



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 23, 2025

Administrator
MN Veterans Home Minneapolis
5101 Minnehaha Avenue South
Minneapolis, MN 55417

RE: CCN: 245620
Cycle Start Date: April 10, 2025

Dear Administrator:

On April 10, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Stefanie Salberg, Regional Operations Supervisor
Metro C District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: stefanie.salberg@state.mn.us
Office: 651-201-4393 Mobile: 651-279-5602

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by July 10, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by October 10, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:
<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



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April 23, 2025

Administrator
MN Veterans Home Minneapolis
5101 Minnehaha Avenue South
Minneapolis, MN 55417

Re: State Nursing Home Licensing Orders
Event ID: VNCO11

Dear Administrator:

The above facility was surveyed on April 7, 2025 through April 10, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

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

Stefanie Salberg, Regional Operations Supervisor
Metro C District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: stefanie.salberg@state.mn.us
Office: 651-201-4393 Mobile: 651-279-5602

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

Please feel free to call me with any questions.



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245620	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/10/2025
NAME OF PROVIDER OR SUPPLIER MN VETERANS HOME MINNEAPOLIS			STREET ADDRESS, CITY, STATE, ZIP CODE 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
E 000	Initial Comments On 4/7/25 - 4/10/25, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance.	E 000			
F 000	INITIAL COMMENTS On 4/7/25 - 4/10/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaints were reviewed with no deficiency issued: H#: H56202487C (MN#: 104565) H#: H56202489C (MN#: 103803) H#:H56202485C (MN#: 106160) H#: H56202486C (MN#: 104681) H#: H56202488C (MN#: 106832) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/01/2025

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.

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

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OMB NO. 0938-0391

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F 000	Continued From page 1	F 000			
F 585 SS=D	Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained. Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the	F 585			6/2/25

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F 585	Continued From page 2 facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions			F 585			

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F 585	Continued From page 3 include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a voiced grievance of a missing shirt was acted upon timely to help facilitate prompt resolution for 1 of 1 resident (R232) who reported such item as missing with no follow-up. Findings include: R232's quarterly Minimum Data Set (MDS) dated 2/7/25, indicated R232 was cognitively intact. R232's progress note failed to identify a missing item reported on 2/28/25. However, there was a late entry on 3/6/25 at 9:30 a.m., R232 expressed to writer his black long sleeve shirt was stolen by			F 585	How will corrective action be accomplished for this resident: R232s missing shirt was replaced on 4/11/25. Other residents potentially affected: All residents/veterans at MVH-Minneapolis have the potential to be affected. Measures put in place/systemic changes to ensure deficiency does not recur: Resident missing items Standard of Work (SOW), form, and log were updated to track resident/family follow-up and further options requested. Re-education		

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F 585	Continued From page 4 a p.m. staff member. R232's progress note dated 3/6/25 at 4:33 p.m., (documented as a late entry) identified R232 pointed out the staff member that allegedly stole his black long sleeve shirt, and the nurse writer immediately removed staff from resident care. The writer and ADON interviewed both the resident and staff member and filed a report with MDH (Minnesota Department of Health). R232's progress notes failed to show follow-up after the missing item was reported. The facility's 2025 Grievance Complaint Log failed to document R232's grievance. The facility's missing item tracker identified R232's with a missing item on 2/28/25. During an interview on 4/7/25 at 4:19 p.m., R232 stated, a black long sleeve shirt was on his chair as he entered his room and while his back was turned a staff member removed the shirt and left the room. R232 stated, when he turned around the staff member and the shirt were gone. The missing item was reported to the nurse manager on 2/28/25. R232 stated "the investigation was lacking". The nurse manager waved him down in the hallway to discuss the camera footage and informed him that staff member would no longer float to his unit, but never came to my room to discuss the results of the investigation or that they were done looking for the shirt. During an interview on 4/8/25 at 11:37 a.m., licensed practical nurse (LPN)-A stated anytime a resident reported a missing item staff checked the resident's room first, then talked with aids and	F 585	will be provided to Social Services, Registered Nurse Managers, Assistant Directors of Nursing, and Safety Officer on these changes and form completion. How corrective action will be monitored: Designee will conduct audits on follow-up being provided to residents/resident representatives for the previous months missing item forms. Audits will be conducted monthly for 3 months. Findings will be reported at upcoming Quality Assurance and Performance Improvement (QAPI) meetings monthly for 3 months and then will be reduced/eliminated per the QAPI committee recommendation based on substantial compliance being met. The Director of Nursing is responsible. Date deficiency will be corrected: Deficient practice will be corrected by 06/02/25.		

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F 585	Continued From page 5 other residents, called laundry and charted a general progress note. LPN-A stated family would be called only if it was necessary. The next shift would be notified of any new missing items during a huddle meeting and the nurse manager was always notified. LPN-A confirmed the unit was equipped with security cameras. During an interview on 4/8/25 at 12:04 p.m., registered nurse manager (RN)-C stated when a resident reported a missing item, a missing item form was completed and sent to laundry, the safety officer, assisted director of nursing (ADON), and the unit social worker. If it was a housekeeping item, such as laundry, that item usually turned up and that documentation would be found under progress notes. RN-C stated during R232's investigation the security camera footage was reviewed, and the staff member was not seen holding any item as he exited the room. RN-C verified a report was filed with OHFC. RN-C stated a claim was filed with the social worker on 2/28/25. During observation and interview on 4/8/25 at 1:31 p.m., social services (SS)-A stated the resident had the right to complete a Tort claim if an item could not be recovered. To prove monetary value, the resident would need a receipt. If the resident did not have a receipt a similar item could be found online, and that value would be used to complete the Tort claim. Once the form was completed it was given to legal department and sent to Saint Paul where a committee approved the claim. SS-A stated a copy of the claim was not kept on file, and then confirmed R232 never came back to file a Tort claim. SS-A provided a blank settlement of claims-not exceeding \$7,000 form. SS-A	F 585			

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F 585	Continued From page 6 confirmed no completed forms were kept on file for R232. During an interview on 4/8/25 at 2:30 p.m., assistant director of nursing (ADON-RN)-D stated a report was submitted to the Department of Health, OHFC specifically for R232's black long sleeve shirt that was reported stolen by the nurse on 2/28/25. RN-D confirmed all completed grievance forms were filed and kept with the director of social services and confirmed there was no follow up with the resident after the report was filed. During an interview on 4/8/25 at 3:00 p.m. RN-C recalled having a conversation with R232 regarding the investigation and referred to the spreadsheet for missing items. RN-C confirmed the tracker failed to show results of the investigation in that only demographic information was completed. RN-C also confirmed not going to the resident's room to discuss the investigation, but did confirm the shirt was discussed in passing while R232 visited across the hall with the social worker. During an interview on 4/9/25 at 9:37 a.m., R232 stated the nurse manager never came back to discuss how the investigation ended. He stated she saw him in front of the social workers office and would say, "I will get back in touch" with him. R232 stated it was dismissed at that point, but he was not satisfied because she never clarified if the investigation was ongoing. R232 confirmed he was not offered the Resident Property Damage/Loss Form and SS-A never offered a Tort or settlement claim for reimbursement on 2/28/25 or anytime thereafter.	F 585			

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F 585	Continued From page 7 During an interview on 4/9/25 at 9:40 a.m., RN-C could not provide the resident property damage/loss form completed for R232 that is directed to be completed in step 1 of 4 in the Minnesota Veteran's Home-Minneapolis Stand of Work Resident Lost/Missing Items protocol. RN-C also confirmed there was no follow up progress note to document an investigation or conversations with R232 after 3/6/25 regarding the missing item. Minnesota Department of Veterans Affairs Policy dated 6/22/23 indicated (A) 1. A claimant will be provided with a claim report and demand form upon request and the claimant has suffered personal injury or negligent loss, damage, or destruction of property.	F 585			
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to conduct accurate and on-going assessments for bruising, and implement skin protection interventions for 1 of 1 resident (R10) reviewed for anticoagulant use, and failed to follow orders for ankle compression sleeves (compression stockings) to legs for 1 of 1	F 684	How will corrective action be accomplished for this resident: R10 was offered derma sleeves to help minimize any future bruising on 4/10/25. R53 has compression stockings available in her room and offered per her order since 4/10/25.		6/2/25

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F 684	Continued From page 8 resident (R53) reviewed for edema. Findings include: R10's annual Minimum Data Set (MDS) dated 2/18/2025, indicated R10 was independent with mobility, used a walker on and off the unit, was cognitively intact, had a diagnoses of anemia and atrial fibrillation, and took an anticoagulant (blood thinning) medication. No other skin conditions or skin concerns were documented. R10's annual skin assessment dated 11/20/2024, described on going skin issues as, "resident bruises easily r/t apixaban usage". R10's care plan dated 11/29/2024, identified the medical management of anticoagulant therapy and included R10 would be free from discomfort, but failed to apply interventions to protect R10's skin while taking an anticoagulant. R10's care plan dated 11/29/2024, stated he communicated most of his needs. R10's active orders included apixaban (an anticoagulant) oral tablets 5 MG tablet dated 3/15/23 with no end date. R10's active orders dated 12/31/2024, included monitoring for a bruise 8 cm x 10 cm on left hand daily. Document Y (yes) if wound is free from signs and symptoms of infection, if pain is managed, and dressing in intact or was changed during the shift. Document N (no) if any of the above areas are of concern in the progress notes. Discontinue when resolved. R10's annual skin assessment dated 2/12/2025,	F 684	Other residents potentially affected: Residents/Veterans receiving anticoagulant medications or compression stockings at MVH-Minneapolis have the potential to be affected. Measures put in place/systemic changes to ensure deficiency does not recur: Residents currently receiving anticoagulant medication were offered derma sleeves. Residents currently ordered to use compression stockings were checked for availability in room and adherence with use was verified. IDT form updated to prompt discussion of any bruising and anticoagulant use; follow-up for offering protective items, such as derma sleeves, will be discussed during quarterly care conferences and as needed. Re-education will be provided to Licensed Nurses, Human Service Technicians (HSTs), Social Services, Registered Nurse Managers (RNM), Registered Nurse Seniors (RNS), and Assistant Directors of Nursing (ADON) on these changes as well as on documenting when orders are not being followed/residents refuse. How corrective action will be monitored: Designee will conduct audits on new anticoagulant orders for residents being offered derma sleeves monthly for 3 months. Designee will conduct audits on compression stockings being in place; 2 residents with compression stockings will be audited per RNM unit; audits will be conducted weekly for 3 months. Findings		

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F 684	Continued From page 9 summarized findings as prone to bruising related to the prescribed medication apixaban, an anticoagulant used to treat atrial fibrillation. R10's progress note dated 4/9/2025, indicated he was independent with mobility. During observation and interview on 4/7/25 at 9:19 am, R10 stated the backs of his hands had been bruised since he started using salve on his legs for edema. R10 confirmed no skin protection sleeves were offered by staff and R10 stated he would like to try skin protection sleeves, especially while sleeping. No skin protection sleeves were observes in the resident's room or bathroom. During an interview on 4/9/25 at 10:00 am, nurse manager (RN)-C stated sleeves were usually recommended, but some residents were not cognitively intact would remove them. They indicated they care planned to the resident's preference. RN-C confirmed no skin protectant was care planned for R10 and no derma sleeves have been used in the past. RN-C was aware of the bruises on both hands, and believed R10 had a history of taking off the sleeves, which she confirmed again, he had never tried in the past. During an interview on 4/9/25 at 12:08 pm, assistant director of nursing (ADON, RN)-D stated the expectation would be for all residents on an anticoagulant, staff would first observe for bruising, and then apply skin protection interventions, like a derma sleeve. RN-D stated the resident would need to be cognitively intact to be able to use the sleeve. Some residents had sleeves and took them off. RN-D stated the sleeves needed to be offered and if the resident	F 684	will be reported at upcoming Quality Assurance and Performance Improvement (QAPI) meetings monthly for 3 months and then will be reduced/eliminated per the QAPI committee recommendation based on substantial compliance being met. The Director of Nursing is responsible. Date deficiency will be corrected: Deficient practice will be corrected by 06/02/25.		

