician.           This MN Requirement is not met as evidenced by: Based on observation, interview and document eview, the facility failed to assess 1 of 1 resident (R28) who was observed self-administering medications.	SANS HOME MINNEAPOLIS       S101 MINNEHAHAA WINNEAPOLIS, MM 2         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG         Continued From page 1       (2 000)         Department of Health orders being submitted belectronically. Although no plan of correction is necessary for State Statutes/Rules, please enter he word "corrected" in the box available for text. 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.       21565         WIN Rule 4658.1325 Subp. 4 Administration of Wedications Self Admin       21565         Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive esident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there s a written order from the attending physician.       21565         This MN Requirement is not met as evidenced by: assed on observation, interview and document eview, the facility failed to assess 1 of 1 resident R28) who was observed self-administering nedications.       Findings include:         Findings include:       R28 was observed sitting in his wheelchair next to he medication cart on 11/12/15, at 10:25 a.m. A icensed practical nurse (LPN)-A administered R28 his morning medication Dutasteride (for enlarged prostate) 0.5 milligram (mg) capsule and then handed R28 a glass of orange juice with 15 m l of valproic acid (for seizure control) 250 mg/5 m l (millimeters) that she reportedy had already added to the glass of juice. LPN-A added     <	Stans HOME MINNEAPOLIS         5101 MINNEAPOLIS, MN 55417           SUMMARY STATEMENT OF DEFICIENCES REGULATORY OR LSC DENTIFYING INFORMATION)         ID PRETIX TAG         PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION)         ID PRETIX TAG         PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY WILD BE PRECEDED BY FULL TAG           Continued From page 1         {2000}         ID PRETIX TAG         PROVIDER'S PLAN OF CORRECTION (EACH OCRRECTIVE ACTION SHOLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)           Continued From page 1         {2000}         ID Department of Health orders being submitted jetcronically. Although no plan of correction is the coessary for State Statutes/Rules, please enter he word "corrected" in the box available for text. Then indicate the proteoric State licensure process, under the heading completion date, the jate your orders will be corrected prior to bectronically submitting to the Minnesota Department of Health.         21565           Subp. 4. Self-administration. A resident may self-administration actice is safe and there s a written order from the attending physician.         21565           This MN Requirement is not met as evidenced by: Sased on observation, interview and document eview, the facility failed to assess 1 of 1 resident R28 was observed self-administering medications.         R28 self administration medication assessment (SAM) dated 11/9/15 reviewed by the IDT and is current. All residents have the potential to be affected.           R28 was observed self-administering medications.         Residents that self-administer medication Dutasterice (for nalraged prostate) 0.5 milligram (mg) ca	

V6NP12

If continuation sheet 2 of 10

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		LETED
		00233	B. WING		R 11/12/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
ΜΝ ΥΕΤΙ	ERANS HOME MINNE		NEHAHA AV POLIS, MN 🖇	ENUE SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLET DATE
21565	Continued From pa	ige 2	21565			
	medication. R28 to	ok two sips, then coughed and		compliance.		
	sputtered. LPN-A a	asked the resident if he was all				
	for you" (so the gla- LPN-A added a sec and handed it back approached R28 an BINGO, and procee away from the nurs	, "Here, let me double cup it ss would be studier to handle). cond cup underneath the first, to R28. An activity staff nd asked he wanted a ride to eded to push his wheelchair ing station toward the elevator. ling his glass of orange juice		DON, ADON responsible.		
	morning medication the resident had a s medication (SAM) a take his medication she did not know, a completed by the re- said she normally g orange juice and al because the reside as anxiety requiring refusing to take his stated that she figu- least get some of th him than to not take knew how much me consumed LPN-A re-	ented R28 had taken all of his hs, the surveyor asked whether self-administration of assessment allowing him to hs independently. LPN-A stated and the assessments were egistered nurses (RNs). LPN-A gave R28 his valproic acid in lowed him take it with him nt "has behaviors" described g redirection by distraction, and medications. LPN-A also red it was better for R28 to at he medication by taking it with e it at all. When asked if she edication the resident had eplied, "No, not really." LPN-A R28 liked orange juice and pop ard for him.				
	had a SAM assess he could independer medications. A Sel dated 11/9/15, had which was "1. Does Administer Medicat	veyor looked for evidence R28 ment completed that showed ently and reliably take his if Administration of Medications only one question answered s Resident Request to Self tions &/or Treatments: If so ssment" and it was answered				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
			A. BUILDING: _	<u></u>	-		
		00233	B. WING			R 11/12/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE			
	ERANS HOME MINNE	5101 MIN	INEHAHA AVE	NUE SOUTH			
		EAFOLIS MINNEAI	POLIS, MN 55	417			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT		(X5) COMPLET	
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO T	HE APPROPRIATE	DATE	
				DEFICIENC	Y)		
21565	Continued From pa	age 3	21565				
	"No " 11/9/15 W/bc	en asked what she would do					
		ssessment did not indicate					
	0	_PN-A stated, "I will go					
		lining room and see how much					
	of the orange juice						
	er une er unge janee						
	LPN-A then procee	eded to walk down the hall to					
	the elevator and ta	ke the elevator down and then					
	across to the next	building to the main dining					
	room where BING	O was being held. R28 was					
	sitting at a table wit	th five other residents. No staff					
	were present at the	e table or nearby. R28's glass					
		s in front of him and was					
		full. LPN-A informed the					
		look like the resident had					
		re of the juice. When she					
		room the surveyor suggested					
		medication and two other					
		ve also reached for and					
		PN-A then said, "I will go and					
		nk his orange juice." LPN-A					
		8 for a minute, and then					
		from the table. LPN-A reported	1				
		o drink the orange juice, and					
		e glass stated she could not tell nedication the resident had					
		e the bottom couple inches of					
		color and it was not possible					
		ed. LPN-A then explained she					
		bose of) the medication and					
		dication cart. She said she was					
		r documentation in the					
	0 0	on administration record					
		had marked that the resident					
		ication, and was going to					
		nstead consumed 60 cc's of					
		PN-A stated it was unclear					
		tion R28 took, since the ice had	l l				
		dication appeared settled in					
		ulcation appeared settled in					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00233	B. WING	B. WING		R 11/12/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
	ERANS HOME MINNE	5101 MI	NNEHAHA AVE	NUE SOUTH			
		MINNEA	POLIS, MN 55	5417			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21565	Continued From pa	age 4	21565				
	stated, "It looked lil drank very little of i document that R28 which was then do then informed RN- R28's medication a medication down th the disposal was of Interdisciplinary tea dated 10/29/15, inc Services: supportiv behavior, depression confusion." Physici Health Services to behavioral disturbat destruction of prop towards staff" A F R28 was seen by p indicated "Dementi Physician orders in capsule every day acid 250 mg/5 ml co orally morning and R28's 10/15 and 11 acid solution 250 m beverage" had beer refused the medicat initiation of the med thirteen times in No On 11/12/15, at 1:4 nursing stated that self-administered h she [LPN-A] had no A 12/18/12, Medicat		1				
		policy read, "To assure safe					

