Minnesota Department of Health

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

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00233 (Y1)	A. Building 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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 21565 Reg. # MN Rule 4658.1325 Subp. 4 LSC	Correction Completed 12/22/2015	ID Prefix 23010 Reg. # MN Rule 4658.4635 A LSC	Correction Completed 12/22/2015	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	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) GL/mm	DATE 01/26/2016	SIGNATURE OF SURVEYOR 35574	DATE 12/22/2015
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	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 — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: V6NP

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00233

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/12/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

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

13.Total Certified Beds **100** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	100			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Elizabeth Nelson, HFE NEII 11/24/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 01/29/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
03001 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE
11/23/2015 (L33)

DETERMINATION APPROVAL

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 facilty 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.

MDH
Minnesota Department of Health

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 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

An equal opportunity employer

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

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

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245620 Y1	A. Building 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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0225 Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4) LSC	Correction Completed 10/11/2015	ID Prefix F0226 Reg. # 483.13(c) LSC	Correction Completed 10/11/2015	ID Prefix F0463 Reg. # 483.70(f) LSC	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

REVIEWED BY STATE AGENCY ☑	REVIEWED BY (INITIALS) GL/mm	DATE 01/29/2016	SIGNATURE OF SURVEYOR 13603	DATE 11/12/2015
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	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 — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: V6NP

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00233

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/12/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

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

13.Total Certified Beds **100** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	100			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Elizabeth Nelson, HFE NEII 11/24/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 01/05/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/23/2015
(L33)

DETERMINATION APPROVAL

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 resuilts of this vists. Post Certificatoin Revisit to follwo.

Minnesota Department of Health

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 recommneded 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:

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

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. 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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245620	A. BUILDING _____ B. WING _____	R 11/12/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An onsite post certification revisit (PCR) was completed on [date of survey]. The certification tags that were corrected can be found on the CMS2567B. Also there are tag/s that were not found corrected and/or new tags were issued at the time of onsite PCR which are located on the CMS2567. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}		
{F 463} SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a call light was available and functioning for 1 of 1 resident (R72) reviewed for environmental concerns. Findings include:	{F 463}	During survey R72 call cord was placed. Care plan was reviewed at the time of survey and residents cognitive inability to use call light. All residents that have room changes have the potential to be affected.	12/4/15

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

Electronically Signed | 12/04/2015

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245620	A. BUILDING _____ B. WING _____	R 11/12/2015

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{F 463}	Continued From page 1 R72's room was observed on 11/12/15, at 9:58 p.m. There was no call light available in the room. A call light box was attached to the wall, but a call light cord was missing. 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 "just moved into the room two weeks ago from 4th floor." LPN-A stated that she saw a call light cord in R72's room "sometime" back but wasn't sure when that was. LPN-A stated that it was a safety issue and that all residents were supposed to have a working accessible call light "at all times." LPN-A stated that staff was supposed to notify person in charge if there were any concerns related to call light, and a place a maintenance order. A registered nurse (RN)-A was interviewed on 11/12/15, at 10:10 a.m. RN-A stated that a call light "is a safety protocol" and that all residents "must" have a functioning call light in their rooms irrespective of whether they were able to use it or not. RN-A stated that her expectation was that staff reported any non-functioning call light "immediately" to the person in charge. RN-A stated that all staff were responsible of making sure call light are functioning "properly" and within reach. RN-A denied any knowledge of call light audits. A human service technician (HST)-A working with R72 was interviewed on 11/12/15, at 10:15 a.m. HST-A verified that R72 did not have a call light in the room. HST-A stated "There was no call light in his room this morning, and there wasn't any when I worked with him on Monday." HST-A	{F 463}	All resident rooms checked to endure call cords are present. Random audits will be conducted weekly by nursing.Findings will be reported to QA committee until QA determines substantial compliance. ED, DON, ADON responsible.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245620	A. BUILDING _____ B. WING _____	R 11/12/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 463}	Continued From page 2	{F 463}		

stated that if a call light was not working, staff was supposed to report "immediately" to the person in charge. HST-A acknowledged that she had not reported the issue to anyone despite having knowledge it was missing. HST-A stated that R72 was not capable of using a call light, but "he is supposed to have one anyway." HST-A stated that, "I should have reported that, but I guess I didn't."

The assistant director of nursing (ADON) was interviewed on 11/12/15, at 11:17 a.m. stated that her expectations was call lights would be working, available and accessible "at all times." The ADON stated that housekeeping staff was responsible for call light audits but was not sure how often they were competed. Several minutes later the ADON approached the surveyor and stated that a call light was now available and functional in R72's room. The ADON also stated that staff were being educated "right now" and call lights "are being audited."

The executive housekeeper (EHK) was interviewed at 11:53 a.m. and stated that every room get cleaned once a week and call lights were checked at that time. The EHK stated random call lights were then completed after housekeepers "have done their checks."

The maintenance manager (MM) was interviewed on 11/12/15, at 1:31 p.m. explained call light audits were performed in all rooms annually. The MM stated nursing staff was responsible for placing work orders in the computer system if there were any issues with a call light. The MM also stated, "I check the orders at least four times a day, sign them off and then assign them to the appropriate party." The MM verified not work

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	245620	A. BUILDING _____ B. WING _____	R 11/12/2015

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{F 463}	Continued From page 3 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 on 10/26/15. 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 needs...Residents 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}		

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

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	(Y2) Multiple Construction	(Y3) Date of Revisit
245620	A. Building B. Wing	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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	**10/11/2015**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	**10/11/2015**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GL/mm	11/24/2015	13603	11/12/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
9/17/2015			

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.