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F 684	Continued From page 10 refused, then the nurses documented the refusal. RN-D confirmed that R10 had not been offered derma sleeves in the past. During observation and interview on 4/9/25 at 3:25 pm, R10 stated he had dark bruising on both his hands. The bruising on the right hand did go up to the wrist and stopped. R10 stated his right hand bruised worse because he slept on his right side. The back of the left hand was also bruised. Neither forearm was bruised nor were his face or shins. R10 verified there was no protective or adaptive items in the room to help support skin from bruising nor had R10 tried any in the past. None was observed. Skin Management Program dated 2/13/2025, identified preventive or routine skin care interventions will be instituted and documented in the resident's EMR and on the resident's initial care plan for the care team to follow. Policy on anticoagulant use/monitoring was requested and not received. R53 R53's annual Minimum Data Set (MDS) dated 3/13/25, indicated R53 had no cognitive impairment, was diagnosed with diabetes, hyperlipidemia, hypertension, and was taking medication used to reduce fluid build up in the body. R53's provider notes dated 1/2/25, and 2/27/25, indicated R53's edema was well managed on low dose Lasix (furosemide - a water pill).	F 684			

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F 684	Continued From page 11 R53's medication administration record (MAR) dated for the month of April 2025, included an order for furosemide oral tablet 10 MG in the morning every Monday, Wednesday, and Friday for edema. R53's Skin Risk Factors MVH form dated 3/7/25, included a section to identify risk factors. The checked box next to "Edema" was not selected. R53's order summary dated 4/3/25 at 7:00 a.m., indicated to apply bilateral ankle compression sleeves in the morning. The orders also indicated removal at 7:00 p.m. R53's treatment administration record (TAR) dated 4/7/25, indicated bilateral ankle compression sleeves were applied in the morning at 8:26 a.m. and indicated at 1:21 p.m. the bilateral ankle compression sleeves were taken off. R53's care plan with a review date of 2/27/25, indicated medical management for diuretic use related to edema, but failed to identify interventions. During observation and interview on 4/7/25 at 6:41 p.m., R53 indicated their right foot was sore and that the pain went away at night. R53 was wearing short, white, socks that extended approximately 2-3 inches above the ankle bone with one inch indentation from the socks on both legs. No compression sleeves, or stockings were worn or visible in the room. R53 stated staff did not put compression sleeves on her legs on 4/6/25 or 4/7/25.			F 684			

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F 684	Continued From page 12 During an interview on 4/8/25 at 2:38 p.m., nursing assistant (NA)-A stated R53 did not wear compression socks and confirmed she was wearing anklets. NA-A looked up R53's Kardex in the computer and identified there were no tasks directing staff to apply compression sleeves. During observation and interview on 4/8/25 at 2:50 p.m., R53 removed her right shoe to discuss her sore foot. Licensed practical nurse (LPN)-A was brought to the room and verified the bilateral edema in R53's lower extremities and the short white socks R53 wore. LPN-A stated, "this is bad", and indicated she usually wore black socks. LPN-A removed both of R53's white socks. R53 had approximately 1 inch indentation from the socks about 2 to 3 inches above the ankle bone on both legs. LPN-A confirmed the right leg had significantly more edema and confirmed the compression socks were not set up or in the room. During observation and interview on 4/9/25 at 9:55 a.m., R53 wore red tread socks and stated ace wraps would be on later. R53 displayed the right leg with continued edema approximately 1 inch indentation 2-3 inches above the ankle bone. During an interview on 4/9/25 at 1010 a.m., RN-C stated R53 complained of pain and recently recovered from an ankle fracture. RN-C confirmed there was an active order for bilateral ankle compression sleeves to be applied in the morning and removed at bedtime and confirmed the (TAR) indicated on 4/7/25, the ankle compression sleeves were documented as applied and removed.	F 684			

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F 684	Continued From page 13 During an interview on 4/9/25 at 12:01 p.m., RN-D stated the expectation was all orders would be followed and the items ordered would be used. A policy for Edema management was requested and not received. Minnesota Department of Veterans Affairs Skin Management Program dated 2/13/25 was provided and however lacked policy and procedures related to edema management.	F 684			
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow up and implement treatment for improved hearing for 1 of 1 residents (R277) when complaints of hearing loss were made. Findings include: R277's quarterly Minimum Data Set (MDS) dated	F 685			6/2/25
			How will corrective action be accomplished for this resident: R277 has an appointment scheduled with audiology on 5/22/25. Other residents potentially affected: All residents/veterans that refused audiology services on admission at MVH-Minneapolis have the potential to be		

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F 685	Continued From page 14 2/21/25, indicated R277 had intact cognition, adequate hearing (no difficulty in everyday conversation), and did not use hearing aids. R277's provider Admit Note dated 10/8/24, indicated R277 had stated he had an audiogram which showed some hearing loss and particularly had difficulty with hearing in crowded rooms. The note indicated that R277 was interested in pursuing further evaluation for hearing aids. R277's medical record was reviewed and did not indicate further follow-up on R277's request for hearing aids. The note indicated R277 had declined in-house audiology services but was interested in an audiology evaluation to work towards getting hearing aids. During an interview on 4/7/25 at 12:57 p.m., R277 stated he had a hearing test around the time he was admitted to the facility in September of 2024 and was told he needed hearing aids but never received any. R277 stated he talked with a doctor about needing these hearing aids but did not recall any updates on them since. R277 stated he had issues hearing others in crowded environments. R277 stated in these environments, he would not hear things people were saying to him so would "just nod my head and smile" and "hope it is nothing important." During an interview on 4/8/25 at 2:27 p.m., registered nurse (RN)-A, the nurse manager of the unit, stated she was unaware of R277 requesting to get hearing aids. RN-A stated, after a brief review of the medical record, that she did see a note indicating R277 had wanted hearing aids but did not see a follow-up on this request but would further investigate it. On 4/9/25 at 10:39 a.m., RN-A stated she had talked with other staff	F 685	affected. Measures put in place/systemic changes to ensure deficiency does not recur: Residents that refused audiology services on admission were re-approached to confirm their preference on if they want to see audiology. Providers will be educated on writing orders for services residents are requesting. Registered Nurse Managers (RNM) and Registered Nurse Seniors (RNS) will review provider notes for any needed follow-up. Any additional service requests will be discussed during quarterly care conferences and as needed. Re-education will be provided to Providers, Social Services, RNM, and RNS on these changes. How corrective action will be monitored: Designee will conduct audits on the previous weeks care conferences, checking for addressing of residents desire to pursue outside services. Audits will be conducted weekly for 3 months. Findings will be reported at upcoming Quality Assurance and Performance Improvement (QAPI) meetings monthly for 3 months and then will be reduced/eliminated per the QAPI committee recommendation based on substantial compliance being met. The Director of Nursing is responsible. Date deficiency will be corrected: Deficient practice will be corrected by 06/02/25.		

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F 685	Continued From page 15 members and further reviewed R277's medical record but did not find evidence that R277's request for hearing aids had been addressed. The facility's Services Not Covered but Made Available to all Admissions-Residents policy dated 10/13/23, identified services, such as audiology, that the facility may provide and may be charged to the residents' personal fund. The policy did not address the process the facility would take to assist the resident in obtaining these audiology services.	F 685			
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure staff assisted 1 of 1 resident (R74), who was reviewed for	F 688			6/2/25
			How will corrective action be accomplished for this resident: R74s fitness gym schedule was		

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F 688	Continued From page 16 restorative nursing program, to attend their GI (general term used for government issued) therapy gym sessions or document reasons resident was not available for attendance. The facility further failed to ensure occupational therapist recommendations were care planned and initiated for one of two residents (R184) who was assessed as at risk for bilateral hand contractures and impaired skin due to clenching fist reviewed for services to prevent decrease in range of motion. Findings include: R74 R74's quarterly Minimum Data Set (MDS) dated 3/17/25, indicated R74 had severe cognitive impairment and no behaviors or rejection of care. R74 had impairment on one side of upper and lower extremity and required substantial to total assistance with activities of daily living. R74 had diagnoses which included coronary artery disease, hypertension, peripheral vascular disease, cerebrovascular accident, hemiplegia or hemiparesis, traumatic brain injury, and asthma. R74 had one day of passive and one day of active range of motion in the last seven days of the look back period. R74's order dated 5/13/22, directed staff to follow fitness gym programming per therapy parameters. R74's care plan printed 4/9/25, indicated the following interventions: -10/4/24, resume fitness GI gym program: Kinevia (motorized therapy device for lower extremities) soft train, base speed 10 rpm (revolutions per minute), resistance 2-3 for 10			F 688	reiterated with staff with attendance being consistent since 4/21/25. R184 ROM recommendations were implemented on 4/9/25. Other residents potentially affected: Residents/Veterans attending fitness gym or having/at risk for contractures at MVH-Minneapolis have the potential to be affected. Measures put in place/systemic changes to ensure deficiency does not recur: Re-education will be provided to Licensed Nurses, Human Service Technicians (HSTs), and Health Unit Coordinators (HUCs) on reading the fitness gym daily schedules. Registered Nurse Managers (RNM), Registered Nurse Seniors (RNS), and Assistant Directors of Nursing (ADON) will receive a list of residents missing fitness gym scheduled times. Re-education will be provided to Licensed Nurses, RNM, RNS, and ADONs on following-up on missed fitness gym attendance and documentation. Re-education will be provided to Therapy, RNM, RNS, and ADON on therapy verbally communicating any new or changed range of motion (ROM) recommendations and setting electronic health record alerts; RNM/RNS will update the residents care plan and orders as appropriate. How corrective action will be monitored: Designee will conduct audits on residents that did not attend the previous		