STATE FORM

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _		COM	E SURVEY PLETED R	
		00233	B. WING			11/12/2015	
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST				
NN VETE	ERANS HOME MINNE		NNEHAHA AVE POLIS, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE	
21565	Continued From pa	age 5	21565				
	own medications/tr assessment of their practice. To provide assure residents a	esidents administering their eatments through ongoing ir ability to continue this e a monitoring system to re receiving and administering accordance with the medical					
	The director of nur- current for SAM, and trained. Residents assessed, and a sy could be devised.	THOD OF CORRECTION: sing could ensure policies are nd licensed staff have been who wish to SAM could be ystem for indicating this to staff Audits could be conducted at nes, and the results brought to ee for review.					
	TIME PERIOD FO (14) days.	R CORRECTION: Fourteen					
{23010}	MN Rule 4658.463 Construction	5 A Nurse Call System; New	{23010}			12/4/15	
	communication sys from the resident a required by this par system, if electrica connected to the e Nurse calls and em of being inactivated central annunciator	a must be equipped with a stem designed to receive calls ind nursing service areas rt. The communication lly powered, must be mergency power supply. hergency calls must be capable d only at the points of origin. A r must be provided where the rom the nurses' station.					
	resident's bed. Ca communication dev they are within read	must be provided for each Il cords, buttons, or other vices must be placed where ch of each resident. A call ist register at the nurses'					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ATE SURVEY	
		IDENTIFICATION NOMBER.	A. BUILDING	·· CC		
		00233	B. WING	1	R 11/12/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
IN VETE	ERANS HOME MINNE	FAPOLIS	NEHAHA AV POLIS, MN 🖇	/ENUE SOUTH 55417		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLE <sup>-</sup> DATE	
{23010}	Continued From pa	age 6	{23010}			
	bedroom, and activ medication room, r room, soiled utility multi-corridor nursi	ight outside the resident vate a duty signal in the nourishment area, clean utility room, and sterilizing room. In ing units, visible signal lights at corridor intersections.				
	by: Based on observat review the facility fa available and func	ient is not met as evidenced ion, interview and document ailed to ensure a call light was tioning for 1 of 1 resident environmental concerns.		During survey R72 call cord was placed. Care plan was reviewed at the time of survey and residents cognitive inability to use call light.		
	Findings include: R72's room was ob	oserved on 11/12/15, at 9:58	All residents that have room change the potential to be affected.	All residents that have room changes ha the potential to be affected.	ve	
	p.m. There was no	call light available in the room attached to the wall, but a cal		All resident rooms checked to endure ca cords are present.	ure call	
	R72 was interviewed LPN-A verified that available in R72's r "just moved into the 4th floor." LPN-A si cord in R72's room sure when that was	I nurse (LPN)-A working with ed on 11/12/15, at 10:05 a.m. there was no call light room. LPN-A stated that R72 e room two weeks ago from tated that she saw a call light "sometime" back but wasn't s. LPN-A stated that it was a		Random audits will be conducted weekly by nursing.Findings will be reported to Q committee until QA determines substant compliance. ED, DON, ADON responsible.	A	
	to have a working times." LPN-A state notify person in cha related to call light, order.	at all residents were supposed accessible call light "at all ed that staff was supposed to arge if there were any concerns and a place a maintenance				
noosta D	11/12/15, at 10:10	(RN)-A was interviewed on a.m. RN-A stated that a call otocol" and that all residents				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
			A. BUILDING: _			
		00233	B. WING		R 11/12/2015	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
IN VETE	ERANS HOME MINNE	FAPOLIS	NEHAHA AVE POLIS, MN 55			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
23010}	Continued From pa	age 7	{23010}			
	irrespective of whe not. RN-A stated th staff reported any r "immediately" to th stated that all staff sure call light are for	tioning call light in their rooms of the they were able to use it or nat her expectation was that non-functioning call light e person in charge. RN-A were responsible of making unctioning "properly" and withir d any knowledge of call light				
	R72 was interviewed HST-A verified that the room. HST-A s in his room this mo when I worked with stated that if a call was supposed to ro person in charge. If had not reported th having knowledge that R72 was not c "he is supposed to	echnician (HST)-A working with ed on 11/12/15, at 10:15 a.m. t R72 did not have a call light in tated "There was no call light orning, and there wasn't any n him on Monday." HST-A light was not working, staff eport "immediately" to the HST-A acknowledged that she ne issue to anyone despite it was missing. HST-A stated apable of using a call light, but have one anyway." HST-A ld have reported that, but I	1			
	interviewed on 11/ <sup>-</sup> her expectations w available and acce stated that housek for call light audits they were compete ADON approached call light was now a R72's room. The A	ctor of nursing (ADON) was 12/15, at 11:17 a.m. stated that vas call lights would be working ssible "at all times." The ADON eeping staff was responsible but was not sure how often ed. Several minutes later the d the surveyor and stated that a available and functional in DON also stated that staff ed "right now" and call lights	, J			
		sekeeper (EHK) was				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
	or connection	IDENTIFICATION NOMBER.	A. BUILDING:			
		00233	B. WING		R 11/12/2015	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
IN VETE	RANS HOME MINNE	FAPOLIS	NNEHAHA AVE POLIS, MN 55			
(X4) ID	SUMMARY ST			PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	·	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET DATE
[23010]	Continued From pa	age 8	{23010}			
	room get cleaned of were checked at the random call lights w housekeepers "haw The maintenance r on 11/12/15, at 1:3 audits were perform MM stated nursing placing work orders there were any issu also stated, "I check a day, sign them of appropriate party."	3 a.m. and stated that every once a week and call lights nat time. The EHK stated were then completed after ve done their checks." manager (MM) was interviewed 1 p.m. explained call light med in all rooms annually. The staff was responsible for s in the computer system if ues with a call light. The MM ck the orders at least four times ff and then assign them to the The MM verified not work ceived for R72's missing call				
	approached survey	n at 1:47 p.m. the ADON yor and stated that a call light been added" and it will "now be and quarterly."				
	9/7/15, identified th cognitively impaired required extensive physical assist with dressing and toilet	nimum Data Set (MDS) dated nat R72 was severely d. MDS also identified that R72 assistance of two person bed mobility, transfer, use. MDS also identified the otal dependence with personal d locomotion.				
	clean inspection lo R72's room as hav inspection. A review	aaintenance monthly room g dated 10/21/15, identified ring "met" the call light w of nursing progress notes transferred to his present roon	ı			
	A facility's Call Ligh	nt Usage policy dated 7/12,				

Minnesc	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00233	B. WING		F 11/1	} 2/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MN VETI	ERANS HOME MINNE		NEHAHA AV POLIS, MN 5	ENUE SOUTH 5417		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
{23010}	Continued From pa	ige 9	{23010}			
	directed that, "Upor light will be explained call light is easily ac chair, in the showed The call light is indi needsResidents w the standard call lig cognitive barriers w will be listed on the	h admission, the use of the call ed to each new resident. The ccessible both in the bed and r and bathroom by the toilet. vidualized to what the resident who may not be able to utilize yht; have physical barriers or <i>i</i> ll be identified and their needs				
Minnesota D	epartment of Health					

# State Form: Revisit Report

(Y1)	Provider / Supplier / CLIA / Identification Number 00233	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 11/12/2015
Name	e 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).

(Y4) Item	(Y5	) Date	(Y4) Item		(Y5) Date	(Y4) Item	(Y5)	Date
ID Prefix	20302	Correction Completed 10/22/2015	ID Prefix	21610	Correction Completed 10/11/2015	ID Prefix	21695	Correction Completed 10/22/2015
	MN State Statute 144.6			MN Rule 4658.1340			MN Rule 4658.1415	
	21990 MN St. Statute 626.557		Reg. #			Reg. #		
ID Prefix Reg. # LSC			Reg. #			ID Prefix Reg. # LSC		
ID Prefix Reg. # LSC			Reg. #					
ID Prefix Reg. # LSC		Correction Completed	Reg. #			ID Prefix Reg. # LSC		
Reviewed E State Agent Reviewed E CMS RO	GL/mn	1	Date: 11/24/20 Date:	Signature of Signature of	13603		Date 11/ Date	/12/2015
	o Survey Completed or 9/17/2015 M: REVISIT REPORT (5			Check for any U Uncorrected I Page 1 of 1	ncorrected Defic Deficiencies (CM			-