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00233	A. BUILDING: _____ B. WING _____	R 11/12/2015

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

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{2 000}	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	{2 000}		

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{2 000}	Continued From page 1 Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the 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.	{2 000}		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as 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 review, the facility failed to assess 1 of 1 resident (R28) who was observed self-administering medications. Findings include: R28 was observed sitting in his wheelchair next to the medication cart on 11/12/15, at 10:25 a.m. A licensed 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 ml of valproic acid (for seizure control) 250 mg/5 ml (millimeters) that she reportedly had already added to the glass of juice. LPN-A added small size ice cubes to the glass of juice and	21565	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. Residents that self-administer medications have been reviewed. EMAR orders have been updated to reflect self-administration. Random weekly audits will be conducted on residents that self-administer medications. Findings will be reported to QA committee and will continue until QA committee determines substantial	12/4/15

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21565	Continued From page 2 medication. R28 took two sips, then coughed and sputtered. LPN-A asked the resident if he was all right, and then said, "Here, let me double cup it for you" (so the glass would be studier to handle). LPN-A added a second cup underneath the first, and handed it back to R28. An activity staff approached R28 and asked he wanted a ride to BINGO, and proceeded to push his wheelchair away from the nursing station toward the elevator. R28 continued holding his glass of orange juice with the medication. After LPN-A documented R28 had taken all of his morning medications, the surveyor asked whether the resident had a self-administration of medication (SAM) assessment allowing him to take his medications independently. LPN-A stated she did not know, and the assessments were completed by the registered nurses (RNs). LPN-A said she normally gave R28 his valproic acid in orange juice and allowed him take it with him because the resident "has behaviors" described as anxiety requiring redirection by distraction, and refusing to take his medications. LPN-A also stated that she figured it was better for R28 to at least get some of the medication by taking it with him than to not take it at all. When asked if she knew how much medication the resident had consumed LPN-A replied, "No, not really." LPN-A further stated that R28 liked orange juice and pop was used as a reward for him. LPN-A and the surveyor looked for evidence R28 had a SAM assessment completed that showed he could independently and reliably take his medications. A Self Administration of Medications dated 11/9/15, had only one question answered which was "1. Does Resident Request to Self Administer Medications &/or Treatments: If so complete this assessment" and it was answered	21565	compliance. DON, ADON responsible.	

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21565	Continued From page 3	21565		

"No." 11/9/15. When asked what she would do next knowing the assessment did not indicate R28 was to SAM, LPN-A stated, "I will go downstairs to the dining room and see how much of the orange juice he has drank."

LPN-A then proceeded to walk down the hall to the elevator and take the elevator down and then across to the next building to the main dining room where BINGO was being held. R28 was sitting at a table with five other residents. No staff were present at the table or nearby. R28's glass of orange juice was in front of him and was approximately 3/4 full. LPN-A informed the surveyor it did not look like the resident had consumed any more of the juice. When she turned to leave the room the surveyor suggested the juice contained medication and two other residents could have also reached for and consumed them. LPN-A then said, "I will go and try to get him to drink his orange juice." LPN-A conversed with R28 for a minute, and then removed the glass from the table. LPN-A reported R28 had refused to drink the orange juice, and while looking at the glass stated she could not tell how much of the medication the resident had consumed because the bottom couple inches of juice was darker in color and it was not possible to tell if it had settled. LPN-A then explained she would "waste" (dispose of) the medication and returned to the medication cart. She said she was going to "undo" her documentation in the electronic medication administration record (eMAR), since she had marked that the resident took all of the medication, and was going to document he had instead consumed 60 cc's of the valproic acid. LPN-A stated it was unclear how much medication R28 took, since the ice had melted and the medication appeared settled in the glass. RN-E approached LPN-A and when

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21565	Continued From page 4	21565		

asked how to document R28's valproic acid RN-E stated, "It looked like from what I saw that he drank very little of it." RN-E instructed LPN-A to document that R28 had refused the valproic acid, which was then documented in the eMAR. LPN-A then informed RN-E she was going to waste R28's medication and both nurses flushed the medication down the toilet. No documentation of the disposal was observed following its disposal.

Interdisciplinary team progress note for R28 dated 10/29/15, indicated "Behavioral Health Services: supportive visits related to increased behavior, depression and self-reported confusion." Physician orders directed Behavioral Health Services to treat for dementia with behavioral disturbance as evidenced by destruction of property and verbal aggression towards staff..." A Physician Visit note indicated R28 was seen by physician on 11/5/15, and indicated "Dementia with agitated behaviors." Physician orders included Dutasteride 0.5 mg oral capsule every day in the morning and valproic acid 250 mg/5 ml oral syrup, 15 ml (750 mg) orally morning and bedtime for seizure control.

R28's 10/15 and 11/15 MAR indicated valproic acid solution 250 mg/5 ml "unspecified mixed with beverage" had been administered. R28 had refused the medication seven times since the initiation of the medication on 10/16/15, and thirteen times in November as of 11/12/15.

On 11/12/15, at 1:40 p.m. assistant director of nursing stated that R28 "should not have self-administered his own medication and that she [LPN-A] had not followed procedure."