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F 688	Continued From page 17 minutes for bilateral lower extremity active assisted range of motion/passive range of motion as resident is able. Staff to provide wheelchair transportation to attend. -10/9/24, escort R74 to the GI fitness gym on Mondays, Wednesdays, and Thursdays for their 11 a.m. appointment. R74's Point of Care (POC) Response History printed 4/10/25, indicated R74 attended two GI gym appointments and was not available for 11 out of 13 sessions. R74's progress notes identified the following for days which were marked as "resident not available" for GI gym appointments: -3/12/25, no notes. -3/13/25, no notes. -3/17/25, documented notes did not indicate reason for R74's missed gym session. -3/19/25, no notes. -3/20/25, indicated R74 attended exercise programs during recreation therapy's quarterly charting period and did not indicate reason for R74's missed gym session. -3/26/25, note at 2:15 p.m. indicated R74 had an appointment via MVH (Minnesota Veterans Home) laptop and did not indicate the time of the appointment. -3/27/25, note at 1:51 p.m. indicated R74 had an appointment at 1:30 p.m. with transportation time of 1:15 p.m.. -4/2/25, no notes. -4/3/25, note at 11:54 a.m. indicated R74 had transportation at 12:15 p.m. for a 1:30 p.m. appointment. -4/7/25, no notes. -4/9/25, note at 3:49 a.m. indicated a nebulizer was given to R74 for wheezing and note at 5:09	F 688	weeks fitness gym scheduled times. Audits will be conducted weekly for 3 months. Designee will conduct audits on residents with ROM program changes/additions, checking for proper care planning and orders. Audits will be conducted weekly for 3 months. Findings will be reported at upcoming Quality Assurance and Performance Improvement (QAPI) meetings monthly for 3 months and then will be reduced/eliminated per the QAPI committee recommendation based on substantial compliance being met. The Director of Nursing is responsible. Date deficiency will be corrected: Deficient practice will be corrected by 06/02/25.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245620	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/10/2025
NAME OF PROVIDER OR SUPPLIER MN VETERANS HOME MINNEAPOLIS			STREET ADDRESS, CITY, STATE, ZIP CODE 5101 MINNEHAHA AVENUE SOUTH MINNEAPOLIS, MN 55417		
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F 688	Continued From page 18 a.m. indicated the nebulizer was effective. During observation on 4/9/25 at 11:09 a.m., R74 was in their wheelchair at a table in the unit's television area. A nursing staff member entered another resident's room, and another staff sat at a chair and charted information. During interview on 4/9/25 at 11:24 a.m., nursing assistant (NA)-D stated they brought residents to the GI gym according to a posted schedule. NA-D stated they did not chart on GI gym attendance and reported to the nurse if residents refused to go to the gym. NA-D verified the posted chart indicated R74 should attend their gym session at 11:00 a.m. on Wednesdays and stated R74 attended their session. During interview on 4/9/25 at 12:01 p.m., physical therapy assistant (PTA)-A stated they completed exercise groups around the building, and PTA-B mainly completed the restorative programs in the GI gym. PTA-A stated managers called to let them know when a resident was not able to attend their appointment, so they may reschedule. PTA-B reviewed the 4/9/25 therapy schedule, and R74 had a red line by their name. PTA-B stated the red line indicated R74 did not attend their GI gym appointment. PTA-B stated they received a call earlier this week to notify them R74 would not attend Monday's session related to illness and had not received a call today. PTA-B stated R74 usually attended about two out of three sessions per week, and nursing did not always document why R74 did not attend their gym appointment. PTA-B charted "resident not available" when R74 did not attend their sessions. PTA-B stated R74 did not tolerate a lot of exercise but pedaled for approximately ten	F 688			

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F 688	Continued From page 19 minutes. During interview on 4/9/25 at 2:28 p.m., registered nurse (RN)-G stated nursing assistants brought residents to the GI gym according to the posted schedule and was told all residents were brought to the gym for their appointments today. RN-G stated they would document if someone notified them a resident did not attend their GI gym appointment. During interview on 4/10/25 at 7:42 a.m., R74 agreed it was important for them to attend GI gym appointments and liked to attend at least twice a week. R74 was observed to cough, and the cough sounded wet and/or productive. During interview on 4/10/25 at 9:28 a.m., RN-F expected staff to document reasons residents were not able to attend their GI gym appointments and correspond with the GI gym staff. RN-F reviewed R74's notes and gym session documentation and verified R74 had appointments and respiratory issues on some gym days and lacked documentation other days. RN-F stated R74 may attend fitness activities with PTA-A and was not sure if the fitness activities on the unit conflicted with the times of R74's GI gym appointments. RN-F stated it was important for residents to attend their gym appointments to help maintain optimal levels of mobility. During interview on 4/10/25 at 10:27 a.m., the assistant director of nursing (ADON)-B stated it was important for staff to ensure residents attended their GI gym appointments and expected staff to document if there was a pattern of refusals. ADON-B stated the interdisciplinary team had a schedule to review GI gym	F 688			

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F 688	Continued From page 20 participation, so they could adjust resident's schedule if needed. R184 R184's quarterly Minimum Data Set (MDS), dated 1/24/25, indicated R184 had a diagnosis of Alzheimer's disease, no impairment of his upper and lower extremities and was dependent on staff for all activities of daily living (ADLs). R184's Progress note, dated 2/28/25, indicated R184 received an occupational therapy (OT) evaluation and would be appropriate for a bilateral upper extremity range of motion restorative nursing program. The note indicated this would be set up by OT. R184's careplan, dated 3/29/24, indicated R184 was at risk for decline in ADLs and functional mobility related to dementia and was on a maintenance program. The careplan lacked any interventions related to bilateral hand contracture prevention (i.e. range of motion, palm protectors or holding an object to prevent clenching hands into a fist.) R184's OT note, dated 2/28/24, indicated R184 did not currently have an upper extremity restorative nursing program and would benefit from "holding an object during the day to decrease the resident's incidence of clenching fists." The note also indicated it was recommended for R184 to participate in "AAROM" (active assisted range of motion) for his bilateral upper extremities. R184's OT note, dated 3/29/25, indicated R184	F 688			

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F 688	Continued From page 21 "would not benefit from bilateral palm protectors but would benefit from alternate interventions to manage "squeezing" of palms (increased tone in hands). OT will instruct the resident's [R184] caregivers regarding encouraging the resident to hold onto a ball or stuffed cat when at rest on the unit." The note further indicated R184 would benefit from a "PROM" (passive range of motion) program. During observation on 4/8/25 at 2:16 p.m., R184 was laying in bed, awake. He did not have anything to hold onto. During an interview on 4/8/25 at 3:14 p.m., occupational therapist (OT)-A stated it was decided R184 would not be appropriate for a hand splint or palm protector but her goal was to have the nursing assistants do range of motion with R184's hands. OT-A stated she talked to a few nurses about having R184 hold onto his stuffed cat when he was up in his wheelchair but had not documented the conversation. OT-A also confirmed the range of motion program had not been passed along to the nursing staff but OT-A had done range of motion with R184's hands "once or twice." During an observation on 4/9/25 at 8:00 a.m., R184 was up in his wheelchair at the breakfast table. There was nothing in R184's hands. Later, at 9:28 a.m., R184 was still up in his wheelchair in the main television area. R184 still had nothing in his hands. During an interview on 4/9/25 at 9:24 a.m., registered nurse (RN)-H stated R184 went to the fitness gym Monday and Friday but was unaware of any intervention for his hands, including range			F 688			

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F 688	Continued From page 22 of motion or holding his stuffed cat in his hands. RN-H checked R184's Kardex, used by staff to know how to care for each resident, and confirmed there were no intervention on his Kardex for his hands. During an interview on 4/9/25 at 10:35 a.m., RN senior and registered nurse (RN)-I stated nursing staff had asked OT to assess R184's hands because nursing staff had concerns about him clenching them. RN-I confirmed OT had not passed along interventions for R184 until yesterday, stating R184 did not have any care planned interventions such as range of motion or holding his stuffed cat as recommended by OT. A facility policy titled Restorative Nursing, revised 12/4/24, indicated "MVH will assess, plan, and implement a restorative nursing program per applicable state and federal rules and regulations to improve or maintain a resident ' s functional status."	F 688			
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to analyze and care plan	F 695			6/2/25
			How will corrective action be accomplished for this resident:		

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F 695	Continued From page 23 R596's multiple declinations to wear supplemental oxygen as ordered for 1 of 1 resident (R596) reviewed for oxygen use. Findings include: R596's quarterly Minimum Data Set (MDS) dated 3/28/25, indicated R596 had intact cognition and no behaviors or rejection of care. R596 had impairments to both sides of lower extremities. R596 required substantial and/or maximal or greater assistance with most activities of daily living, setup or clean-up assistance with eating, and supervision or touching assistance with oral hygiene. R596's diagnoses included anemia, heart failure, hypertension, renal failure, diabetes mellitus, depression, post-traumatic stress disorder, COPD (chronic obstructive pulmonary disease), and respiratory failure. The MDS indicated R596 had oxygen therapy. R596's care plan printed 4/8/25, indicated R596 required oxygen therapy with focus area initiated on 12/31/24. Care plan interventions included: -1/7/25, assist to change from portable oxygen tank to room tank. -1/7/25, assist to set oxygen flow rate as ordered. -1/7/25, monitor oxygen saturation rates. Another care plan focus area dated 1/7/25, indicated R596 was on continuous oxygen treatment for emphysema and/or COPD. Care plan interventions included: -1/7/25, give oxygen therapy as ordered by the physician. -1/7/25, head of bed to be elevated or out of bed upright in a chair during episodes of difficulty breathing. -1/7/25, monitor for difficulty breathing on	F 695	R596s orders for oxygen saturation checks and supplemental oxygen were updated on 4/29/25; care plan reviewed and updated. Other residents potentially affected: Residents/Veterans using supplemental oxygen at MVH-Minneapolis have the potential to be affected. Measures put in place/systemic changes to ensure deficiency does not recur: Re-education will be provided to Licensed Nurses and Human Service Technicians (HSTs) on supplemental oxygen use, risks and benefits discussion with residents/families if oxygen is being refused/removed, and documentation/appropriate follow-up of refusals. Education: With repeated refusals, document, risks/benefits, care plan, resp assessment, update provider as needed How corrective action will be monitored: Designee will conduct audit on residents using supplemental oxygen for compliance with use or documentation of refusals. Audits will be conducted weekly for 3 months. Findings will be reported at upcoming Quality Assurance and Performance Improvement (QAPI) meetings monthly for 3 months and then will be reduced/eliminated per the QAPI committee recommendation based on substantial compliance being met. The Director of Nursing is responsible.		

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F 695	Continued From page 24 exertion. Remind resident not to push beyond endurance. R596's care plan lacked documentation of resident refusal to use oxygen, or any other reason for non-oxygen use. R596's order dated 12/30/24, directed staff to maintain R596's oxygen saturation level 90% (percent) or above with continuous supplement oxygen at two to four liters per minute (LPM) via nasal cannula and document liter flow every shift. R596's oxygen saturation summary report printed 4/10/25, indicated oxygen saturation level method was "Room Air" on 65 times from 12/30/24 to 4/9/25. R596's progress notes indicated: -4/9/25 at 11:35 a.m., R596's oxygen saturation level was 92% on RA (room air). -3/11/25 at 8:49 p.m., R596's oxygen saturation level was 92% on RA. -3/9/25 at 11:11 p.m., R596's oxygen saturation level was 97% on RA. -3/6/25 at 10:28 p.m., R596 was offered supplemental oxygen, kept on for less than an hour, then removed and stated they did not need it. R596 was educated about the importance of oxygen and aware of the risk and benefits. The note indicated "will continue to monitor" as the action taken. -3/6/25 at 10:10 a.m., R596's oxygen saturation level was 91% on RA. -2/28/25 at 1:46 p.m., blood clots were noted in R596's urine bag. R596's oxygen saturation level was 91% at four liters of supplemental oxygen. R596 declined to keep oxygen on and educated on risk and benefits. The notes "Action" section	F 695	Date deficiency will be corrected: Deficient practice will be corrected by 06/02/25.		