DEPARTMENT OF HEALTH AND HUMAN SERVICES					<b>CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>			
MEDICARE/MEDICAID CERTIFICATION				CATION	AND TRANSMITTAL	ID: V6NP		
	PART I -	TO BE COMPI	LETED BY 1	THE STA	TE SURVEY AGENCY	Fa	cility ID: 00233	
<ol> <li>MEDICARE/MEDICAID PROVIDER NO.         <ul> <li>(L1) 245620</li> </ul> </li> <li>STATE VENDOR OR MEDICAID NO.         <ul> <li>(L2) 743749800</li> </ul> </li> </ol>		3. NAME AND ADDRESS OF FACILITY (L3) MN VETERANS HOME MINNEAL (L4) 5101 MINNEHAHA AVENUE SOU" (L5) MINNEAPOLIS, MN				4. TYPE OF ACTION:       2 (L8)         1. Initial       2. Recertification         3. Termination       4. CHOW         5. Validation       6. Complaint		
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)		7. PROVIDER/SUPPLIER CATEGORY           01 Hospital         05 HHA         09 ESRD			<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey After C	9. Other	
6. DATE OF SURVEY       09/17/2015       (L34)         8. ACCREDITATION STATUS:       (L10)         0 Unaccredited       1 TJC         2 AOA       3 Other		02 SNF/NF/Dual06 PRTF10 NF03 SNF/NF/Distinct07 X-Ray11 ICF/IID04 SNF08 OPT/SP12 RHC		14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 06/30			
	02 (L18) 00 (L17)	Complianc 1. A X B. Not in Con	nce With equirements te Based On: .cceptable POC	gram	And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code * Code: <b>B</b> *	6. Scope of Servi 7. Medical Direc	ices Limit tor	
		Requirem	ents and/or reppi		Couc. D	(E12)		
14. LTC CERTIFIED BED BREAKDOWN				15. FACILITY MEETS				
18 SNF 18/19 SNF 100	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMARKS	G (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):				
17. SURVEYOR SIGNATURE Date :					18. STATE SURVEY AGENCY APPROVAL Date:			
Jane Teipel, HFE NEII	11/21/2015 (L19)			Mark Meath, Enforcement Specialist 11/23/2015 (L20)				
PART I	I - TO BE	COMPLETED I	BY HCFA RI	EGIONA	L OFFICE OR SINGLE S	TATE AGENCY		
19. DETERMINATION OF ELIGIBILITY       20. COMPLIANCE WITH CIVIL RIGHTS ACT:          1. Facility is Eligible to Participate          2. Facility is not Eligible				<ol> <li>Statement of Financial Solvency (HCFA-2572)</li> <li>Ownership/Control Interest Disclosure Stmt (HCFA-1513)</li> <li>Both of the Above :</li> </ol>				
	(L21)							
22. ORIGINAL DATE 23.	LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION:	: (L	30)	
OF PARTICIPATION <b>01/06/2014</b>	BEGINNINC	<b>G DATE</b>	ENDING DATE	TE	VOLUNTARY     00       01-Merger, Closure	INVOLUNTARY 05-Fail to Meet Health/Safety		
(L24)	(L41) (L25)			02-Dissatisfaction W/ Reimbursement 06-Fail to Meet A		eet Agreement		
25. LTC EXTENSION DATE: 27. ALTERNATIVE SANCTIONS				03-Risk of Involuntary Termination 04-Other Reason for Withdrawal 07 Provider Status Change				
A. Suspension of Admi			Admissions: (L44)			07-Provider 00-Active	07-Provider Status Change 00-Active	
(L27)	uspension Date:							
			(L45)					
28. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO.					30. REMARKS			
03001								
(L28) (L31				(L31)				
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	I OF APPROVAI	DATE				
(L32) (L33)					DETERMINATION APPROVAL			



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered October 1, 2015

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

RE: Project Number S5620002, H5620010

Dear Mr. Glad:

On September 14, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for an abbreviated standard survey, completed on September 1, 2015. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On September 17, 2015, the Minnesota Departments of Health and Public Safety completed a standard survey 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 to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections are required. As a result of our finding that the facility is not achieved substantial compliance. This Department is imposing the following Category 1 remedy:

• State Monitoring effective October 6, 2015. (42 CFR 488.422)

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective December 1, 2015. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective December 1, 2015. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 1, 2015. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, MN Veterans Home Minneapolis is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective December 1, 2015. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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 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;

<u>Remedies</u> - 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;

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

<u>Informal Dispute Resolution</u> - 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 Metro D Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: gayle.lantto@state.mn.us Phone: (651) 201-3794 Fax: (651) 215-9697

## 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.

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

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

- 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 December 1, 2015 (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 March 1, 2016 (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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</u>

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 plan of correction.

A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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.

## **APPEAL RIGHTS**

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <u>https://dab.efile.hhs.gov</u> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

## Jan.Suzuki@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services Departmental Appeals Board, MS 6132 Director, Civil Remedies Division 330 Independence Avenue, S.W. Cohen Building – Room G-644 Washington, D.C. 20201 (202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Jan Suzuki, Principal Program Representative by phone at (312)886-5209 or by e-mail at Jan.Suzuki@cms.hhs.gov.

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

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			·		APPROVED	
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0		/IB NO. 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			· /	E SURVEY IPLETED	
		245620	B. WING		·····	09/	17/2015	
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	ERANS HOME MINNE	APOLIS			101 MINNEHAHA AVENUE SOUTH			
				N	MINNEAPOLIS, MN 55417			
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F 000	INITIAL COMMENT	ſS	F 0	00				
F 225 SS=D	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the form. Your electron be used as verificat Upon receipt of an on-site revisit of you validate that substa regulations has beet your verification. 483.13(c)(1)(ii)-(iii), INVESTIGATE/REF ALLEGATIONS/INE The facility must no been found guilty of mistreating residen had a finding entered registry concerning of residents or misa and report any know court of law against indicate unfitness for other facility staff to or licensing authorit The facility must en involving mistreatm including injuries of misappropriation of immediately to the a to other officials in a	acceptable electronic POC, an ur facility may be conducted to initial compliance with the en attained in accordance with (c)(2) - (4) PORT DIVIDUALS at employ individuals who have f abusing, neglecting, or ts by a court of law; or have ed into the State nurse aide abuse, neglect, mistreatment appropriation of their property; wledge it has of actions by a t an employee, which would or service as a nurse aide or the State nurse aide registry ties. unknown source and resident property are reported administrator of the facility and accordance with State law I procedures (including to the	F 2	25			10/11/15	
LABORATOR	/ DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE	
	ically Signed						10/09/2015	

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.

PRINTED: 11/13/2015

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	The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to immediately report allegations of potential abuse to the designated State agency (SA) as required for 1 of 1 residents (R15) who reported potential staff mistreatment. In addition, the facility failed to thoroughly investigate the allegations. Findings include: R15's Minnesota Veterans Home Progress Note dated 8/30/15, indicated, "Writer got a report from primary nurse that resident [R15] had an irregular shaped bruise on lower left chin." The progress noted further indicated, "Resident had alleged to have been assaulted by two peopleresident has a history of hallucinationsNo maltreatment is suspected at this time."					
				Incident of alleged abuse/neglect has been reported to the designate agency and thoroughly investigate Disposition received on Septembe 2015. All incidents of alleged abuse are la reported to the designated state as and investigated. Staff educated on facility Resident Prevention Plan for reporting alleg of abuse/neglect. Audits will be conducted weekly or incidents of alleged abuse/neglect timeliness of reporting to the desig state agency. Findings will be revi by the Quality Assurance Committ Audits will continue indefinitely unt Interdisciplinary Team determines substantial compliance. Administrator or designee is respon	e state d. r 29, peing gency ations n for jnated ee. il the	

Facility ID: 00233

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	policies and proced mistreatment, negle	evelop and implement written lures that prohibit ect, and abuse of residents on of resident property.					
	by: Based on interview facility failed to follo related to immediat potential abuse to t (SA) as required for reported potential s	NT is not met as evidenced y and document review the pw policies and procedures e reporting of allegations of he designated State agency r 1 of 1 residents (R15) who taff mistreatment. In addition, thoroughly investigate the		Incident of alleged abuse/neglect by R1 has been reported to designate state agency and thoroughly investigated. Disposition received on September 29, 2015. All incidents of alleged abuse are being reported to the designated state agency and thoroughly investigated. All staff educated on facility Resident Prevention Plan for reporting allegations			
	indicated the purpo from maltreatment" form abuse, neglec directed staff to imm any suspicion that a policy further direct	nt Protection Plan policy se was, "To protect residents and to protect all residents t, and harm. The policy nediately reported to the SA abuse may have occurred. The s staff to notify the DON to coordinate an		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 Quality Assurance Committee. Audits will continue indefinitely until the Interdisciplinary Team determines substantial compliance. Administrator or designee is responsible			

Facility ID: 00233

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	director of nursing unknown origin is r agencyIf a reside enough for us to re on R15's jaw and t DON stated, the in	v on 9/15/15, at 7:02 p.m. the (DON) stated, "Any bruise of reportable to the State ent said it happened, that is eport it." In regard to the bruise he allegation of abuse, the cident had not been reported N further stated, "In hind sight,				