A 12/18/12, Medication/Treatments, Self-Administered policy read, "To assure safe

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00233	A. BUILDING: _____ B. WING _____	R 11/12/2015

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

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21565	Continued From page 5 administration for residents administering their own medications/treatments through ongoing assessment of their ability to continue this practice. To provide a monitoring system to assure residents are receiving and administering their medication in accordance with the medical provider's order." SUGGESTED METHOD OF CORRECTION: The director of nursing could ensure policies are current for SAM, and licensed staff have been trained. Residents who wish to SAM could be assessed, and a system for indicating this to staff could be devised. Audits could be conducted at medication pass times, and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21565		
{23010}	MN Rule 4658.4635 A Nurse Call System; New Construction The nurses' station must be equipped with a communication system designed to receive calls from the resident and nursing service areas required by this part. The communication system, if electrically powered, must be connected to the emergency power supply. Nurse calls and emergency calls must be capable of being inactivated only at the points of origin. A central annunciator must be provided where the door is not visible from the nurses' station. A. A nurse call must be provided for each resident's bed. Call cords, buttons, or other communication devices must be placed where they are within reach of each resident. A call from a resident must register at the nurses'	{23010}		12/4/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00233	A. BUILDING: _____ B. WING _____	R 11/12/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{23010}	Continued From page 6 station, activate a light outside the resident bedroom, and activate a duty signal in the medication room, nourishment area, clean utility room, soiled utility room, and sterilizing room. In multi-corridor nursing units, visible signal lights must be provided at corridor intersections. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a call light was available and functioning for 1 of 1 resident (R72) reviewed for environmental concerns. Findings include: R72's room was observed on 11/12/15, at 9:58 p.m. There was no call light available in the room. A call light box was attached to the wall, but a call light cord was missing. 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 "just moved into the room two weeks ago from 4th floor." LPN-A stated that she saw a call light cord in R72's room "sometime" back but wasn't sure when that was. LPN-A stated that it was a safety issue and that all residents were supposed to have a working accessible call light "at all times." LPN-A stated that staff was supposed to notify person in charge if there were any concerns related to call light, and a place a maintenance order. A registered nurse (RN)-A was interviewed on 11/12/15, at 10:10 a.m. RN-A stated that a call light "is a safety protocol" and that all residents	{23010}	During survey R72 call cord was placed. Care plan was reviewed at the time of survey and residents cognitive inability to use call light. All residents that have room changes have the potential to be affected. All resident rooms checked to endure call cords are present. Random audits will be conducted weekly by nursing.Findings will be reported to QA committee until QA determines substantial compliance. ED, DON, ADON responsible.	

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{23010}	Continued From page 7	{23010}		

"must" have a functioning call light in their rooms irrespective of whether they were able to use it or not. RN-A stated that her expectation was that staff reported any non-functioning call light "immediately" to the person in charge. RN-A stated that all staff were responsible of making sure call light are functioning "properly" and within reach. RN-A denied any knowledge of call light audits.

A human service technician (HST)-A working with R72 was interviewed on 11/12/15, at 10:15 a.m. HST-A verified that R72 did not have a call light in the room. HST-A stated "There was no call light in his room this morning, and there wasn't any when I worked with him on Monday." HST-A stated that if a call light was not working, staff was supposed to report "immediately" to the person in charge. HST-A acknowledged that she had not reported the issue to anyone despite having knowledge it was missing. HST-A stated that R72 was not capable of using a call light, but "he is supposed to have one anyway." HST-A stated that, "I should have reported that, but I guess I didn't."

The assistant director of nursing (ADON) was interviewed on 11/12/15, at 11:17 a.m. stated that her expectations was call lights would be working, available and accessible "at all times." The ADON stated that housekeeping staff was responsible for call light audits but was not sure how often they were competed. Several minutes later the ADON approached the surveyor and stated that a call light was now available and functional in R72's room. The ADON also stated that staff were being educated "right now" and call lights "are being audited."

The executive housekeeper (EHK) was

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	00233	A. BUILDING: _____ B. WING _____	R 11/12/2015

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{23010}	Continued From page 8	{23010}		

interviewed at 11:53 a.m. and stated that every room get cleaned once a week and call lights were checked at that time. The EHK stated random call lights were then completed after housekeepers "have done their checks."

The maintenance manager (MM) was interviewed on 11/12/15, at 1:31 p.m. explained call light audits were performed in all rooms annually. The MM stated nursing staff was responsible for placing work orders in the computer system if there were any issues with a call light. The MM also stated, "I check the orders at least four times a day, sign them off and then assign them to the appropriate party." The MM verified not work 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 on 10/26/15.

A facility's Call Light Usage policy dated 7/12,

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{23010}	Continued From page 9 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 needs...Residents 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."	{23010}		

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00233	A. Building B. Wing	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 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** Reg. # **MN State Statute 144.6503** LSC	Correction Completed **10/22/2015**	ID Prefix **21610** Reg. # **MN Rule 4658.1340 Subp.** LSC	Correction Completed **10/11/2015**	ID Prefix **21695** Reg. # **MN Rule 4658.1415 Subp.** LSC	Correction Completed **10/22/2015**
ID Prefix **21990** Reg. # **MN St. Statute 626.557 Sul** LSC	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

Reviewed By _____ **State Agency**	**Reviewed By** GL/mm	**Date:** 11/24/2015	**Signature of Surveyor:** 13603	**Date:** 11/12/2015
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**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 **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: V6NP

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00233

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/17/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

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

13.Total Certified Beds **100** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	100			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Jane Teipel, HFE NEII 11/21/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 11/23/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

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

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

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

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

DEPARTMENT CONTACT

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

Gayle Lantto, Unit Supervisor
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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction.