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F 695	Continued From page 25 indicated the nurse practitioner was notified, and staff received new orders for catheter irrigation and did not observe blood clots after irrigation completed. The note indicated the oncoming nurse would be notified about the situation and did not mention other actions taken for declination of oxygen use. R596 also required oxygen therapy. -2/26/25 at 1:37 a.m., R596 refused to use continuous oxygen. -2/25/25 at 2:20 a.m., R596 refused to use supplemental oxygen via nasal cannula for the shift and told staff they did not need supplemental oxygen. -2/22/25 at 7:58 a.m., R596 refused to use oxygen treatment. Staff check oxygen saturation and was between 84-88% on room air. Staff offered to apply oxygen, and oxygen saturation increased to 92% when on three liters of supplemental oxygen. -2/21/25 at 10:52 p.m., R596 refused supplemental oxygen via nasal cannula. -2/20/25 at 11:18 a.m., R596 declined supplemental oxygen, was educated on risks and benefits, and did not have shortness of breath or respiratory distress. -2/17/25 at 6:17 a.m., R596 refused supplemental oxygen and stated they were fine. -1/29/25 at 2:37 p.m., R596's oxygen saturation was 93% on RA. -1/28/25 at 6:07 a.m., R596's oxygen saturation was 94% on RA. -1/27/25 at 5:38 a.m., R596 declined use of supplemental oxygen during most of the night. R596 agreed to wear, and staff would observe nasal cannula removed during checks. R596 reported they did not want the supplemental oxygen and did not need it. R596 was educated on risks and benefits and did not have shortness	F 695			

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F 695	Continued From page 26 of breath or respiratory distress. -1/25/25 at 1:33 p.m., R596's oxygen saturation was 94% on RA. -1/20/25 at 1:49 p.m., R596's oxygen saturation was 93% on RA. -1/18/25 at 2:42 p.m., R596's oxygen saturation was 94% on RA. -1/16/25 at 2:56 p.m., R596's oxygen saturation was 96% on RA. Provider notes lacked documentation of R596 supplemental oxygen refusals and/or declinations. During observation on 4/7/25 at 1:32 p.m., R596 sat in their wheelchair in the unit's television area near the nursing station and cart. R596 had an oxygen tank on the back of their wheelchair and did not have the attached nasal cannula applied. During observation which started on 4/8/25 at 12:18 p.m., nursing assistant (NA)-E pushed R596 in their wheelchair into the dining room. R596 had an oxygen tank on the back of their wheelchair, and the attached nasal cannula was not applied and on R596's stomach. NA-E positioned R596 at a dining room table and applied a clothing protector on R596. At 12:22 p.m., registered nurse (RN)-G checked R596's blood sugar, and R596 still did not have their supplemental oxygen on. At 12:29 p.m., RN-G wheeled R596 out of the dining area, and R596 still did not have their supplemental oxygen on. At 12:34 p.m., R596 was at the dining table, did not have their supplemental oxygen on, and took deep breaths in and out. At 12:37 p.m., RN-G spoke with R596. R596 was not taking deep breaths and still did not wear their	F 695			

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F 695	Continued From page 27 supplemental oxygen. At 12:52 p.m., R596 still did not have their oxygen on and took deep breaths. At 12:56 p.m., R596 asked NA-E to take them back to their room and took deep breaths. At 12:57 p.m., NA-E assisted R596 out of the dining area, and R596 still did not wear their supplemental oxygen. During interview on 4/8/25 at 1:13 p.m., RN-G stated they followed oxygen orders from the provider. RN-G stated they documented if a resident did not wear their ordered supplemental oxygen, monitored the resident closely, encouraged the resident to wear supplemental oxygen, and notified the provider. RN-G stated R596 wore their oxygen during mealtime and did not see R596 with the nasal cannula off. RN-G stated R596 had a history of taking their nasal cannula off, they reminded R596 to wear their supplemental oxygen, and they were not sure why R596 took off their supplemental oxygen. During interview on 4/8/25 at 1:24 p.m., NA-E stated some residents did not want to wear their supplemental oxygen even if oxygen use was on their care plan. They encouraged residents to wear their oxygen and notified the nurse when residents did not. NA-E verified R596 did not have their supplemental oxygen on during mealtime and stated R596 agreed to wear the nasal cannula when brought back to their room after their meal. NA-E stated R596 refused supplemental oxygen on and off during the day with no pattern of times and stated R596 reported their breathing was okay. During interview on 4/8/25 at 3:03 p.m., licensed practical nurse (LPN)-B stated they followed	F 695			

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F 695	Continued From page 28 orders for oxygen use. LPN-B redirected and educated residents who did not want to wear their supplemental oxygen and monitored their oxygen saturation and other vitals. LPN-B documented continuous refusals and notified the provider and nurse manager. LPN-B stated R596 was quick to place nasal cannula back on when reminded, did not think R596 was aware their nasal cannula was off at times, and did not think it was a deliberate action. During interview on 4/8/25 at 3:11 p.m., NA-F stated R596 took their nasal cannula off at times when in bed, even after staff placed it back on. NA-F was not sure if R596 knew their nasal cannula was off sometimes and stated R596 did not tell them why they removed it. During interview on 4/9/25 at 2:33 p.m., R596 was in their bed and did not have their nasal cannula on. R596 stated the nasal cannula slid off, they could not get it back on, and thought it had been off for thirty minutes. R596 got the oxygen tubing around one ear, nasal cannula in nares, and was unable to loop the tubing around their other ear. R596 placed their call light on and stated they were breathing "alright". At 2:36 p.m., NA-E entered the room, placed the nasal cannula on R596, and slid the adjuster upwards towards NA-E's chin. During interview on 4/10/25 at 9:28 a.m., RN-F expected staff to document about residents who refused oxygen use or other reasons for residents to not wear ordered oxygen. RN-F expected staff to contact the provider and care plan non-oxygen use if there was a consistent issue and it affected their oxygen level. RN-F was not aware R596 refused their oxygen use or of	F 695			

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F 695	Continued From page 29 other reasons R596 did not wear their oxygen. During interview on 4/10/25 at 10:27 a.m., assistant director of nursing (ADON)-B expected staff to have on-going risk and benefit conversations with R596 and care plan about R596's habits of oxygen use if concerns were on-going. ADON-B expected staff to ask why R596 removed the oxygen or look at a different type of tubing if falling off. ADON-B stated oxygen use was important for residents who had oxygen orders. The facility's Medication Administration policy dated 12/4/24, indicated current standards of practice would be followed when administering medications through alternate routes such as nasal, and medication not administered would include an explanation.	F 695			
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents'	F 726			6/2/25

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F 726	Continued From page 30 needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and document review, the facility failed to ensure staff were competent to apply medicated ointment for 1 of 1 resident (R232) reviewed for self-administration. Findings include: R232's quarterly Minimum Data Set (MDS) dated 2/7/25, indicated R232 was cognitively intact, had a diagnosis of diabetes and was receiving skin treatments to areas other than his feet. R232's care plan dated 1/30/25, failed to identify a self administration medication program. R232's order summary report identified an active order for Triamcinolone Acetonide External Ointment 0.025% (Topical) applied to itchy dry skin, with a start date of 9/12/24, with no end date. R232's SAM's (self-administration of medication and/or treatments) dated 2/1/25, indicated the			F 726	How will corrective action be accomplished for this resident: R232 requested and was able to demonstrate proper self-administration of his medicated cream on 4/9/25. Other residents potentially affected: Residents/Veterans who have a self-administer to keep creams at bedside order at MVH-Minneapolis have the potential to be affected. Measures put in place/systemic changes to ensure deficiency does not recur: Reeducation will be provided to Licensed Nurses and Human Service Technicians (HSTs) on medicated topicals needing to be provided by a Licensed Nurse or resident with a self-administer order and that medicated topicals are not to be left in the residents room unless the resident has a self-administration and able to keep at bedside order.		

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F 726	Continued From page 31 resident did not want to self-administer medications. R232's treatment administration record dated March 2025 through April 2025 indicated daily documentation of unsupervised self administration for Triamcinolone Acetonide External Ointment with directions to be applied to itchy/dry skin topically every morning and at bedtime. During an observation and interview on 4/9/25 at 9:05 a.m., the Triamcinolone Acetonide External Ointment 0.025% container with a pharmacy label was set out on the resident's shelf. R232 stated the aids applied the cream. During an interview on 4/9/25 at 9:52 a.m., nursing assistant (NA)-B stated aids applied cream to R232. During an interview on 4/9/25 at 11:01 a.m., director of nursing (DON) stated medicated creams were not administered by nursing assistants in Long Term Care. During an interview on 4/9/25 at 11:36 a.m., nursing assistant (NA)-C verified he washed R232's body and applied the cream all over the arms and legs. The cream was used for bad, dry, scaling skin. NA-C verified he knew to use a medium amount and to use gloves, once a day, during his shift. NA-C verified the cream stayed in R232's room all the time. During an interview on 4/9/25 at 11:38 a.m., registered nurse (RN)-E, nurse educator for the campus, verified that the campus did not have trained medication aids (TMAs).	F 726	How corrective action will be monitored: Designee will conduct audits on residents with cream self-administration orders and who is applying the medicated creams. Audits will be conducted weekly for 3 months. Findings will be reported at upcoming Quality Assurance and Performance Improvement (QAPI) meetings monthly for 3 months and then will be reduced/eliminated per the QAPI committee recommendation based on substantial compliance being met. The Director of Nursing is responsible. Date deficiency will be corrected: Deficient practice will be corrected by 06/02/25.		

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F 726	Continued From page 32 During an interview on 4/9/25 at 11:59 a.m., licensed practical nurse (LPN)-A stated nursing assistants could put on prescription/medicated cream and lotion if they knew how it was applied. LPN-A stated as part of her orientation and training it was explained that if the resident could confirm to the nurse that the nursing assistant understood how and where the medicated cream should be applied, then the nursing assistant could apply the cream and report back to the LPN. LPN-A confirmed the e-MAR was then marked off after the nursing assistant completed the task. During an interview on 4/9/25 at 12:02 p.m., assistant director of nursing (ADON RN)-C confirmed no TMAs were trained to work on the campus. If residents had a prescription lotion, the expectation would be a licensed staff would apply the lotion. They stated there was no such program that allowed the LPN to check with the resident to confirm the nursing assistant applied the medicated lotion correctly, and the LPN must apply the lotion and mark the MAR. Per Policy Medication Administration, dated 12/4/24, Only certified/licensed staff will administer medications.	F 726			
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.	F 812			6/2/25

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F 812	Continued From page 33 (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to serve food in a sanitary manner by failing to ensure staff properly contained hair with a hairnet/beard net while preparing plates of foods brought into the facility to serve to residents for a meal. This had the potential to affect 32 residents who reside in building 19 on 3rd floor. Findings include: During observation in building 19 on 3rd floor on 4/9/25 at 12:06 p.m., lunch was being served by staff from the dining room island/counter. The meal consisted of fried chicken, mashed potatoes, gravy, coleslaw and buns. Two staff were observed to be using resident menu ticket and preparing resident plates. The 2 staff were observed to be wearing gloves but were not wearing hairnets while placing food items on resident plates and standing over food items. During interview on 4/9/25 at 12:14 p.m., assistant director of nursing (ADON)-A stated	F 812	How will corrective action be accomplished for this resident: The 32 residents provided with the take-out meal have been without adverse events. Other residents potentially affected: Residents/Veterans receiving plated food during activities at MVH-Minneapolis have the potential to be affected. Measures put in place/systemic changes to ensure deficiency does not recur: Reeducation will be provided to recreation staff on the need to wear hairnets when plating food. How corrective action will be monitored: Designee will conduct audits on use of hairnets when plating resident food during activities. One Audit per week will be conducted for 3 months. Findings will be reported at upcoming Quality Assurance and Performance Improvement (QAPI)		