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MN VETI	ERANS HOME MINNE	APOLIS		5101 MINNEHAHA AVENUE SOUTH MINNEAPOLIS, MN 55417		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 226	report indicated the allegations, she sta the incident prior to was unaware if any regarding R15's alle During an interview registered nurse (R for the nurse mana resided. RN-E said report dated 8/30/1 incident." After talki possible cause for t reportable due to th though R15 reporte RN-E stated he did R15's allegation tha During an interview administrator stated allegations of abuse reported." Although the administrator ha allegation of assaul had no previous kn made by R15. He for should have been r During an interview licensed practical n out the initial incide told her "Two guys something." She fu allegations to the R During an interview ADON-B stated, Th	ed this." Although the incident DON had been notified of the ted she had no knowledge of the surveyor's inquiry and investigation was completed egation of assault. Ton 9/15/15, at 7:51 p.m. a N)-E stated he was covering ger of the unit in which R15 he had reviewed the incident 5, "a few days after the ng to staff to determine a the injury, he did not feel it was be possibility of self-injury even ad he had been "assaulted." not interview staff regarding at he had been assaulted. on 9/15/15 at 8:05 p.m. the d, "Our protocol is that all e or maltreatment will be the incident report indicated ad been notified of the t, the administrator stated he owledge of the allegations urther stated, "The incident	F 22	6		

If continuation sheet Page 7 of 10

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI		ATE SURVEY
ND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	OMPLETED
		245620	B. WING	0	9/17/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
MN VET	ERANS HOME MINNE	APOLIS		5101 MINNEHAHA AVENUE SOUTH MINNEAPOLIS, MN 55417	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
F 226	she knew R15 well building. ADON-B e "makes up a lot of staff had assaulted call" not to report th she did not initiate	ige 7 , as he formerly resided in her explained that because R15 stories," although he stated him, she made a "judgment he incident. ADON-B stated any investigation into the d statement as to how it	F 22	6	
F 463 SS=D	ROOMS/TOILET/B The nurses' station resident calls throu		F 46	3	10/11/15
	by: Based on observat review the facility fa functioning for 1 of environmental cond Findings include: R94's call light was at 10:43 a.m. The cond when activated. A asked to check R94 not ring nor light up the registered nurs not working, who w or maintenance sta was able to use his some cognitive imp him every two hour	NT is not met as evidenced tion, interview and document ailed to ensure a call light was 1 resident (R94) reviewed for cerns. tested for function on 9/14/15, call light neither rang nor lit up nursing assistant (NA)-A was 4's call light, and again it did b. NA-A stated she would notify e (RN)-A about R94's call light ould then notify housekeeping ff to fix it. NA-A reported R94 call light, but because of bairment, staff also checked on s to offer toileting. NA-A also walked with a walker but		R94¿s call light has been repaired. The call lights in the building are functioning. Random audits will be conducted month on each unit to ensure proper function of call lights. The findings will be reviewed by the Quality Assurance Committee. Audits wi continue indefinitely until the Interdisciplinary Team determines substantial compliance. Administrator or designee is responsible Corrective action will be completed by October 11, 2015.	Í

If continuation sheet Page 8 of 10

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	11/13/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245620	B. WING			09/	17/2015
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
	ERANS HOME MINNE	APOLIS			101 MINNEHAHA AVENUE SOUTH MINNEAPOLIS, MN 55417		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 463	needed reminders a On 9/15/15, at 12:2 observed placed or functioning when te 6:45 a.m. RN-B sta not functioning it wa If the call light need replace it, but beyon maintenance staff of unaware of any call been completed by On 9/16/15, at 7:23 with a walker. Altho independently, he m chair or the bed. N confused and seldo anticipated the resid Later that morning a administrator (AA) s residents' call lights AA stated if a reside working nursing wo repair into the elect maintenance would unaware of any call currently being com understanding facili function checks. Later at 1:14 p.m. th (ADON) stated she to be in working or was unaware of any completed.	and cues as to where to go. 20 p.m. R94's call light was in top of his bed, and was ested. The following day at ated that when call lights were as considered a safety issue. ded a new cord the nurse could and that staff needed to notify of the problem. RN-B was I light audits that may have in nursing staff. B a.m. NA-B stated R94 walked bugh he could sit down needed a little boost up from a IA-B said R94 was mostly om used his call light. Staff	F 4	463			

If continuation sheet Page 9 of 10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING       (X3) DATE SURVEY COMPLETED         NAME OF PROVIDER OR SUPPLIER       245620       B. WING       09/17/2015         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE 5101 MINNEHAHA AVENUE SOUTH MINNEAPOLIS, MN 55417       5101 MINNEHAHA AVENUE SOUTH MINNEAPOLIS, MN 55417       (X3) DATE SURVEY COMPLETED			I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	: 11/13/2015 APPROVED : 0938-0391
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE ZIP CODE STOT MINNEHAPA AUXINUS       MV VETERANS HOME MINNEAPOLIS     STREET ADDRESS, CITY, STATE ZIP CODE STOT MINNEHAPA AUXINUS SOLUTI MINNEAPOLIS, MN 55417       MV UPERANS HOME MINNEAPOLIS     SUMMARY STATEMENT OF DEFICIENCIES (EXAMPLE)     ID PROVIDERS PLAN OF CORRECTION (EXAMPLE)       MV TETERANS HOME MINNEAPOLIS (FAG)     SUMMARY STATEMENT OF DEFICIENCIES (EXAMPLE)     ID PROVIDERS PLAN OF CORRECTION (EXAMPLE)     PROVIDERS PLAN OF CORRECTION (EXAMPLE)       MV TETERANS (FAG)     SUMMARY STATEMENT OF DEFICIENCIES (EXAMPLE)     ID PROVIDERS PLAN OF CORRECTION (EXAMPLE)     PROVIDERS PLAN OF CORRECTION (EXAMPLE)     OUT (EXAMPLE)       F 463     Continued From page 9 9/16/15, at 7:58 a.m. he stated the maintenance staff had replaced the faulty cord within an hour of notification. The director also stated residents' call light were completed in the past. However, two years ago the central office stopped preventive maintenance checks of the building. The director further stated if there was an issue in a resident from housekeeping staff notified maintenance staff. Hus as also verified no work order request had been put into the system prior to the surveyor's observation R94's call light was not functioning.     At 8:21 a.m. the health information staff (HIS)-A showed he had a paper template which included checking residents' rooms and call lights on R94's floor. The HIS suppained once the request was put into the system, the paper was made on 9/14/15. In addition, the paper work requests and verified the only request for R94's call light.     On 9/17/15, at 9:00 a.m. the director of nursing stated she expected all residents' call lights to be properly functioning.         A ca	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,		LE CONSTRUCTION	(X3) DAT	E SURVEY
MN VETERANS HOME MINNEAPOLIS     Stot MINNEAPOLIS       MAN UP     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 DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     ID PREFIX TAG     PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY)     COMPLETIO DATE       F 463     Continued From page 9 9/16/15, at 7:58 a.m. he stated the maintenance staff had been emailed on 9/14/15, regarding R94% call light not functioning and that one of his staff had replaced the faulty cord within an hour of notification. The director also stated residents' call light audits were completed in the past. However, two years ago the central office stopped preventive maintenance checks of the building. The director further stated if there was an issue in a resident room housekeeping staff notified maintenance staff. It was also verified no work order request had been put into the system prior to the surveyor's observation R94's call light was not functioning.     At 8.21 a.m. the health information staff (HIS)-A showed he had a paper template which included checking residents' rooms and call lights on R94's floor. The HIS explained once the request was put into the system, the paper was no longer kept. The HIS looked onto the computer into the facility's system for work request log kept at nurse's station revealed lore was no work request for R94's call light.     On 9/17/15, at 9:00 a.m. the director of nursing stated she expected all residents' call lights to be properly functioning.       A call light policy was requested but was not     A call light policy was requested but was not			245620	B. WING	i		09/	17/2015
Important         Important <t< td=""><td>NAME OF F</td><td>PROVIDER OR SUPPLIER</td><td></td><td>-</td><td></td><td></td><td></td><td></td></t<>	NAME OF F	PROVIDER OR SUPPLIER		-				
PRÉPIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION)       PRÉFIX TAG       (EACH OERRECTIVE ACTION SHOULD BE CROSS-REFERENCEDED TO THE APPROPRIATE DEFICIENCY)         F 463       Continued From page 9 9/16/15, at 7:58 a.m. he stated the maintenance staff had been emailed on 9/14/15, regarding R94's call light not functioning and that one of his staff had replaced the faulty cord within an hour of notification. The director also stated residents' call light audits were completed in the past. However, two years ago the central office stopped preventive maintenance checks of the building. The director further stated if there was an issue in a resident room housekeeping staff notified maintenance staff. It was also verified no work order request had been put into the system prior to the surveyor's observation R94's call light was not functioning.         At 8:21 a.m. the health information staff (HIS)-A showed he had a paper template which included checking residents' rooms and call lights on R94's floor. The HIS explained once the request was put into the system, the paper was no longer kept. The HIS looked onto the computer into the facility's system for work requests and verified the only request for repair was made on 9/14/15. In addition, the paper work request log kept at nurse's station revealed there was no work request for R94's call light.         On 9/17/15, at 9:00 a.m. the director of nursing stated she expected all residents' call lights to be properly functioning.         A call light policy was requested but was not		ERANS HOME MINNE	APOLIS					
<ul> <li>9/16/15, at 7:58 a.m. he stated the maintenance staff had been emailed on 9/14/15, regarding R94's call light not functioning and that one of his staff had replaced the faulty cord within an hour of notification. The director also stated residents' call light audits were completed in the past. However, two years ago the central office stopped preventive maintenance checks of the building. The director further stated if there was an issue in a resident room housekeeping staff notified maintenance staff. It was also verified no work order request had been put into the system prior to the surveyor's observation R94's call light audit been put into the system prior to the surveyor's observation R94's call light was not functioning.</li> <li>At 8:21 a.m. the health information staff (HIS)-A showed he had a paper template which included checking residents' rooms and call lights on R94's floor. The HIS explained once the request was put into the system, or work requests and verified the only reguest for repair was made on 9/14/15. In addition, the paper work request log kept at nurse's station revealed there was no work request for R94's call light.</li> <li>On 9/17/15, at 9:00 a.m. the director of nursing stated she expected all residents' call lights to be properly functioning.</li> <li>A call light policy was requested but was not</li> </ul>	PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	COMPLETION
	F 463	9/16/15, at 7:58 a.m staff had been ema R94's call light not f staff had replaced t of notification. The call light audits were However, two years stopped preventive building. The direct an issue in a reside notified maintenand work order request prior to the surveyo was not functioning At 8:21 a.m. the he showed he had a po- checking residents' R94's floor. The HI was put into the sys kept. The HIS looke facility's system for only request for rep addition, the paper nurse's station rever request for R94's ca On 9/17/15, at 9:00 stated she expected properly functioning A call light policy wa	n. he stated the maintenance ailed on 9/14/15, regarding functioning and that one of his the faulty cord within an hour director also stated residents' re completed in the past. Is ago the central office maintenance checks of the stor further stated if there was ent room housekeeping staff ce staff. It was also verified no had been put into the system or's observation R94's call light g. ealth information staff (HIS)-A aper template which included ' rooms and call lights on IS explained once the request stem, the paper was no longer ed onto the computer into the work requests and verified the bair was made on 9/14/15. In work request log kept at ealed there was no work all light. 0 a.m. the director of nursing d all residents' call lights to be g.	F 4	463			