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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 https://dab.efile.hhs.gov 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

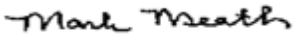
Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation 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, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245620	A. BUILDING _____ B. WING _____	09/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225		10/11/15

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

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F 225	Continued From page 1 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 people...resident has a history of hallucinations...No maltreatment is suspected at this time." Review of an untitled facility document dated 8/30/15, indicated R15 had a light purple,	F 225	Incident of alleged abuse/neglect by R15 has been reported to the 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 investigated. Staff educated on facility Resident Prevention Plan for reporting allegations of abuse/neglect. Audits will be conducted weekly on incidents of alleged abuse/neglect for timeliness of reporting to the designated state agency. Findings will be reviewed by the Quality Assurance Committee. Audits will continue indefinitely until the Interdisciplinary Team determines substantial compliance. Administrator or designee is responsible and immediately notified.	

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F 225	Continued From page 2 irregular shaped bruise approximately 2 x 1.8 centimeters (cm) to left side of his face, under his jaw. Although the document further indicated R15 had reported, "Two guys came in the middle of the night and assaulted me," it was noted, "No maltreatment suspected." The document noted the director of nursing (DON) and the administrator were notified of the incident on 8/30/15, at 1:00 p.m. as well as the on-call assistant director of nursing (ADON)-B. R15's quarterly Minimum Data Set (MDS) dated 8/19/15, indicated the resident was moderately cognitively impaired and required assistance of two staff for transfers, toileting, dressing and bed mobility. R15's care plan dated 8/18/15, indicated he had impaired decision making ability and communication. During an interview on 9/15/15, at 7:02 p.m. the director of nursing (DON) stated, "Any bruise of unknown origin is reportable to the State agency...If a resident said it happened, that is enough for us to report it." In regard to the bruise on R15's jaw and the allegation of abuse, the DON stated, the incident had not been reported to the SA. The DON further stated, "In hind sight, I would have reported this." Although the incident report indicated the DON had been notified of the allegations, she stated she had no knowledge of the incident prior to the surveyor's inquiry and was unaware if any investigation was completed regarding R15's allegation of assault. During an interview on 9/15/15, at 7:51 p.m. a registered nurse (RN)-E stated he was covering for the nurse manager of the unit in which R15 resided. RN-E said he had reviewed the incident report dated 8/30/15, "a few days after the	F 225	Corrective action will be completed by October 11, 2015.	

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F 225	Continued From page 3	F 225		

incident." After talking to staff to determine a possible cause for the injury, he did not feel it was reportable due to the possibility of self-injury even though R15 reported he had been "assaulted." RN-E stated he did not interview staff regarding R15's allegation that he had been assaulted.

During an interview on 9/15/15 at 8:05 p.m. the administrator stated, "Our protocol is that all allegations of abuse or maltreatment will be reported." Although the incident report indicated the administrator had been notified of the allegation of assault, the administrator stated he had no previous knowledge of the allegations made by R15. He further stated, "The incident should have been reported."

During an interview on 9/16/15, at 11:06 a.m. a licensed practical nurse (LPN)-B stated she filled out the initial incident report. LPN-B stated, R15 told her "Two guys came in at midnight and did something." She further stated she reported the allegations to the RN on duty per the policy.

During an interview on 9/17/15 at 8:45 a.m. ADON-B stated, The RN supervisor called her to talk about the allegation made by R15. She stated she knew R15 well, as he formerly resided in her building. ADON-B explained that because R15 "makes up a lot of stories," although he stated staff had assaulted him, she made a "judgment call" not to report the incident. ADON-B stated she did not initiate any investigation into the resident's injury and statement as to how it happened.

A 10/28/13, Resident Protection Plan policy indicated the purpose was, "To protect residents from maltreatment" and to protect all residents

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F 225	Continued From page 4 form abuse, neglect, and harm. The policy directed staff to immediately reported to the SA any suspicion that abuse may have occurred. The policy further directs staff to notify the administrator and DON to coordinate an investigation.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to follow policies and procedures related to immediate reporting of 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: A 10/28/13, Resident Protection Plan policy indicated the purpose was, "To protect residents from maltreatment" and to protect all residents form abuse, neglect, and harm. The policy directed staff to immediately reported to the SA any suspicion that abuse may have occurred. The policy further directs staff to notify the administrator and DON to coordinate an investigation.	F 226	Incident of alleged abuse/neglect by R15 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 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	10/11/15

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F 226	Continued From page 5 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 people...resident has a history of hallucinations...No maltreatment is suspected at this time." Review of an untitled facility document dated 8/30/15, indicated R15 had a light purple, irregular shaped bruise approximately 2 x 1.8 centimeters (cm) to left side of his face, under his jaw. Although the document further indicated R15 had reported, "Two guys came in the middle of the night and assaulted me," it was noted, "No maltreatment suspected." The document noted the director of nursing (DON) and the administrator were notified of the incident on 8/30/15, at 1:00 p.m. as well as the on-call assistant director of nursing (ADON)-B. R15's quarterly Minimum Data Set (MDS) dated 8/19/15, indicated the resident was moderately cognitively impaired and required assistance of two staff for transfers, toileting, dressing and bed mobility. R15's care plan dated 8/18/15, indicated he had impaired decision making ability and communication. During an interview on 9/15/15, at 7:02 p.m. the director of nursing (DON) stated, "Any bruise of unknown origin is reportable to the State agency...If a resident said it happened, that is enough for us to report it." In regard to the bruise on R15's jaw and the allegation of abuse, the DON stated, the incident had not been reported to the SA. The DON further stated, "In hind sight,	F 226	and immediately notified. Corrective action will be completed by October 11, 2015.	