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F 812	Continued From page 34 recreational therapy had set up the "special" meal for today and the food being served was brought into the facility. ADON-A verified the staff who were placing the food on residents' plates were not wearing hairnets and their hair was not properly contained. ADON-A stated she was unsure if this was a requirement as the meal was not being served out of the kitchenette or by the dietary staff. ADON-A stated the staff were wearing gloves. ADON-A stated hairnets were worn so "nothing gets in the food." During interview on 4/10/25 at 9:27 a.m., culinary director (CD)-A stated the expectation was staff should wear hairnets when "plating" food. During an interview on 4/10/25 at 9:28 a.m., director of dietary services (DDS)-A stated the expectation would be whoever was plating the resident food would be expected to wear a hair net. DDS-A stated the reason for wearing hairnets was to not contaminate the food. During an interview on 4/10/25 at 9:54 a.m., director of nursing (DON) stated the expectation of staff who are preparing and preparing residents plates would be hairnets are worn so that the food would not be contaminated. A facility policy titled Dress, Appearance, and Hygiene in the Workplace, revised 2/21/20, indicated "Hair (including facial hair) must be tied back and/or covered, if required by work related regulations or because of safety, sanitation or other care reasons and must be clean."	F 812	meetings monthly for 3 months and then will be reduced/eliminated per the QAPI committee recommendation based on substantial compliance being met. The Director of Nursing is responsible. Date deficiency will be corrected: Deficient practice will be corrected by 06/02/25.		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880			6/2/25

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F 880	Continued From page 35 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation,	F 880			

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F 880	Continued From page 36 depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure enhanced barrier precautions (EBP) were utilized appropriately for 2 of 2 residents (R269, R595) reviewed for EBP related to wounds. In addition, staff failed to perform appropriate hand hygiene for 1 of 1 resident (R595) observed to receive cares in enhanced barrier precautions. Findings include: EBP NOT FOLLOWED AND LACK OF HAND	F 880	How will corrective action be accomplished for this resident: R269 and R595 had enhanced barrier precautions (EBP) initiated on 4/9/25. R595s Human Service Technician (HST) was re-educated on hand hygiene during resident cares on 4/9/25. Other residents potentially affected: All residents/veterans at MVH-Minneapolis have the potential to be affected.		

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F 880	Continued From page 37 HYGIENE R595's entry tracking record dated 4/3/25, indicated R595 returned to the facility from a short-term general hospital. R595's care plan printed 4/9/25, indicated: -12/30/24, R595 had MRSA (methicillin-resistant staphylococcus aureus; "staph" germ which have resistance to antibiotics) to a wound on the second toe of right foot and required contact precautions and meticulous hand washing. -4/1/25, R595 required enhanced barrier precautions. -4/4/25, R595 required assist of two staff to transfer with full body lift and physical assist of one staff for lying/sitting bed mobility. R595 positioned self in bed with used of bilateral grab bars and overhead trapeze. R595's physician order dated 2/28/17, indicated R595 used a condom catheter at night. Another order dated 4/7/25, indicated R595 took cefpodoxime proxetil (an antibiotic which treats certain infections caused by bacteria) oral tablet 200 mg by mouth every twelve hours for seven days for right foot infection. During observation and interview on 4/7/25 at 1:03 p.m., R595 had an enhanced barrier precautions sign on their door which identified the high-contact cares for which staff were required to wear a gown and gloves. A second sign indicated contact precautions-enteric precautions, and highlighted staff needed to wear gowns and gloves. The second sign also indicated staff needed to use dedicated equipment, bleach disinfectant, and soap and water for hand hygiene even after alcohol gel use. Further, the second			F 880	Measures put in place/systemic changes to ensure deficiency does not recur: Residents were reviewed for appropriate initiation/use of EBP. Re-education will be provided to Licensed Nurses and HSTs on requirements related to initiation of EBP and what activities require EBP personal protective equipment (PPE) to be worn. Re-education will be provided to Licensed Nurses and HSTs on proper hand hygiene during resident cares. How corrective action will be monitored: Designee will conduct audits on new admits, residents with new wounds, and hospital returns for proper EBP needs. Audits will be conducted weekly for 3 months. Designee will conduct audits on proper hand hygiene during resident cares. Audits will be conducted on 2 residents per Registered Nurse Manager (RNM) unit per week; audits will continue for 3 months. Findings will be reported at upcoming Quality Assurance and Performance Improvement (QAPI) meetings monthly for 3 months and then will be reduced/eliminated per the QAPI committee recommendation based on substantial compliance being met. The Director of Nursing is responsible. Date deficiency will be corrected: Deficient practice will be corrected by 06/02/25.		

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F 880	Continued From page 38 sign indicated resident must stay in room for 48 hours beyond the last symptom. R595 stated they had an infected wound and had to have their toes amputated. R595 stated they were able to leave their room as they desired. R595 had a shoe on the left foot and boot on their right foot. During observation on 4/9/25 at 10:12 a.m., nursing assistant (NA)-G and NA-H wore gloves and no gowns. R595 sat on a commode with a sling around them and was raised with a mechanical lift off the commode. NA-G performed peri-cares, removed gloves, did not perform hand hygiene, applied gloves, grabbed an incontinence bed pad from a drawer, and placed it on the bed. NA-G removed the plastic bag with bowel movement from the commode, removed gloves, did not perform hand hygiene, and applied gloves. NA-G and NA-H assisted R595 onto the bed and assisted R595 to turn in bed to apply R595's incontinence product and pants. NA-G and NA-H then transferred R595 from the bed to wheelchair. During interview on 4/9/25 at 10:25 a.m., NA-H stated R595 had a leg infection, and staff wore gowns when they assisted R595 to dress and didn't need a gown to transfer R595. During interview on 4/9/25 at 10:47 a.m., licensed practical nurse (LPN)-C stated R595 had a wound and was on enhanced barrier precautions. LPN-C stated staff did not need to wear a gown to transfer R595 but needed a gown and gloves to provide peri-cares and wound care. LPN-C stated one sign was related to R595's catheter and another to their wound. During interview on 4/9/25 at 10:54 a.m., NA-G	F 880			

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F 880	Continued From page 39 confirmed they should have worn gown and gloves to provide R595 with peri-cares and transfer. NA-G verified they did not perform hand hygiene between glove changes and should have. During interview on 4/10/25 at 10:27 a.m., ADON-B expected staff to wear gloves and gowns when they performed peri-cares and when they transferred a resident on enhanced barrier precautions. ADON-B stated there was a risk for the spread of infection when staff did not use gowns and gloves during high-contact cares. ADON-B expected staff to perform hand hygiene between glove changes to prevent the spread of pathogens. The facility's Infection Prevention and Control Program dated 10/23/24, directed staff to wear gowns and gloves during high contact resident care activities for residents in enhanced barrier precautions. High contact resident care activities included transferring, changing briefs, providing hygiene, and assisting with toileting. The facility's Hand Hygiene policy dated 9/17/24, directed staff to remove gloves and complete hand hygiene during resident care if moving from a contaminated body site to a clean body site and to reapply gloves if appropriate. EBP NOT ASSIGNED R269's quarterly Minimum Data Set (MDS) dated 3/18/25, indicated R269 had intact cognition and required substantial/maximal to total assistance with dressing, toileting hygiene, footwear, transfers, and bed mobility. R269's diagnoses included diabetes mellitus, osteoarthritis,			F 880			

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F 880	Continued From page 40 traumatic brain injury, hemiplegia (weakness on one side of the body), and seizures. The MDS indicated R269 had a stage two pressure ulcer. R269's care plan printed 4/10/25, lacked indication of enhanced barrier precautions. R269's physician order dated 4/1/25, directed staff to wash left big to with normal saline/wound cleanser, pat dry, apply small amount of medi-honey, cover with two-by-two gauze, wrap with kerlix dressing/tape daily and as needed and to discontinue the order when area healed. Orders did not indicate enhanced barrier precautions. R269's Skin and Wound Evaluation dated 4/6/25, indicated R269 had a stage two pressure ulcer since 3/13/25, to their left dorsum first metatarsal phalangeal joint (the joint located at the base of the left big toe). The wound measured 0.8 by 0.6 cm (centimeters), had 10% (percent) epithelial (pink/white in color and final stage of wound healing) coverage, 20% granulation (red, bumpy tissue in wound bed), 70% slough (dead tissue within a wound which appears yellow, tan, or white), no evidence of infection, and light serous exudate (clear wound fluid or drainage). R269's wound was treated and dressing intact, and the wound was improving. During observation on 4/10/25 at 7:50 a.m., R269 did not have an enhanced barrier precautions sign on their door or personal protective equipment cart outside of their room. During interview on 4/10/25 at 10:02 a.m., licensed practical nurse (LPN)-C stated R269 had an open pressure wound on their left big toe and			F 880			

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

PRINTED: 05/07/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245620	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/10/2025
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F 880	Continued From page 41 dressing changes were completed in the evenings. LPN-C stated staff wore gown and gloves during R269's dressing changes. LPN-C stated the wound nurse, assistant director of nursing (ADON), and infection preventionist determined which residents required enhanced barrier precautions. During interview on 4/10/25 at 10:07 a.m., nursing assistant (NA)-I stated staff did not use enhanced barrier precautions for R269. NA-I stated enhanced barrier precautions were not in R269's care plan and confirmed there was no enhanced barrier precautions sign or personal protective equipment cart outside R269's door. NA-I stated R269 did not have a catheter or feeding tube like other residents who required enhanced barrier precautions. During interview on 4/10/25 at 10:20 a.m., registered nurse (RN)-J stated residents who required enhanced barrier precautions had a sign on their door and PPE cart outside their door. The senior RN or floor nurses set up the signage and PPE cart. RN-J stated R269 had a stage two pressure ulcer on their toe and may need enhanced barrier precautions due to R269's wound. During interview on 4/10/25 at 10:27 a.m., ADON-B stated the infection preventionists were the main staff to look over which residents required enhanced barrier precautions, but the interdisciplinary team worked together to ensure residents were on correct precautions. ADON-B stated residents with an open area and MDRO (multidrug-resistant bacteria; organisms which are resistant to typical antibacterial treatments) required enhanced barrier precautions. ADON-B	F 880			

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F 880	Continued From page 42 reviewed R269's care plan and stated the care plan did not indicate R269 had an MDRO. The facility's Infection Prevention and Control Program dated 10/23/24, indicated residents with wounds, such as pressure ulcers, or indwelling medical devices are particularly susceptible and should be identified and have EBP established.	F 880			

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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: On 4/7/25 - 4/10/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

05/01/25

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed with NO citations were issued: H#: H56202487C (MN#: 104565) H#: H56202489C (MN#: 103803) H#:H56202485C (MN#: 106160) H#: H56202486C (MN#: 104681) H#: H56202488C (MN#: 106832) Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading	2 000			

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2 000	Continued From page 2 completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000			
2 270	MN Rule 4658.0090 Use of Oxygen A nursing home must develop and implement policies and procedures for the safe storage and use of oxygen. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to analyze and care plan R596's multiple declinations to wear supplemental oxygen as ordered for 1 of 1 resident (R596) reviewed for oxygen use. Findings include: R596's quarterly Minimum Data Set (MDS) dated 3/28/25, indicated R596 had intact cognition and no behaviors or rejection of care. R596 had impairments to both sides of lower extremities. R596 required substantial and/or maximal or greater assistance with most activities of daily living, setup or clean-up assistance with eating, and supervision or touching assistance with oral hygiene. R596's diagnoses included anemia,	2 270	Corrected		4/10/25