Facility ID: 00233

If continuation sheet Page 10 of 10

	MENT OF HEALTH			5620	600	FORM	09/22/2015 APPROVED .0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		1 '	PLE CONSTRUCTION 3 01 - BLDG 19	(X3) DATE SU COMPLE	
		245620		B. WING		09/18	8/2015
	ROVIDER OR SUPPLIER ERANS HOME MINI	NEAPOLIS	5101 MI		STATE, ZIP CODE A AVENUE SOUTH IN 55417		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCI BE PRECEDED BY FULL INTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	ſS		K 000	· · ·		
		Survey was conduct					
	Marshal Division on time of this survey, Minneapolis, Buildir compliance with the	nent of Public Safety, a September 18, 201 Minnesota Veterans ang 19, was found in s a requirements for pa	5. At the Home substantial articipation				
	483.70(a), Life Safe edition of National F (NFPA) Standard 10 Chapter 18 New He	id at 42 CFR, Subpa ety from Fire, and the Fire Protection Assoc 01, Life Safety Code ealth Care. At this tim	e 2000 ciation (LSC), ne, we are				
	This 4 story, Type II basement and was facility is fully fire sp detection in the corr corridors which are department notificat non-Medicare receiv by 2-hour fire walls is no parking within facility and all cookin conducted in a sepa	Medicare Certification (222) construction v constructed in 2012, prinkler protected wit idors and areas ope monitored for autom tion. The facility is a ving facilities and is with 90-minute doors the facility, is a smo ng for the residents is arated building. The 20 beds and had a co	vithout a . The h smoke in to the natic fire ttached to separated s. There ke-free is facility				
	The requirement at MET.	42 CFR, Subpart 48		ATURF	TITLE		(X6) DATE
LADUKAIUH	T DIRECTOR'S UR PROVI	DEMOUPPLIER REPRESE	INTAILINE 9 9168	INTURE	1116		1

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.



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered October 1, 2015

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5620002

Dear Mr. Glad:

The above facility was surveyed on September 14, 2015 through September 17, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules 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 <u>only a suggestion</u> 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 <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. 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 at (651) 201-3794 or email at: gayle.lantto@state.mn.us.

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.

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

Sincerely, Monte Meeth

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

Minnesc	ota Department of He	alth				
-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00233	B. WING		09/1	7/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MN VET	ERANS HOME MINNE		NEHAHA AVI POLIS, MN 5	ENUE SOUTH 5417		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defict herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	surveyors of this De above provider and orders are issued. completed, please these orders and re Minnesota Departm	FS: 15, 16, and 17, 2015, epartment's staff, visited the the following correction When corrections are sign and date, make a copy of eturn the original to the nent of Health, Division of				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 10/09/15

Electronically Signed

STATE FORM

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE COMF	SURVEY	
		00233	B. WING	B. WING		09/17/2015	
AME OF F	PROVIDER OR SUPPLIER		T ADDRESS, CITY, S	TATE, ZIP CODE	05/	17/2013	
IN VETE	ERANS HOME MINNE	FAPOLIS	MINNEHAHA AVE EAPOLIS, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE	
2 000	Continued From pa	age 1	2 000				
		pring, Licensing and ams; P.O. Box 64900, St. Pa 9900.	ul,				
2 302	MN State Statute 1 or related disorder	44.6503 Alzheimer's diseas train	e 2 302			10/9/15	
	ALZHEIMER'S DIS DISORDER TRAIN MN St. Statute 144						
	Alzheimer's disease or related of segregated or gene care staff	lity serves persons with disorders, whether in a eral unit, the facility's direct ors must be trained in demer	ntia				
	related disorders; (2) assistance with (3) problem solving and (4) communication (c) The facility shal written or electronic training program, th trained, the frequer topics covered.	of Alzheimer's disease and activities of daily living; with challenging behaviors;					
	This MN Requirem	ent is not met as evidenced and document review, the	4	All new residents/families	will be given the		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00233	B. WING		09/1	7/2015
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
IN VETE	RANS HOME MINNE		NEHAHA AV POLIS, MN 🖇	ENUE SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 302	Continued From pa	ge 2	2 302			
	information regardin related disorders as Findings include: During a review of the training program, en- consumers had been electronic, a descrip program, the catego frequency of trainin covered. At the time numerous residents Alzheimer's disease When interviewed, director of nursing (	ure consumers were provided ng Alzheimer's disease or s required. the facility's Alzheimer's vidence was lacking to show en provided in written or otion of Alzheimer's training ories of employees trained, the g and the basic topics e of the survey the facility had s with primary diagnoses of e or other dementia. on 9/16/15, at 1:44 p.m. the (DON) stated written or on provided to consumers was		Alzheimer¿s Training Disc statement. The disclosure written description of the t category of employees tra frequency of training and covered. Audits will be conducted n ensure residents are rece description of the Alzheim program. Findings will be reviewed Assurance Committee. Au continue until the Interdisc determines substantial co The Administrator or desig responsible. Corrective action will be c October 22, 2015.	e contains a raining program, ined, the the basic topic nonthly to iving the written er¿s training by the Quality udits will ciplinary Team mpliance. gnee is	
	employee developm	5 a.m. the human resources nent (HRED) staff reported the a policy related to required J.	)			
	The DON or design regarding staff train packet so consume information. The DO	THOD OF CORRECTION: the could add information ting to the resident admission ers were aware of this DN or designee could educate uirement and conduct audits to				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21610	MN Rule 4658.1340 and Preparation Are	0 Subp. 1 Medicine Cabinet ea;Storage	21610			10/9/15