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F 226	Continued From page 6	F 226		

I would have reported this." Although the incident report indicated the DON had been notified of the allegations, she stated she had no knowledge of the incident prior to the surveyor's inquiry and was unaware if any investigation was completed regarding R15's allegation of assault.

During an interview on 9/15/15, at 7:51 p.m. a registered nurse (RN)-E stated he was covering for the nurse manager of the unit in which R15 resided. RN-E said he had reviewed the incident report dated 8/30/15, "a few days after the incident." After talking to staff to determine a possible cause for the injury, he did not feel it was reportable due to the possibility of self-injury even though R15 reported he had been "assaulted." RN-E stated he did not interview staff regarding R15's allegation that he had been assaulted.

During an interview on 9/15/15 at 8:05 p.m. the administrator stated, "Our protocol is that all allegations of abuse or maltreatment will be reported." Although the incident report indicated the administrator had been notified of the allegation of assault, the administrator stated he had no previous knowledge of the allegations made by R15. He further stated, "The incident should have been reported."

During an interview on 9/16/15, at 11:06 a.m. a licensed practical nurse (LPN)-B stated she filled out the initial incident report. LPN-B stated, R15 told her "Two guys came in at midnight and did something." She further stated she reported the allegations to the RN on duty per the policy.

During an interview on 9/17/15 at 8:45 a.m. ADON-B stated, The RN supervisor called her to talk about the allegation made by R15. She stated

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F 226	Continued From page 7 she knew R15 well, as he formerly resided in her building. ADON-B explained that because R15 "makes up a lot of stories," although he stated staff had assaulted him, she made a "judgment call" not to report the incident. ADON-B stated she did not initiate any investigation into the resident's injury and statement as to how it happened.	F 226		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a call light was functioning for 1 of 1 resident (R94) reviewed for environmental concerns. Findings include: R94's call light was tested for function on 9/14/15, at 10:43 a.m. The call light neither rang nor lit up when activated. A nursing assistant (NA)-A was asked to check R94's call light, and again it did not ring nor light up. NA-A stated she would notify the registered nurse (RN)-A about R94's call light not working, who would then notify housekeeping or maintenance staff to fix it. NA-A reported R94 was able to use his call light, but because of some cognitive impairment, staff also checked on him every two hours to offer toileting. NA-A also explained that R94 walked with a walker but	F 463	R94¿s call light has been repaired. The call lights in the building are functioning. Random audits will be conducted monthly on each unit to ensure proper function of call lights. The 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. Corrective action will be completed by October 11, 2015.	10/11/15

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F 463	Continued From page 8	F 463		

needed reminders and cues as to where to go.

On 9/15/15, at 12:20 p.m. R94's call light was observed placed on top of his bed, and was functioning when tested. The following day at 6:45 a.m. RN-B stated that when call lights were not functioning it was considered a safety issue. If the call light needed a new cord the nurse could replace it, but beyond that staff needed to notify maintenance staff of the problem. RN-B was unaware of any call light audits that may have been completed by nursing staff.

On 9/16/15, at 7:23 a.m. NA-B stated R94 walked with a walker. Although he could sit down independently, he needed a little boost up from a chair or the bed. NA-B said R94 was mostly confused and seldom used his call light. Staff anticipated the resident's needs.

Later that morning at 9:57 a.m. the assistant administrator (AA) stated he expected all residents' call lights to be in working order. The AA stated if a resident's call light was found not working nursing would submit this request to repair into the electronic work order system and maintenance would fix the call light. He was unaware of any call lights audits that were currently being completed, but it was his understanding facility staff used to do call light function checks.

Later at 1:14 p.m. the assistant director of nursing (ADON) stated she expected residents' call lights to be in working order. The ADON also stated she was unaware of any call light audits being completed.

During an interview with maintenance director on

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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 provided by facility.	F 463		

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	245620	A. BUILDING **01 - BLDG 19** B. WING _____	**09/18/2015**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on September 18, 2015. At the time of this survey, Minnesota Veterans Home Minneapolis, Building 19, was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. At this time, we are not recommending Medicare Certification. This 4 story, Type II (222) construction without a basement and was constructed in 2012. The facility is fully fire sprinkler protected with smoke detection in the corridors and areas open to the corridors which are monitored for automatic fire department notification. The facility is attached to non-Medicare receiving facilities and is separated by 2-hour fire walls with 90-minute doors. There is no parking within the facility, is a smoke-free facility and all cooking for the residents is conducted in a separated building. The facility has a capacity of 100 beds and had a census of 91 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Gayle Lantto 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,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00233	A. BUILDING: _____ B. WING _____	09/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On September 14, 15, 16, and 17, 2015, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of	2 000		