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2 270	Continued From page 3 heart failure, hypertension, renal failure, diabetes mellitus, depression, post-traumatic stress disorder, COPD (chronic obstructive pulmonary disease), and respiratory failure. The MDS indicated R596 had oxygen therapy. R596's care plan printed 4/8/25, indicated R596 required oxygen therapy with focus area initiated on 12/31/24. Care plan interventions included: -1/7/25, assist to change from portable oxygen tank to room tank. -1/7/25, assist to set oxygen flow rate as ordered. -1/7/25, monitor oxygen saturation rates. Another care plan focus area dated 1/7/25, indicated R596 was on continuous oxygen treatment for emphysema and/or COPD. Care plan interventions included: -1/7/25, give oxygen therapy as ordered by the physician. -1/7/25, head of bed to be elevated or out of bed upright in a chair during episodes of difficulty breathing. -1/7/25, monitor for difficulty breathing on exertion. Remind resident not to push beyond endurance. R596's care plan lacked documentation of resident refusal to use oxygen, or any other reason for non-oxygen use. R596's order dated 12/30/24, directed staff to maintain R596's oxygen saturation level 90% (percent) or above with continuous supplement oxygen at two to four liters per minute (LPM) via nasal cannula and document liter flow every shift. R596's oxygen saturation summary report printed 4/10/25, indicated oxygen saturation level method was "Room Air" on 65 times from 12/30/24 to	2 270			

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2 270	Continued From page 4 4/9/25. R596's progress notes indicated: -4/9/25 at 11:35 a.m., R596's oxygen saturation level was 92% on RA (room air). -3/11/25 at 8:49 p.m., R596's oxygen saturation level was 92% on RA. -3/9/25 at 11:11 p.m., R596's oxygen saturation level was 97% on RA. -3/6/25 at 10:28 p.m., R596 was offered supplemental oxygen, kept on for less than an hour, then removed and stated they did not need it. R596 was educated about the importance of oxygen and aware of the risk and benefits. The note indicated "will continue to monitor" as the action taken. -3/6/25 at 10:10 a.m., R596's oxygen saturation level was 91% on RA. -2/28/25 at 1:46 p.m., blood clots were noted in R596's urine bag. R596's oxygen saturation level was 91% at four liters of supplemental oxygen. R596 declined to keep oxygen on and educated on risk and benefits. The notes "Action" section indicated the nurse practitioner was notified, and staff received new orders for catheter irrigation and did not observe blood clots after irrigation completed. The note indicated the oncoming nurse would be notified about the situation and did not mention other actions taken for declination of oxygen use. R596 also required oxygen therapy. -2/26/25 at 1:37 a.m., R596 refused to use continuous oxygen. -2/25/25 at 2:20 a.m., R596 refused to use supplemental oxygen via nasal cannula for the shift and told staff they did not need supplemental oxygen. -2/22/25 at 7:58 a.m., R596 refused to use oxygen treatment. Staff check oxygen saturation and was between 84-88% on room air. Staff	2 270			

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2 270	Continued From page 5 offered to apply oxygen, and oxygen saturation increased to 92% when on three liters of supplemental oxygen. -2/21/25 at 10:52 p.m., R596 refused supplemental oxygen via nasal cannula. -2/20/25 at 11:18 a.m., R596 declined supplemental oxygen, was educated on risks and benefits, and did not have shortness of breath or respiratory distress. -2/17/25 at 6:17 a.m., R596 refused supplemental oxygen and stated they were fine. -1/29/25 at 2:37 p.m., R596's oxygen saturation was 93% on RA. -1/28/25 at 6:07 a.m., R596's oxygen saturation was 94% on RA. -1/27/25 at 5:38 a.m., R596 declined use of supplemental oxygen during most of the night. R596 agreed to wear, and staff would observe nasal cannula removed during checks. R596 reported they did not want the supplemental oxygen and did not need it. R596 was educated on risks and benefits and did not have shortness of breath or respiratory distress. -1/25/25 at 1:33 p.m., R596's oxygen saturation was 94% on RA. -1/20/25 at 1:49 p.m., R596's oxygen saturation was 93% on RA. -1/18/25 at 2:42 p.m., R596's oxygen saturation was 94% on RA. -1/16/25 at 2:56 p.m., R596's oxygen saturation was 96% on RA. Provider notes lacked documentation of R596 supplemental oxygen refusals and/or declinations. During observation on 4/7/25 at 1:32 p.m., R596 sat in their wheelchair in the unit's television area near the nursing station and cart. R596 had an oxygen tank on the back of their wheelchair and	2 270			

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2 270	Continued From page 6 did not have the attached nasal cannula applied. During observation which started on 4/8/25 at 12:18 p.m., nursing assistant (NA)-E pushed R596 in their wheelchair into the dining room. R596 had an oxygen tank on the back of their wheelchair, and the attached nasal cannula was not applied and on R596's stomach. NA-E positioned R596 at a dining room table and applied a clothing protector on R596. At 12:22 p.m., registered nurse (RN)-G checked R596's blood sugar, and R596 still did not have their supplemental oxygen on. At 12:29 p.m., RN-G wheeled R596 out of the dining area, and R596 still did not have their supplemental oxygen on. At 12:34 p.m., R596 was at the dining table, did not have their supplemental oxygen on, and took deep breaths in and out. At 12:37 p.m., RN-G spoke with R596. R596 was not taking deep breaths and still did not wear their supplemental oxygen. At 12:52 p.m., R596 still did not have their oxygen on and took deep breaths. At 12:56 p.m., R596 asked NA-E to take them back to their room and took deep breaths. At 12:57 p.m., NA-E assisted R596 out of the dining area, and R596 still did not wear their supplemental oxygen. During interview on 4/8/25 at 1:13 p.m., RN-G stated they followed oxygen orders from the provider. RN-G stated they documented if a resident did not wear their ordered supplemental oxygen, monitored the resident closely, encouraged the resident to wear supplemental oxygen, and notified the provider. RN-G stated R596 wore their oxygen during mealtime and did not see R596 with the nasal cannula off. RN-G stated R596 had a history of taking their nasal	2 270			

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2 270	Continued From page 7 cannula off, they reminded R596 to wear their supplemental oxygen, and they were not sure why R596 took off their supplemental oxygen. During interview on 4/8/25 at 1:24 p.m., NA-E stated some residents did not want to wear their supplemental oxygen even if oxygen use was on their care plan. They encouraged residents to wear their oxygen and notified the nurse when residents did not. NA-E verified R596 did not have their supplemental oxygen on during mealtime and stated R596 agreed to wear the nasal cannula when brought back to their room after their meal. NA-E stated R596 refused supplemental oxygen on and off during the day with no pattern of times and stated R596 reported their breathing was okay. During interview on 4/8/25 at 3:03 p.m., licensed practical nurse (LPN)-B stated they followed orders for oxygen use. LPN-B redirected and educated residents who did not want to wear their supplemental oxygen and monitored their oxygen saturation and other vitals. LPN-B documented continuous refusals and notified the provider and nurse manager. LPN-B stated R596 was quick to place nasal cannula back on when reminded, did not think R596 was aware their nasal cannula was off at times, and did not think it was a deliberate action. During interview on 4/8/25 at 3:11 p.m., NA-F stated R596 took their nasal cannula off at times when in bed, even after staff placed it back on. NA-F was not sure if R596 knew their nasal cannula was off sometimes and stated R596 did not tell them why they removed it. During interview on 4/9/25 at 2:33 p.m., R596 was in their bed and did not have their nasal	2 270			

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2 270	Continued From page 8 cannula on. R596 stated the nasal cannula slid off, they could not get it back on, and thought it had been off for thirty minutes. R596 got the oxygen tubing around one ear, nasal cannula in nares, and was unable to loop the tubing around their other ear. R596 placed their call light on and stated they were breathing "alright". At 2:36 p.m., NA-E entered the room, placed the nasal cannula on R596, and slid the adjuster upwards towards NA-E's chin. During interview on 4/10/25 at 9:28 a.m., RN-F expected staff to document about residents who refused oxygen use or other reasons for residents to not wear ordered oxygen. RN-F expected staff to contact the provider and care plan non-oxygen use if there was a consistent issue and it affected their oxygen level. RN-F was not aware R596 refused their oxygen use or of other reasons R596 did not wear their oxygen. During interview on 4/10/25 at 10:27 a.m., assistant director of nursing (ADON)-B expected staff to have on-going risk and benefit conversations with R596 and care plan about R596's habits of oxygen use if concerns were on-going. ADON-B expected staff to ask why R596 removed the oxygen or look at a different type of tubing if falling off. ADON-B stated oxygen use was important for residents who had oxygen orders. The facility's Medication Administration policy dated 12/4/24, indicated current standards of practice would be followed when administering medications through alternate routes such as nasal, and medication not administered would include an explanation.	2 270			

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2 270	Continued From page 9 SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies for oxygen use including assessment, implementation, and staff education. The DON or designee could audit oxygen use for residents affected and take that information to QAPI to ensure compliance and determine the need for further education/monitoring/compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 270			
2 300	MN Rule 4658.0105 Competency A nursing home must ensure that direct care staff are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through the comprehensive resident assessments and described in the comprehensive plan of care, and are able to perform their assigned duties. This MN Requirement is not met as evidenced by: Based on observations, interview, and document review, the facility failed to ensure staff were competent to apply medicated ointment for 1 of 1 resident (R232) reviewed for self-administration. Findings include: R232's quarterly Minimum Data Set (MDS) dated 2/7/25, indicated R232 was cognitively intact, had a diagnosis of diabetes and was receiving skin treatments to areas other than his feet. R232's care plan dated 1/30/25, failed to identify a self administration medication program.	2 300	Corrected		4/10/25

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2 300	Continued From page 10 R232's order summary report identified an active order for Triamcinolone Acetonide External Ointment 0.025% (Topical) applied to itchy dry skin, with a start date of 9/12/24, with no end date. R232's SAM's (self-administration of medication and/or treatments) dated 2/1/25, indicated the resident did not want to self-administer medications. R232's treatment administration record dated March 2025 through April 2025 indicated daily documentation of unsupervised self administration for Triamcinolone Acetonide External Ointment with directions to be applied to itchy/dry skin topically every morning and at bedtime. During an observation and interview on 4/9/25 at 9:05 a.m., the Triamcinolone Acetonide External Ointment 0.025% container with a pharmacy label was set out on the resident's shelf. R232 stated the aids applied the cream. During an interview on 4/9/25 at 9:52 a.m., nursing assistant (NA)-B stated aids applied cream to R232. During an interview on 4/9/25 at 11:01 a.m., director of nursing (DON) stated medicated creams were not administered by nursing assistants in Long Term Care. During an interview on 4/9/25 at 11:36 a.m., nursing assistant (NA)-C verified he washed R232's body and applied the cream all over the arms and legs. The cream was used for bad, dry, scaling skin. NA-C verified he knew to use a	2 300			