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00233	B. WING		09/17/2015	
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY,	STATE, ZIP CODE		
IN VETI	ERANS HOME MINNE	- APOLIS		ENUE SOUTH		
(X4) ID			POLIS, MN	PROVIDER'S PLAN OF CORREC		(YE)
PREFIX TAG(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)PREFIX TAG(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE CROSS-REFERENCED TO THE				(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLE DATE
21610	Continued From pa	age 3	21610			
	must store all drug under proper temp only authorized nui access to the keys	e of drugs. A nursing home s in locked compartments erature controls, and permit rsing personnel to have ent is not met as evidenced				
	by: Based on observation, interview and document review, the facility failed to properly dispose of wasted medications for 1 of 1 resident (R22) who declined medications when offered.			All licensed staff responsible fo administering medications have trained to the current procedure medication destruction. Random audits will be conducte to observe for correct dispositio	e been e related to ed monthly	
	Findings include: R22's medications were set up by a licensed practical nurse (LPN)-A on 9/15/15, at 8:45 a.m. The medications included enteric coated aspirin 81 milligram (mg) (for stroke and heart attack prevention), extended release potassium 10 millequivalents (for low potassium), furosemide 20 mg (to reduce fluid in the tissues), Metoprolol 12.5 mg (for high blood pressure/heart issues), and levothyroxine 75 micrograms (thyroid replacement). LPN-A entered R22's room at 9:00 to administer the medications to the resident. R22 was lying awake in bed, but declined taking the medications, saying he would instead come t get them in a half hour.		<ul> <li>b observe for correct disposition</li> <li>medication.</li> <li>Findings will be reviewed by the Assurance Committee. Audits we continue until the Interdisciplinal determines substantial complia</li> <li>The director of nursing or design responsible.</li> <li>Corrective action will be complete October 15, 2015</li> </ul>	e Quality vill Iry Team nce. nee is		
LPN-A returned hallway adjacer disposed of the unsecured tras medication cart resident refuse medications ha	LPN-A returned to hallway adjacent to disposed of the me unsecured trash di medication cart. L resident refuses th medications have a	Froom with the medications, the medication cart in the the dining room. LPN-A then edications in the attached, spenser on the side of the PN-A then stated, "When a eir medications and the already been dispensed, we save them in the cart."				

STATEMEN	DT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED	
		00233	B. WING		09/	09/17/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
		5101 MIN	NEHAHA AVE	NUE SOUTH			
	ERANS HOME MINNE	APOLIS MINNEAF	POLIS, MN 55	5417			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLET DATE	
21610	Continued From pa	age 4	21610				
	R22's Medication Administration Record (MAR) dated 9/15/15, indicated the resident refused the medications, however, the MAR lacked any documentation regarding the method of destruction.						
	registered nurse (RN) unused medications w disposed of into the "I consisted of a plastic that absorbed the me Rx Destroyers were lo medication rooms thre each floor RN manag educating nurses on t	a on 9/15/15, at 10:35 a.m. a RN)-A reported all non-narcotic is were expected to be e "Rx Destroyer" which tic bottle containing a solution medication. RN-A stated the e located in all of the throughout the facility, and ager was responsible for on their units regarding the all nurses should have been					
	resident refused m have re-approache It would have been dispensed medicat cart or put the med located in the medi was absolutely una	9/15/15, at 10:55 a.m. if a edications, the nurse should of the resident at a later time. acceptable to either store the ions in the locked medication lication in the Rx Destroyer ication room. RN-B reported it acceptable to throw away any e trash, as any resident could d the medications.					
	reported when a re was documented a trash. The excepti- thinner) which wen narcotics. LPN-A s into the trash was s and said she had n	n 9/15/15, at 11:00 p.m. LPN-A esident refused medications it and they were thrown into the on was Coumadin (blood t into the Black Box, and stated throwing the medications standard practice at the facility, not been provided with any o using the Rx Destroyer or					

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:			E SURVEY PLETED	
		00233	B. WING		09/17/2015		
IAME OF F	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE				
AN VETE	ERANS HOME MINNE	- APOLIS	NNEHAHA AVE APOLIS, MN 55				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE	
21610	Continued From pa	age 5	21610				
	medications. LPN-, Destroyer informat but denied receivin regarding its use. The assistant direct interviewed on 9/17 stated it was an ex medications should and the medication Destroyer or other container in the loc up by the vendor. The Destroyer was curr medication rooms. education on the R would have been to container that was rooms. The ADON received education as they had only st 7/24/15. The ADO medications should trash, and the prace ADON said any con the trash and retrie	re ways of disposing of A then recalled seeing Rx ion posted on a bulletin board ig any formal education tor of nursing (ADON)-B was 7/15, at 9:40 a.m. The ADON pectation all refused d have been charted as such, is be placed in the Rx medication destruction the ADON confirmed the Rx rently available in all If nurses had not received the fix Destroyer, an alternative o use the medication collection still available in all medication confirmed all nurses had not a regarding the Rx Destroyer, arted using the system on N confirmed absolutely no d have been disposed of in the tice was unacceptable. The infused resident could get into eve the medications. A copy of was then provided, and the	e 1				
	ADON verified the currently being flus Fentanyl patches.	only medications that were hed via the sewer system was					
	staff to dispose of the sewer system.	ion Destruction Policy directed medications by flushing down					
	Process Improvem provided to staff re	Administration Practice and ents outlined education lated to medication formation notes staff had beer					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X3	) DATE SURVEY COMPLETED	
		00233	B. WING		09/17/2015	
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S	STATE, ZIP CODE	03/11/2013	
	ERANS HOME MINNE	5101 MI	NNEHAHA AV	ENUE SOUTH		
		MINNEA	POLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
21610	Continued From pa	age 6	21610			
	except Fentanyl pa was also noted eig	unused/unwanted medication: tches into the Rx Destroyer. It ht nurses had received the o utilizing the Rx Destroyer.				
	The director of nur policies and proceed practices at the fact responsibility for a be trained in the cu	THOD OF CORRECTION: sing or designee could ensure dures accurately reflect curren sility. All persons with dministering medications could urrent procedures. Audits d and the results brought to the for review.	t I			
	TIME PERIOD FO (14) days.	R CORRECTION: Fourteen				
21695	MN Rule 4658.141 Housekeeping, Op	5 Subp. 4 Plant eration, & Maintenance	21695		10/9/15	
	provide housekeep necessary to maint comfortable interio	eeping. A nursing home must bing and maintenance services tain a clean, orderly, and r, including walls, floors, fixtures, equipment, lighting,	:			
	by: Based on observat interview, the facilit was kept clean and maintained. This h	ent is not met as evidenced ion, document review and ty failed to ensure equipment d floors and walls were ad the potential to affect residents residing on 6-1 and		The director of housekeeping will revi the policy and procedure to ensure it current, and staff responsible are re-educated. The carpeting, wheelcha resident mechanical lifts and elevator panels have been addressed. Random audits will be conducted mon to observe for proper cleaning of carp and wheelchairs. Resident mechanica	is airs, wall nthly pets	

STATE FORM

6899

V6NP11

If continuation sheet 7 of 16

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/17/2015	
		00233	B. WING			
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
MN VET	ERANS HOME MINNE	APOLIS	NEHAHA AV OLIS, MN 5	ENUE SOUTH 55417		
(X4) ID PREFIX TAG	RÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COM	(X5) IPLET DATE
21695	R37's Broda wheele observed on 9/14/1 thick build up of dat below the right arm were soiled with pir orange drip was se frame, and the foot 9/17/15, at 10:00 a. observed to be in th A registered nurse of the chair at the ti RN-G explained tha 6-1 was scheduled evening. After resid wheelchairs were ta cleaned by houseke the wheelchair clea 9/14/15, the same e observations were chair had been clea written on the form. was not clean, and wiped off spills/soili housekeeper (LH)- had to be clenaned into the cleaning ma staff were to use a remove all soil. Three of four stand be unclean on 9/17 reddish brown splat frame. The other li padded covers wer verified the conditio would have expected happened. LH-A th	chair was heavily soiled when 5 at 3:45 p.m. There was a rk matter along the frame rest. Both sides of the chair ak-colored spills, a solidified en on the underside of the rests were soiled as well. On m. the wheelchair was again he same unclean condition. (RN)-G verified the condition me of the second observation. at wheelchair cleaning for unit for every other Monday dents were in bed, their aken to a cleaning area to be seping staff. RN-G provided ning check-off list dated	21695	will be audited for soiled or cracke padded covers and unclean surfa Findings will be reviewed by the O Assurance Committee. Audits will continue until the Interdisciplinary determines substantial complianc The Administrator or designee is responsible Corrective action will be complete October 22, 2015	ces. Quality Team e.	