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2 000	Continued From page 1 Compliance Monitoring, Licensing and Certification Programs; P.O. Box 64900, St. Paul, Minnesota 55164-0900.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the	2 302	All new residents/families will be given the	10/9/15

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2 302	Continued From page 2 facility failed to ensure consumers were provided information regarding Alzheimer's disease or related disorders as required. Findings include: During a review of the facility's Alzheimer's training program, evidence was lacking to show consumers had been provided in written or electronic, a description of Alzheimer's training program, the categories of employees trained, the frequency of training and the basic topics covered. At the time of the survey the facility had numerous residents with primary diagnoses of Alzheimer's disease or other dementia. When interviewed, on 9/16/15, at 1:44 p.m. the director of nursing (DON) stated written or electronic information provided to consumers was unavailable. On 9/17/15, at 10:55 a.m. the human resources employee development (HRED) staff reported the facility did not have a policy related to required Alzheimer's training. SUGGESTED METHOD OF CORRECTION: The DON or designee could add information regarding staff training to the resident admission packet so consumers were aware of this information. The DON or designee could educate staff about this requirement and conduct audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302	Alzheimer¿s Training Disclosure statement. The disclosure contains a written description of the training program, category of employees trained, the frequency of training and the basic topic covered. Audits will be conducted monthly to ensure residents are receiving the written description of the Alzheimer¿s training program. Findings will be reviewed by the Quality Assurance Committee. Audits will continue until the Interdisciplinary Team determines substantial compliance. The Administrator or designee is responsible. Corrective action will be completed by October 22, 2015.	
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage	21610		10/9/15

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21610	Continued From page 3 Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement 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. 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 to get them in a half hour. After leaving R22's room with the medications, LPN-A returned to the medication cart in the hallway adjacent to the dining room. LPN-A then disposed of the medications in the attached, unsecured trash dispenser on the side of the medication cart. LPN-A then stated, "When a resident refuses their medications and the medications have already been dispensed, we are not suppose to save them in the cart."	21610	All licensed staff responsible for administering medications have been trained to the current procedure related to medication destruction. Random audits will be conducted monthly to observe for correct disposition of medication. Findings will be reviewed by the Quality Assurance Committee. Audits will continue until the Interdisciplinary Team determines substantial compliance. The director of nursing or designee is responsible. Corrective action will be completed by October 15, 2015	

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21610	Continued From page 4 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. During an interview on 9/15/15, at 10:35 a.m. a registered nurse (RN)-A reported all non-narcotic unused medications were expected to be disposed of into the "Rx Destroyer" which consisted of a plastic bottle containing a solution that absorbed the medication. RN-A stated the Rx Destroyers were located in all of the medication rooms throughout the facility, and each floor RN manager was responsible for educating nurses on their units regarding the system, therefore, all nurses should have been educated. RN-B explained on 9/15/15, at 10:55 a.m. if a resident refused medications, the nurse should have re-approached the resident at a later time. It would have been acceptable to either store the dispensed medications in the locked medication cart or put the medication in the Rx Destroyer located in the medication room. RN-B reported it was absolutely unacceptable to throw away any medications into the trash, as any resident could have then accessed the medications. During interview on 9/15/15, at 11:00 p.m. LPN-A reported when a resident refused medications it was documented and they were thrown into the trash. The exception was Coumadin (blood thinner) which went into the Black Box, and narcotics. LPN-A stated throwing the medications into the trash was standard practice at the facility, and said she had not been provided with any education related to using the Rx Destroyer or	21610		

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21610	Continued From page 5	21610		

any other alternative ways of disposing of medications. LPN-A then recalled seeing Rx Destroyer information posted on a bulletin board, but denied receiving any formal education regarding its use.

The assistant director of nursing (ADON)-B was interviewed on 9/17/15, at 9:40 a.m. The ADON stated it was an expectation all refused medications should have been charted as such, and the medications be placed in the Rx Destroyer or other medication destruction container in the locked medication room picked up by the vendor. The ADON confirmed the Rx Destroyer was currently available in all medication rooms. If nurses had not received the education on the Rx Destroyer, an alternative would have been to use the medication collection container that was still available in all medication rooms. The ADON confirmed all nurses had not received education regarding the Rx Destroyer, as they had only started using the system on 7/24/15. The ADON confirmed absolutely no medications should have been disposed of in the trash, and the practice was unacceptable. The ADON said any confused resident could get into the trash and retrieve the medications. A copy of the facility policies was then provided, and the ADON verified the only medications that were currently being flushed via the sewer system was Fentanyl patches.

A 7/11/12, Medication Destruction Policy directed staff to dispose of medications by flushing down the sewer system.