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2 300	Continued From page 11 medium amount and to use gloves, once a day, during his shift. NA-C verified the cream stayed in R232's room all the time. During an interview on 4/9/25 at 11:38 a.m., registered nurse (RN)-E, nurse educator for the campus, verified that the campus did not have trained medication aids (TMAs). During an interview on 4/9/25 at 11:59 a.m., licensed practical nurse (LPN)-A stated nursing assistants could put on prescription/medicated cream and lotion if they knew how it was applied. LPN-A stated as part of her orientation and training it was explained that if the resident could confirm to the nurse that the nursing assistant understood how and where the medicated cream should be applied, then the nursing assistant could apply the cream and report back to the LPN. LPN-A confirmed the e-MAR was then marked off after the nursing assistant completed the task. During an interview on 4/9/25 at 12:02 p.m., assistant director of nursing (ADON RN)-C confirmed no TMAs were trained to work on the campus. If residents had a prescription lotion, the expectation would be a licensed staff would apply the lotion. They stated there was no such program that allowed the LPN to check with the resident to confirm the nursing assistant applied the medicated lotion correctly, and the LPN must apply the lotion and mark the MAR. Per Policy Medication Administration, dated 12/4/24, Only certified/licensed staff will administer medications. SUGGESTED METHOD OF CORRECTION: The	2 300			

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2 300	Continued From page 12 director of nursing (DON) or designee could develop systems to ensure appropriate training is in place for staff holding certifications/licensure. The DON or designee could educate all appropriate staff on those systems,. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 300			
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded with the potential for inaccurate federal reimbursement and resident care planning for 1 of 3 residents (R277) reviewed for MDS accuracy. Findings include: R277's admission MDS dated 9/10/24, indicated R277 had no "mouth or facial pain, discomfort or difficulty with chewing." R277's dental health history assessment dated 9/4/24, indicated R277 was currently experiencing	2 550	Corrected	5/1/25	

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2 550	Continued From page 13 "dental pain or discomfort". R277's admission assessment dated 9/4/24, indicated R277 had mouth pain. R277's care plan dated 2/24/25, indicated R277 had his own teeth and was able to brush them independently. The care plan did not include a history of dental pain. During an interview on 4/10/25 at 8:51 a.m., registered nurse (RN)-B, the MDS coordinator, confirmed he oversaw completing the MDSs for R277's unit. After reviewing the medical record, RN-B confirmed that R277's MDS should have been coded to indicate he had mouth pain per the assessments completed during the look-back period. The facility's Resident Assessment- Care Plan policy dated 2/1/23, indicated the facility would complete MDS assessments according to the Federal, State, local and agency requirements, for each resident. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring that each individual resident's comprehensive assessment is accurately completed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff accurately complete assessments. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 550			

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2 875	Continued From page 14	2 875	Corrected		4/10/25
2 875	MN Rule 4658.0520 Subp. 2 I Adequate and Proper Nursing Care; Monitor TPR Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: I. Monitoring resident temperature, pulse, respiration, and blood pressure as often as indicated by the resident's condition but at least weekly. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to conduct accurate and on-going assessments for bruising, and implement skin protection interventions for 1 of 1 resident (R10) reviewed for anticoagulant use, and failed to follow orders for ankle compression sleeves (compression stockings) to legs for 1 of 1 resident (R53) reviewed for edema. Findings include: R10's annual Minimum Data Set (MDS) dated 2/18/2025, indicated R10 was independent with mobility, used a walker on and off the unit, was cognitively intact, had a diagnoses of anemia and atrial fibrillation, and took an anticoagulant (blood thinning) medication. No other skin conditions or skin concerns were documented. R10's annual skin assessment dated 11/20/2024, described on going skin issues as, "resident bruises easily r/t apixaban usage". R10's care plan dated 11/29/2024, identified the medical management of anticoagulant therapy and included R10 would be free from discomfort,				

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2 875	Continued From page 15 but failed to apply interventions to protect R10's skin while taking an anticoagulant. R10's care plan dated 11/29/2024, stated he communicated most of his needs. R10's active orders included apixaban (an anticoagulant) oral tablets 5 MG tablet dated 3/15/23 with no end date. R10's active orders dated 12/31/2024, included monitoring for a bruise 8 cm x 10 cm on left hand daily. Document Y (yes) if wound is free from signs and symptoms of infection, if pain is managed, and dressing in intact or was changed during the shift. Document N (no) if any of the above areas are of concern in the progress notes. Discontinue when resolved. R10's annual skin assessment dated 2/12/2025, summarized findings as prone to bruising related to the prescribed medication apixaban, an anticoagulant used to treat atrial fibrillation. R10's progress note dated 4/9/2025, indicated he was independent with mobility. During observation and interview on 4/7/25 at 9:19 am, R10 stated the backs of his hands had been bruised since he started using salve on his legs for edema. R10 confirmed no skin protection sleeves were offered by staff and R10 stated he would like to try skin protection sleeves, especially while sleeping. No skin protection sleeves were observed in the resident's room or bathroom. During an interview on 4/9/25 at 10:00 am, nurse manager (RN)-C stated sleeves were usually recommended, but some residents were not	2 875			

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2 875	Continued From page 16 cognitively intact would remove them. They indicated they care planned to the resident's preference. RN-C confirmed no skin protectant was care planned for R10 and no derma sleeves have been used in the past. RN-C was aware of the bruises on both hands, and believed R10 had a history of taking off the sleeves, which she confirmed again, he had never tried in the past. During an interview on 4/9/25 at 12:08 pm, assistant director of nursing (ADON, RN)-D stated the expectation would be for all residents on an anticoagulant, staff would first observe for bruising, and then apply skin protection interventions, like a derma sleeve. RN-D stated the resident would need to be cognitively intact to be able to use the sleeve. Some residents had sleeves and took them off. RN-D stated the sleeves needed to be offered and if the resident refused, then the nurses documented the refusal. RN-D confirmed that R10 had not been offered derma sleeves in the past. During observation and interview on 4/9/25 at 3:25 pm, R10 stated he had dark bruising on both his hands. The bruising on the right hand did go up to the wrist and stopped. R10 stated his right hand bruised worse because he slept on his right side. The back of the left hand was also bruised. Neither forearm was bruised nor were his face or shins. R10 verified there was no protective or adaptive items in the room to help support skin from bruising nor had R10 tried any in the past. None was observed. Skin Management Program dated 2/13/2025, identified preventive or routine skin care interventions will be instituted and documented in the resident's EMR and on the resident's initial care plan for the care team to follow.	2 875			

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2 875	Continued From page 17 Policy on anticoagulant use/monitoring was requested and not received. R53 R53's annual Minimum Data Set (MDS) dated 3/13/25, indicated R53 had no cognitive impairment, was diagnosed with diabetes, hyperlipidemia, hypertension, and was taking medication used to reduce fluid build up in the body. R53's provider notes dated 1/2/25, and 2/27/25, indicated R53's edema was well managed on low dose Lasix (furosemide - a water pill). R53's medication administration record (MAR) dated for the month of April 2025, included an order for furosemide oral tablet 10 MG in the morning every Monday, Wednesday, and Friday for edema. R53's Skin Risk Factors MVH form dated 3/7/25, included a section to identify risk factors. The checked box next to "Edema" was not selected. R53's order summary dated 4/3/25 at 7:00 a.m., indicated to apply bilateral ankle compression sleeves in the morning. The orders also indicated removal at 7:00 p.m. R53's treatment administration record (TAR) dated 4/7/25, indicated bilateral ankle compression sleeves were applied in the morning at 8:26 a.m. and indicated at 1:21 p.m. the bilateral ankle compression sleeves were taken off.	2 875			

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2 875	Continued From page 18 R53's care plan with a review date of 2/27/25, indicated medical management for diuretic use related to edema, but failed to identify interventions. During observation and interview on 4/7/25 at 6:41 p.m., R53 indicated their right foot was sore and that the pain went away at night. R53 was wearing short, white, socks that extended approximately 2-3 inches above the ankle bone with one inch indentation from the socks on both legs. No compression sleeves, or stockings were worn or visible in the room. R53 stated staff did not put compression sleeves on her legs on 4/6/25 or 4/7/25. During an interview on 4/8/25 at 2:38 p.m., nursing assistant (NA)-A stated R53 did not wear compression socks and confirmed she was wearing anklets. NA-A looked up R53's Kardex in the computer and identified there were no tasks directing staff to apply compression sleeves. During observation and interview on 4/8/25 at 2:50 p.m., R53 removed her right shoe to discuss her sore foot. Licensed practical nurse (LPN)-A was brought to the room and verified the bilateral edema in R53's lower extremities and the short white socks R53 wore. LPN-A stated, "this is bad", and indicated she usually wore black socks. LPN-A removed both of R53's white socks. R53 had approximately 1 inch indentation from the socks about 2 to 3 inches above the ankle bone on both legs. LPN-A confirmed the right leg had significantly more edema and confirmed the compression socks were not set up or in the room. During observation and interview on 4/9/25 at	2 875			

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2 875	Continued From page 19 9:55 a.m., R53 wore red tread socks and stated ace wraps would be on later. R53 displayed the right leg with continued edema approximately 1 inch indentation 2-3 inches above the ankle bone. During an interview on 4/9/25 at 1010 a.m., RN-C stated R53 complained of pain and recently recovered from an ankle fracture. RN-C confirmed there was an active order for bilateral ankle compression sleeves to be applied in the morning and removed at bedtime and confirmed the (TAR) indicated on 4/7/25, the ankle compression sleeves were documented as applied and removed. During an interview on 4/9/25 at 12:01 p.m., RN-D stated the expectation was all orders would be followed and the items ordered would be used. A policy for Edema management was requested and not received. Minnesota Department of Veterans Affairs Skin Management Program dated 2/13/25 was provided and however lacked policy and procedures related to edema management. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents with impaired skin integrity, to assure they are receiving ongoing monitoring and assessment of the skin along with the necessary treatment/services to promote improvement. The director of nursing or designee, could conduct random audits of the delivery of care; review nursing assessments; to ensure appropriate care and services are implemented and reduce the risk of edema not being cared for properly.	2 875			

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2 875	Continued From page 20 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 875	Corrected	4/10/25	
2 890	MN Rule 4658.0525 Subp. 2 A Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure staff assisted 1 of 1 resident (R74), who was reviewed for restorative nursing program, to attend their GI therapy gym sessions or document reasons resident was not available for attendance. The facility further failed to ensure occupational therapist recommendations were care planned and initiated for one of two residents (R184) who was assessed as at risk for bilateral hand contractures and impaired skin due to clenching fist reviewed for services to prevent decrease in range of motion.	2 890			

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2 890	Continued From page 21 Findings include: R184 R184's quarterly Minimum Data Set (MDS), dated 1/24/25, indicated R184 had a diagnosis of Alzheimer's disease, no impairment of his upper and lower extremities and was dependent on staff for all activities of daily living (ADLs). R184's Progress note, dated 2/28/25, indicated R184 received an occupational therapy (OT) evaluation and would be appropriate for a bilateral upper extremity range of motion restorative nursing program. The note indicated this would be set up by OT. R184's careplan, dated 3/29/24, indicated R184 was at risk for decline in ADLs and functional mobility related to dementia and was on a maintenance program. The careplan lacked any interventions related to bilateral hand contracture prevention (i.e. range of motion, palm protectors or holding an object to prevent clenching hands into a fist.) R184's OT note, dated 2/28/24, indicated R184 did not currently have an upper extremity restorative nursing program and would benefit from "holding an object during the day to decrease the resident's incidence of clenching fists." The note also indicated it was recommended for R184 to participate in "AAROM" (active assisted range of motion) for his bilateral upper extremities. R184's OT note, dated 3/29/25, indicated R184 "would not benefit from bilateral palm protectors but would benefit from alternate interventions to manage "squeezing" of palms (increased tone in hands). OT will instruct the resident's [R184]	2 890			