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED	
		00233	B. WING	B. WING		09/17/2015	
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE			
ΜΝ VET	ERANS HOME MINNE	APOLIS	NNEHAHA AVE POLIS, MN 55				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		SUMMARY STATEMENT OF DEFICIENCIES     ID     PROVIDER'S PLAN OF CORRECTION       (EACH DEFICIENCY MUST BE PRECEDED BY FULL     PREFIX     (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLET DATE	
21695	Continued From pa	age 8	21695				
	conducted with the The carpeting on u was found to be he AA verified the stat to expectations." T for Building 17 were exposing a sharp e	00 a.m. a facility tour was assistant administrator (AA). nit 6-1 in the resident lounge eavily stained and soiled. The e of the carpeting was not "up The wall panels in the elevator e chipped and gouged edge. The edge was just above uard rail at arm level, potentially idents.					
	policy directed staf equipment is done risk of transmissior	nent Cleaning and Disinfection f, "Cleaning or disinfection of as necessary to decrease the n of infectious organisms and nd sanitary environment."					
	The director of hou nursing could ensu current, and staff re training. Audits cou	THOD OF CORRECTION: sekeeping with the director of re appropriate policies were esponsible would receive uld be conducted, and the he quality committee for					
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one					
21990	MN St. Statute 626 Maltreatment of Vu	5.557 Subd. 4 Reporting - Inerable Adults	21990			10/9/15	
	immediately make entry point. Use of for the deaf or othe considered an oral point may not requi extent possible, the	ng. A mandated reporter shall an oral report to the common a telecommunications device er similar device shall be report. The common entry ire written reports. To the e report must be of sufficient he vulnerable adult, the					

STATEME	DIA Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/17/2015	
		00233	B. WING			
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
MN VET	ERANS HOME MINNE	- APOLIS	NEHAHA A\ POLIS, MN 🗄	/ENUE SOUTH 55417		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		SUMMARY STATEMENT OF DEFICIENCIES     ID     PROVIDER'S PLAN OF CORRECT       (EACH DEFICIENCY MUST BE PRECEDED BY FULL     PREFIX     (EACH CORRECTIVE ACTION SHOL)			(X5) COMPLET DATE
21990	caregiver, the nature maltreatment, any maltreatment, the incident, and any or reporter believes in the suspected maltreporter may disclose in section 13.02, and section 144.335, to comply with this sure this MN Requirements by: Based on interview facility failed to immediate the facility failed to immediate the facility failed to allegations. Findings include: R15's Minnesota V dated 8/30/15, indicated for the facility failed to allegations. Findings include: R15's Minnesota V dated 8/30/15, indicated for the facility failed to allegations. Findings include: R15's Minnesota V dated 8/30/15, indicated for the facility failed to allegations.	re and extent of the suspected evidence of previous name and address of the date, and location of the other information that the night be helpful in investigating treatment. A mandated ose not public data, as defined and medical records under o the extent necessary to abdivision. The extent necessary to abdivision. The extent necessary to abdivision. The extent review the nediately report allegations of the designated State agency or 1 of 1 residents (R15) who staff mistreatment. In addition, thoroughly investigate the determined an irregular ower left chin." The progress ated, "Resident had alleged to ed by two peopleresident has nationsNo maltreatment is	21990	Incident of alleged abuse/negle has been reported to designate agency and thoroughly investig Disposition received on Septem 2015. All incidents of alleged abuse a reported to the designated state and thoroughly investigated. Staff educated on facility Resid Prevention Plan for reporting al abuse/neglect. Audits will be conducted weekly incidents of alleged abuse/negl timeliness of reporting to the de state agency. Findings will be r the Quality Assurance Committ will continue indefinitely until the Interdisciplinary Team determin no longer necessary. Administrator or designee is res Corrective action will be comple October 22, 2015	state ated. aber 29, re being a agency ent legations of v on ect for esignated reviewed by ee. Audits es they are sponsible.	

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		00233	B. WING		09/17/2015	
AME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	TATE, ZIP CODE	03/	17/2015
		5101 MIN				
	ERANS HOME MINNE	APOLIS MINNEAF	OLIS, MN 55	5417		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21990	Continued From pa	age 10	21990			
	the director of nurs administrator were 8/30/15, at 1:00 p.r assistant director o R15's quarterly Mir 8/19/15, indicated t cognitively impaired two staff for transfe mobility. R15's care	ected." The document noted ing (DON) and the notified of the incident on n. as well as the on-call f nursing (ADON)-B. nimum Data Set (MDS) dated the resident was moderately d and required assistance of ers, toileting, dressing and bed e plan dated 8/18/15, indicated ecision making ability and				
	director of nursing unknown origin is r agencyIf a reside enough for us to re on R15's jaw and the DON stated, the ind to the SA. The DOI I would have report report indicated the allegations, she stat the incident prior to	y on 9/15/15, at 7:02 p.m. the (DON) stated, "Any bruise of eportable to the State ent said it happened, that is port it." In regard to the bruise he allegation of abuse, the cident had not been reported N further stated, "In hind sight, ted this." Although the incident e DON had been notified of the ated she had no knowledge of the surveyor's inquiry and v investigation was completed egation of assault.				
	registered nurse (F for the nurse mana resided. RN-E said report dated 8/30/1 incident." After talk possible cause for reportable due to th though R15 reported	on 9/15/15, at 7:51 p.m. a RN)-E stated he was covering ger of the unit in which R15 he had reviewed the incident 5, "a few days after the ing to staff to determine a the injury, he did not feel it was he possibility of self-injury even ed he had been "assaulted."				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00233	B. WING	B. WING		17/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
ΜΝ VET	ERANS HOME MINNE	APOLIS	NEHAHA AVE POLIS, MN 55			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21990	Continued From pa	ge 11	21990			
	administrator stated allegations of abuse reported." Although the administrator ha allegation of assaul had no previous kn made by R15. He fu should have been r During an interview licensed practical n out the initial incide told her "Two guys" something." She fu allegations to the R During an interview ADON-B stated, Th talk about the allegations to the R During an interview ADON-B stated, Th talk about the allegations and the she knew R15 well, building. ADON-B et "makes up a lot of a staff had assaulted call" not to report the she did not initiate a resident's injury and happened. A 10/28/13, Reside	r on 9/16/15, at 11:06 a.m. a urse (LPN)-B stated she filled nt report. LPN-B stated, R15 came in at midnight and did rther stated she reported the N on duty per the policy. To n 9/17/15 at 8:45 a.m. the RN supervisor called her to ation made by R15. She stated as he formerly resided in her explained that because R15 stories," although he stated him, she made a "judgment the incident. ADON-B stated any investigation into the d statement as to how it ant Protection Plan policy				
	from maltreatment" form abuse, neglec directed staff to imr any suspicion that a policy further direct	se was, "To protect residents and to protect all residents t, and harm. The policy nediately reported to the SA abuse may have occurred. The s staff to notify the OON to coordinate an				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00233	B. WING		09/17/2015		
NAME OF	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE				
IN VET	ERANS HOME MINNE	- APOLIS	NEHAHA AVE POLIS, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE	
21990	Continued From pa	age 12	21990				
	The director of nur could ensue all alle reported and then mistreatment. Trai be provided. Audit	THOD OF CORRECTION: sing and licensed social worke egations are immediately investigated for potential ining for appropriate staff could is could be conducted and the ought to the quality committee					
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one					
23010	MN Rule 4658.463 Construction	5 A Nurse Call System; New	23010			10/9/15	
	communication sys from the resident a required by this pa system, if electrica connected to the e Nurse calls and em of being inactivated central annunciato	n must be equipped with a stem designed to receive calls and nursing service areas rt. The communication Ily powered, must be mergency power supply. nergency calls must be capable d only at the points of origin. A r must be provided where the rom the nurses' station.					
	resident's bed. Ca communication der they are within read from a resident mu station, activate a l bedroom, and activ medication room, r room, soiled utility multi-corridor nursi	must be provided for each Il cords, buttons, or other vices must be placed where ch of each resident. A call ist register at the nurses' ight outside the resident vate a duty signal in the nourishment area, clean utility room, and sterilizing room. In ing units, visible signal lights at corridor intersections.					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED 	
		00233				
			DRESS, CITY,	•		
/N VET	ERANS HOME MINNE		INEHAHA AV POLIS, MN 5	ENUE SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLE DATE
23010	Continued From pa	ige 13	23010			
23010	This MN Requireme by: Based on observati review the facility fa functioning for 1 of environmental cond Findings include: R94's call light was at 10:43 a.m. The cond when activated. And asked to check R94 not ring nor light up the registered nurse not working, who w or maintenance sta was able to use his some cognitive imp him every two hour explained that R94 needed reminders On 9/15/15, at 12:2 observed placed or functioning when te 6:45 a.m. RN-B sta not functioning it wa If the call light need replace it, but beyo maintenance staff of unaware of any call been completed by On 9/16/15, at 7:23 with a walker. Altho independently, he r chair or the bed. N	ent is not met as evidenced ion, interview and document ailed to ensure a call light was 1 resident (R94) reviewed for cerns. tested for function on 9/14/15, call light neither rang nor lit up nursing assistant (NA)-A was 4's call light, and again it did b. NA-A stated she would notify e (RN)-A about R94's call light ould then notify housekeeping if to fix it. NA-A reported R94 c call light, but because of bairment, staff also checked on s to offer toileting. NA-A also walked with a walker but and cues as to where to go. 20 p.m. R94's call light was n top of his bed, and was ested. The following day at ted that when call lights were as considered a safety issue. led a new cord the nurse could nd that staff needed to notify of the problem. RN-B was I light audits that may have		On a routine basis, the call I each room will be checked to housekeeping. Random audits will be condu on each unit to ensure comp call light system is functionin The findings will be reviewed Quality Assurance Committe continue indefinitely until the Interdisciplinary Team detern substantial compliance. Administrator or designee is Corrective action will be con October 15, 2015.	ucted monthly bliance and the ng properly. d by the ee. Audits will mines responsible.	