A 7/15, Medication Administration Practice and Process Improvements outlined education provided to staff related to medication destruction. The information notes staff had been

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21610	Continued From page 6 instructed to place unused/unwanted medications except Fentanyl patches into the Rx Destroyer. It was also noted eight nurses had received the education related to utilizing the Rx Destroyer. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could ensure policies and procedures accurately reflect current practices at the facility. All persons with responsibility for administering medications could be trained in the current procedures. Audits could be conducted and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21610		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation, document review and interview, the facility failed to ensure equipment was kept clean and floors and walls were maintained. This had the potential to affect approximately 131 residents residing on 6-1 and in Building 17. Findings include:	21695	The director of housekeeping will review the policy and procedure to ensure it is current, and staff responsible are re-educated. The carpeting, wheelchairs, resident mechanical lifts and elevator wall panels have been addressed. Random audits will be conducted monthly to observe for proper cleaning of carpets and wheelchairs. Resident mechanical lifts	10/9/15

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21695	Continued From page 7 R37's Broda wheelchair was heavily soiled when observed on 9/14/15 at 3:45 p.m. There was a thick build up of dark matter along the frame below the right arm rest. Both sides of the chair were soiled with pink-colored spills, a solidified orange drip was seen on the underside of the frame, and the footrests were soiled as well. On 9/17/15, at 10:00 a.m. the wheelchair was again observed to be in the same unclean condition. A registered nurse (RN)-G verified the condition of the chair at the time of the second observation. RN-G explained that wheelchair cleaning for unit 6-1 was scheduled for every other Monday evening. After residents were in bed, their wheelchairs were taken to a cleaning area to be cleaned by housekeeping staff. RN-G provided the wheelchair cleaning check-off list dated 9/14/15, the same evening the original observations were made. The list indicated R37's chair had been cleaned, with the word "done" written on the form. RN-G verified R37's chair was not clean, and said it was expected staff wiped off spills/soiling when it happened. A lead housekeeper (LH)-A then explained Broda chairs had to be clenaned by hand, as they did not fit into the cleaning machine. He further explained staff were to use a special sanitizer cleaner and remove all soil. Three of four standing lifts were also observed to be unclean on 9/17/15, at 10:00 a.m. One lift had reddish brown splatters on the bottom of the frame. The other lift handles were soiled and padded covers were cracked and split. RN-G verified the condition of the lifts and stated she would have expected staff to clean spills as they happened. LH-A then explained that all lifts and stands were supposed to be cleaned daily.	21695	will be audited for soiled or cracked padded covers and unclean surfaces. Findings will be reviewed by the Quality Assurance Committee. Audits will continue until the Interdisciplinary Team determines substantial compliance. The Administrator or designee is responsible Corrective action will be completed by October 22, 2015	

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21695	Continued From page 8 On 9/17/15, at 11:00 a.m. a facility tour was conducted with the assistant administrator (AA). The carpeting on unit 6-1 in the resident lounge was found to be heavily stained and soiled. The AA verified the state of the carpeting was not "up to expectations." The wall panels in the elevator for Building 17 were chipped and gouged exposing a sharp edge. The edge was just above the height of the guard rail at arm level, potentially posing a risk to residents. A 11/16/11, Equipment Cleaning and Disinfection policy directed staff, "Cleaning or disinfection of equipment is done as necessary to decrease the risk of transmission of infectious organisms and maintain a clean and sanitary environment." SUGGESTED METHOD OF CORRECTION: The director of housekeeping with the director of nursing could ensure appropriate policies were current, and staff responsible would receive training. Audits could be conducted, and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		
21990	MN St. Statute 626.557 Subd. 4 Reporting - Maltreatment of Vulnerable Adults Subd. 4. Reporting. A mandated reporter shall immediately make an oral report to the common entry point. Use of a telecommunications device for the deaf or other similar device shall be considered an oral report. The common entry point may not require written reports. To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the	21990		10/9/15

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21990	Continued From page 9 caregiver, the nature and extent of the suspected maltreatment, any evidence of previous maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment. A mandated reporter may disclose not public data, as defined in section 13.02, and medical records under section 144.335, to the extent necessary to comply with this subdivision. This MN 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 people...resident has a history of hallucinations...No maltreatment is suspected at this time." Review of an untitled facility document dated 8/30/15, indicated R15 had a light purple, irregular shaped bruise approximately 2 x 1.8 centimeters (cm) to left side of his face, under his jaw. Although the document further indicated R15 had reported, "Two guys came in the middle of the night and assaulted me," it was noted, "No	21990	Incident of alleged abuse/neglect by R15 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. Staff educated on facility Resident Prevention Plan for reporting allegations of abuse/neglect. Audits will be conducted weekly on incidents of alleged abuse/neglect for timeliness of reporting to the designated state agency. Findings will be reviewed by the Quality Assurance Committee. Audits will continue indefinitely until the Interdisciplinary Team determines they are no longer necessary. Administrator or designee is responsible. Corrective action will be completed by October 22, 2015	

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21990	Continued From page 10 maltreatment suspected." The document noted the director of nursing (DON) and the administrator were notified of the incident on 8/30/15, at 1:00 p.m. as well as the on-call assistant director of nursing (ADON)-B. R15's quarterly Minimum Data Set (MDS) dated 8/19/15, indicated the resident was moderately cognitively impaired and required assistance of two staff for transfers, toileting, dressing and bed mobility. R15's care plan dated 8/18/15, indicated he had impaired decision making ability and communication. During an interview on 9/15/15, at 7:02 p.m. the director of nursing (DON) stated, "Any bruise of unknown origin is reportable to the State agency...If a resident said it happened, that is enough for us to report it." In regard to the bruise on R15's jaw and the allegation of abuse, the DON stated, the incident had not been reported to the SA. The DON further stated, "In hind sight, I would have reported this." Although the incident report indicated the DON had been notified of the allegations, she stated she had no knowledge of the incident prior to the surveyor's inquiry and was unaware if any investigation was completed regarding R15's allegation of assault. During an interview on 9/15/15, at 7:51 p.m. a registered nurse (RN)-E stated he was covering for the nurse manager of the unit in which R15 resided. RN-E said he had reviewed the incident report dated 8/30/15, "a few days after the incident." After talking to staff to determine a possible cause for the injury, he did not feel it was reportable due to the possibility of self-injury even though R15 reported he had been "assaulted." RN-E stated he did not interview staff regarding R15's allegation that he had been assaulted.	21990		