Minnesota Department of Health         STATEMENT OF DEFICIENCIES         AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:         00233		(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING			(X3) DATE SURVEY COMPLETED 09/17/2015	
				09/		
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	ERANS HOME MINNE	- APOLIS	NNEHAHA AVE POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
23010	Continued From pa	age 14	23010			
	administrator (AA) residents' call lights AA stated if a resid working nursing wo repair into the elect maintenance would unaware of any cal currently being con understanding facil function checks. Later at 1:14 p.m. t (ADON) stated she to be in working or was unaware of an completed. During an interview 9/16/15, at 7:58 a.r staff had been ema R94's call light not staff had replaced to of notification. The call light audits wer However, two years stopped preventive building. The direct an issue in a reside notified maintenant work order request	at 9:57 a.m. the assistant stated he expected all s to be in working order. The ent's call light was found not buld submit this request to tronic work order system and d fix the call light. He was lights audits that were npleted, but it was his lity staff used to do call light the assistant director of nursing expected residents' call lights der. The ADON also stated she by call light audits being with maintenance director on m. he stated the maintenance ailed on 9/14/15, regarding functioning and that one of his the faulty cord within an hour director also stated residents' re completed in the past. s ago the central office e maintenance checks of the etor further stated if there was ent room housekeeping staff ce staff. It was also verified no is had been put into the system or's observation R94's call light				
	showed he had a p checking residents R94's floor. The H	ealth information staff (HIS)-A paper template which included ' rooms and call lights on IS explained once the request stem, the paper was no longer				

Image: Provider Supplementation     (20) P	Minnesc	ta Department of He	alth				ATTIOVED
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       MN VETERANS HOME MINNEAPOLIS     5101 MINNEAPOLIS, MN 55417       (xi) ID PREFIX TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH EDFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     DI PREFIX TAG     PROVIDER'S PLAN OF CORRECTION (EACH EDFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     DI PREFIX TAG     Continued From page 15     Convertere DATE       23010     Continued From page 15     Continued From page 15     Convertere addition, the paper work requests and verified the only request for revailed there was no work request for R94's call light.     Con 9/17/15, at 9:00 a.m. the director of nursing stated she expected all residents' call lights to be properly functioning.     A call light policy was requested but was not provided by facility.       SUGGESTED METHOD OF CORRECTION: The environmental services director or administrator with the director of nursing could ensure polices addressed preventive malignant including call light checks. Staff could conduct audits and the results could be brought to the quality committee for their review.       TIME PERIOD FOR CORRECTION: Fourteen				. ,			
Image: Provide a state of the example of the examp			00233	B. WING		09/1	7/2015
MN VETERANS HOME MINNEAPOLIS         MINNEAPOLIS, MN 55417           Image: Construct of the second secon	NAME OF I	PROVIDER OR SUPPLIER					
PRÉFIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PRÉFIX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY)       cowint for DATE         23010       Continued From page 15       23010       23010       Image: Complexity of the computer into the facility's system for work requests and verified the only request for repair was made on 9/14/15. In addition, the paper work request log kept at nurse's station revealed there was no work request for R94's call light.       2000       Image: Complexity of the complexity of t	MN VETI	ERANS HOME MINNE					
<ul> <li>kept. The HIS looked onto the computer into the facility's system for work requests and verified the only request for repair was made on 9/14/15. In addition, the paper work request log kept at nurse's station revealed there was no work request for R94's call light.</li> <li>On 9/17/15, at 9:00 a.m. the director of nursing stated she expected all residents' call lights to be properly functioning.</li> <li>A call light policy was requested but was not provided by facility.</li> <li>SUGGESTED METHOD OF CORRECTION: The environmental services director or administrator with the director of nursing could ensure polices addressed preventive malignant including call light checks. Staff could conduct audits and the results could be brought to the quality committee for their review.</li> <li>TIME PERIOD FOR CORRECTION: Fourteen</li> </ul>	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETE
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Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered October 1, 2015

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

Re: Enclosed State Boarding Care Home Licensing Orders - Project Number S5620002

Dear Mr. Glad:

The above facility survey was completed on September 17, 2015 for the purpose of assessing compliance with Minnesota Department of Health Boarding Care Home Rules and to investigate complaint number . 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.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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 Boarding Care 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 is 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.

When all orders are corrected, the order form should be acknowledged electronically and submitted to this office at 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 at (651) 201-3794 or email: gayle.lantto@state.mn.us.

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.

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

Minneso	ta Department of He	alth			ATTIOVED	
STATEMENT OF DEFICIENCIES (X1) PROV		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00233	B. WING		09/1	7/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
MN VET	ERANS HOME MINNE		NNEHAHA AV POLIS, MN 5	ENUE SOUTH 5417		
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3 000	INITIAL COMMEN	rs	3 000			
	*****ATTENTIO	DN*****				
	BOARDING CAP LICENSING CORF					
	144A.10, this corre pursuant to a surve found that the defic herein are not corre not corrected shall	Minnesota Statute, section ction order has been issued by. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.				
	corrected requires requirements of the number and MN Ru When a rule contai comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been compliance with all a rule provided at the tag ule number indicated below. Ins several items, failure to the items will be considered Lack of compliance upon uny item of multi-part rule will sment of a fine even if the item uring the initial inspection was				
	that may result from orders provided that the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	surveyors of this De	TS: 15, 16, and 17, 2015, epartment's staff, visited the no violations were noted.				
LABORATOR		DER/SUPPLIER REPRESENTATIVE'S SI	GNATURE	TITLE		(X6) DATE
Electron	ically Signed					10/09/15

If continuation sheet 1 of 1