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	00233	A. BUILDING: _____ B. WING _____	09/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21990	Continued From page 11 During an interview on 9/15/15 at 8:05 p.m. the administrator stated, "Our protocol is that all allegations of abuse or maltreatment will be reported." Although the incident report indicated the administrator had been notified of the allegation of assault, the administrator stated he had no previous knowledge of the allegations made by R15. He further stated, "The incident should have been reported." During an interview on 9/16/15, at 11:06 a.m. a licensed practical nurse (LPN)-B stated she filled out the initial incident report. LPN-B stated, R15 told her "Two guys came in at midnight and did something." She further stated she reported the allegations to the RN on duty per the policy. During an interview on 9/17/15 at 8:45 a.m. ADON-B stated, The RN supervisor called her to talk about the allegation made by R15. She stated she knew R15 well, as he formerly resided in her building. ADON-B explained that because R15 "makes up a lot of stories," although he stated staff had assaulted him, she made a "judgment call" not to report the incident. ADON-B stated she did not initiate any investigation into the resident's injury and statement as to how it happened. A 10/28/13, Resident Protection Plan policy indicated the purpose was, "To protect residents from maltreatment" and to protect all residents form abuse, neglect, and harm. The policy directed staff to immediately reported to the SA any suspicion that abuse may have occurred. The policy further directs staff to notify the administrator and DON to coordinate an investigation.	21990		

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21990	Continued From page 12 SUGGESTED METHOD OF CORRECTION: The director of nursing and licensed social worker could ensue all allegations are immediately reported and then investigated for potential mistreatment. Training for appropriate staff could be provided. Audits could be conducted and the results could be brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21990		
23010	MN Rule 4658.4635 A Nurse Call System; New Construction The nurses' station must be equipped with a communication system designed to receive calls from the resident and nursing service areas required by this part. The communication system, if electrically powered, must be connected to the emergency power supply. Nurse calls and emergency calls must be capable of being inactivated only at the points of origin. A central annunciator must be provided where the door is not visible from the nurses' station. A. A nurse call must be provided for each resident's bed. Call cords, buttons, or other communication devices must be placed where they are within reach of each resident. A call from a resident must register at the nurses' station, activate a light outside the resident bedroom, and activate a duty signal in the medication room, nourishment area, clean utility room, soiled utility room, and sterilizing room. In multi-corridor nursing units, visible signal lights must be provided at corridor intersections.	23010		10/9/15

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23010	Continued From page 13 This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a call light was functioning for 1 of 1 resident (R94) reviewed for environmental concerns. Findings include: R94's call light was tested for function on 9/14/15, at 10:43 a.m. The call light neither rang nor lit up when activated. A nursing assistant (NA)-A was asked to check R94's call light, and again it did not ring nor light up. NA-A stated she would notify the registered nurse (RN)-A about R94's call light not working, who would then notify housekeeping or maintenance staff to fix it. NA-A reported R94 was able to use his call light, but because of some cognitive impairment, staff also checked on him every two hours to offer toileting. NA-A also explained that R94 walked with a walker but needed reminders and cues as to where to go. On 9/15/15, at 12:20 p.m. R94's call light was observed placed on top of his bed, and was functioning when tested. The following day at 6:45 a.m. RN-B stated that when call lights were not functioning it was considered a safety issue. If the call light needed a new cord the nurse could replace it, but beyond that staff needed to notify maintenance staff of the problem. RN-B was unaware of any call light audits that may have been completed by nursing staff. On 9/16/15, at 7:23 a.m. NA-B stated R94 walked with a walker. Although he could sit down independently, he needed a little boost up from a chair or the bed. NA-B said R94 was mostly confused and seldom used his call light. Staff anticipated the resident's needs.	23010	On a routine basis, the call light system in each room will be checked by housekeeping. Random audits will be conducted monthly on each unit to ensure compliance and the call light system is functioning properly. The 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. Corrective action will be completed by October 15, 2015.	

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23010	Continued From page 14	23010		

Later that morning at 9:57 a.m. the assistant administrator (AA) stated he expected all residents' call lights to be in working order. The AA stated if a resident's call light was found not working nursing would submit this request to repair into the electronic work order system and maintenance would fix the call light. He was unaware of any call lights audits that were currently being completed, but it was his understanding facility staff used to do call light function checks.

Later at 1:14 p.m. the assistant director of nursing (ADON) stated she expected residents' call lights to be in working order. The ADON also stated she was unaware of any call light audits being completed.

During an interview with maintenance director on 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

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23010	Continued From page 15 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 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 (14) days.	23010		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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

Minnesota Department of Health

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3 000	INITIAL COMMENTS *****ATTENTION****** BOARDING CARE HOME LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On September 14, 15, 16, and 17, 2015, surveyors of this Department's staff, visited the above provider and no violations were noted.	3 000		

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

Electronically Signed | 10/09/15