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2 890	Continued From page 22 caregivers regarding encouraging the resident to hold onto a ball or stuffed cat when at rest on the unit." The note further indicated R184 would benefit from a "PROM" (passive range of motion) program. During observation on 4/8/25 at 2:16 p.m., R184 was laying in bed, awake. He did not have anything to hold onto. During an interview on 4/8/25 at 3:14 p.m., occupational therapist (OT)-A stated it was decided R184 would not be appropriate for a hand splint or palm protector but her goal was to have the nursing assistants do range of motion with R184's hands. OT-A stated she talked to a few nurses about having R184 hold onto his stuffed cat when he was up in his wheelchair but had not documented the conversation. OT-A also confirmed the range of motion program had not been passed along to the nursing staff but OT-A had done range of motion with R184's hands "once or twice." During an observation on 4/9/25 at 8:00 a.m., R184 was up in his wheelchair at the breakfast table. There was nothing in R184's hands. Later, at 9:28 a.m., R184 was still up in his wheelchair in the main television area. R184 still had nothing in his hands. During an interview on 4/9/25 at 9:24 a.m., registered nurse (RN)-H stated R184 went to the fitness gym Monday and Friday but was unaware of any intervention for his hands, including range of motion or holding his stuffed cat in his hands. RN-H checked R184's Kardex, used by staff to know how to care for each resident, and confirmed there were no intervention on his Kardex for his hands.	2 890			

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2 890	Continued From page 23 During an interview on 4/9/25 at 10:35 a.m., RN senior and registered nurse (RN)-I stated nursing staff had asked OT to assess R184's hands because nursing staff had concerns about him clenching them. RN-I confirmed OT had not passed along interventions for R184 until yesterday, stating R184 did not have any care planned interventions such as range of motion or holding his stuffed cat as recommended by OT. R74 R74's quarterly Minimum Data Set (MDS) dated 3/17/25, indicated R74 had severe cognitive impairment and no behaviors or rejection of care. R74 had impairment on one side of upper and lower extremity and required substantial to total assistance with activities of daily living. R74 had diagnoses which included coronary artery disease, hypertension, peripheral vascular disease, cerebrovascular accident, hemiplegia or hemiparesis, traumatic brain injury, and asthma. R74 had one day of passive and one day of active range of motion in the last seven days of the look back period. R74's order dated 5/13/22, directed staff to follow fitness gym programming per therapy parameters. R74's care plan printed 4/9/25, indicated the following interventions: -10/4/24, resume fitness GI gym program: Kinevia (motorized therapy device for lower extremities) soft train, base speed 10 rpm (revolutions per minute), resistance 2-3 for 10 minutes for bilateral lower extremity active assisted range of motion/passive range of motion as resident is able. Staff to provide wheelchair transportation to attend.	2 890			

Minnesota Department of Health

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2 890	Continued From page 24 -10/9/24, escort R74 to the GI fitness gym on Mondays, Wednesdays, and Thursdays for their 11 a.m. appointment. R74's Point of Care (POC) Response History printed 4/10/25, indicated R74 attended two GI gym appointments and was not available for 11 out of 13 sessions. R74's progress notes identified the following for days which were marked as "resident not available" for GI gym appointments: -3/12/25, no notes. -3/13/25, no notes. -3/17/25, documented notes did not indicate reason for R74's missed gym session. -3/19/25, no notes. -3/20/25, indicated R74 attended exercise programs during recreation therapy's quarterly charting period and did not indicate reason for R74's missed gym session. -3/26/25, note at 2:15 p.m. indicated R74 had an appointment via MVH (Minnesota Veterans Home) laptop and did not indicate the time of the appointment. -3/27/25, note at 1:51 p.m. indicated R74 had an appointment at 1:30 p.m. with transportation time of 1:15 p.m.. -4/2/25, no notes. -4/3/25, note at 11:54 a.m. indicated R74 had transportation at 12:15 p.m. for a 1:30 p.m. appointment. -4/7/25, no notes. -4/9/25, note at 3:49 a.m. indicated a nebulizer was given to R74 for wheezing and note at 5:09 a.m. indicated the nebulizer was effective. During observation on 4/9/25 at 11:09 a.m., R74 was in their wheelchair at a table in the unit's television area. A nursing staff member entered	2 890			

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2 890	Continued From page 25 another resident's room, and another staff sat at a chair and charted information. During interview on 4/9/25 at 11:24 a.m., nursing assistant (NA)-D stated they brought residents to the GI gym according to a posted schedule. NA-D stated they did not chart on GI gym attendance and reported to the nurse if residents refused to go to the gym. NA-D verified the posted chart indicated R74 should attend their gym session at 11:00 a.m. on Wednesdays and stated R74 attended their session. During interview on 4/9/25 at 12:01 p.m., physical therapy assistant (PTA)-A stated they completed exercise groups around the building, and PTA-B mainly completed the restorative programs in the GI gym. PTA-A stated managers called to let them know when a resident was not able to attend their appointment, so they may reschedule. PTA-B reviewed the 4/9/25 therapy schedule, and R74 had a red line by their name. PTA-B stated the red line indicated R74 did not attend their GI gym appointment. PTA-B stated they received a call earlier this week to notify them R74 would not attend Monday's session related to illness and had not received a call today. PTA-B stated R74 usually attended about two out of three sessions per week, and nursing did not always document why R74 did not attend their gym appointment. PTA-B charted "resident not available" when R74 did not attend their sessions. PTA-B stated R74 did not tolerate a lot of exercise but pedaled for approximately ten minutes. During interview on 4/9/25 at 2:28 p.m., registered nurse (RN)-G stated nursing assistants brought residents to the GI gym according to the posted schedule and was told all residents were	2 890			

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2 890	Continued From page 26 brought to the gym for their appointments today. RN-G stated they would document if someone notified them a resident did not attend their GI gym appointment. During interview on 4/10/25 at 7:42 a.m., R74 agreed it was important for them to attend GI gym appointments and liked to attend at least twice a week. R74 was observed to cough, and the cough sounded wet and/or productive. During interview on 4/10/25 at 9:28 a.m., RN-F expected staff to document reasons residents were not able to attend their GI gym appointments and correspond with the GI gym staff. RN-F reviewed R74's notes and gym session documentation and verified R74 had appointments and respiratory issues on some gym days and lacked documentation other days. RN-F stated R74 may attend fitness activities with PTA-A and was not sure if the fitness activities on the unit conflicted with the times of R74's GI gym appointments. RN-F stated it was important for residents to attend their gym appointments to help maintain optimal levels of mobility. During interview on 4/10/25 at 10:27 a.m., the assistant director of nursing (ADON)-B stated it was important for staff to ensure residents attended their GI gym appointments and expected staff to document if there was a pattern of refusals. ADON-B stated the interdisciplinary team had a schedule to review GI gym participation, so they could adjust resident's schedule if needed. A facility policy titled Restorative Nursing, revised 12/4/24, indicated "MVH will assess, plan, and implement a restorative nursing program per applicable state and federal rules and regulations	2 890			

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2 890	Continued From page 27 to improve or maintain a resident ' s functional status." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), therapy department, or designee could ensure recommended therapy exercises, to include range of motion and other interventions, are relayed to nursing staff and implemented timely into the residents' plan of care. The facility could update or create policies and procedures and educate staff on specific requirements or interventions related to nursing restorative programs. The DON, therapy department, or designee could perform audits for a designated amount of time as determined by the Quality Assurance Performance Improvement (QAPI) committee to ensure recommended therapy interventions are relayed to nursing staff and implement timely. The facility could report those findings to QAPI for further recommendations and determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 890			
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by:	21015			4/10/25

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21015	Continued From page 28 Based on observation, interview and document review, the facility failed to serve food in a sanitary manner by failing to ensure staff properly contained hair with a hairnet/beard net while preparing plates of foods brought into the facility to serve to residents for a meal. This had the potential to affect 32 residents who reside in building 19 on 3rd floor. Findings include: During observation in building 19 on 3rd floor on 4/9/25 at 12:06 p.m., lunch was being served by staff from the dining room island/counter. The meal consisted of fried chicken, mashed potatoes, gravy, coleslaw and buns. Two staff were observed to be using resident menu ticket and preparing resident plates. The 2 staff were observed to be wearing gloves but were not wearing hairnets while placing food items on resident plates and standing over food items. During interview on 4/9/25 at 12:14 p.m., assistant director of nursing (ADON)-A stated recreational therapy had set up the "special" meal for today and the food being served was brought into the facility. ADON-A verified the staff who were placing the food on residents' plates were not wearing hairnets and their hair was not properly contained. ADON-A stated she was unsure if this was a requirement as the meal was not being served out of the kitchenette or by the dietary staff. ADON-A stated the staff were wearing gloves. ADON-A stated hairnets were worn so "nothing gets in the food." During interview on 4/10/25 at 9:27 a.m., culinary director (CD)-A stated the expectation was staff should wear hairnets when "plating" food.	21015	Corrected		

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21015	Continued From page 29 During an interview on 4/10/25 at 9:28 a.m., director of dietary services (DDS)-A stated the expectation would be whoever was plating the resident food would be expected to wear a hair net. DDS-A stated the reason for wearing hairnets was to not contaminate the food. During an interview on 4/10/25 at 9:54 a.m., director of nursing (DON) stated the expectation of staff who are preparing and preparing residents plates would be hairnets are worn so that the food would not be contaminated. A facility policy titled Dress, Appearance, and Hygiene in the Workplace, revised 2/21/20, indicated "Hair (including facial hair) must be tied back and/or covered, if required by work related regulations or because of safety, sanitation or other care reasons and must be clean." SUGGESTED METHOD OF CORRECTION: The administrator, registered dietitian, or designee could ensure staff properly contain hair with hairnets/beardnets while preparing food to prevent contamination of food served to residents of the facility. The facility could update or create policies and procedures, and educate staff on specific requirements or interventions related to food preparation. The administrator, registered dietitian, or designee could perform audits for a designated amount of time as determined by the Quality Assurance Performance Improvement (QAPI) committee to ensure food items are prepared in a safe manner. The facility could report those findings to QAPI for further recommendations and determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: Twenty-one	21015			

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21015	Continued From page 30 (21) days.	21015			
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery	21880			4/10/25

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21880	Continued From page 31 centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a voiced grievance of a missing shirt was acted upon timely to help facilitate prompt resolution for 1 of 1 resident (R232) who reported such item as missing with no follow-up. Findings include: R232's quarterly Minimum Data Set (MDS) dated 2/7/25, indicated R232 was cognitively intact. R232's progress note failed to identify a missing item reported on 2/28/25. However, there was a late entry on 3/6/25 at 9:30 a.m., R232 expressed to writer his black long sleeve shirt was stolen by a p.m. staff member. R232's progress note dated 3/6/25 at 4:33 p.m., (documented as a late entry) identified R232 pointed out the staff member that allegedly stole his black long sleeve shirt, and the nurse writer immediately removed staff from resident care. The writer and ADON interviewed both the resident and staff member and filed a report with MDH (Minnesota Department of Health). R232's progress notes failed to show follow-up after the missing item was reported.	21880	Corrected		

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21880	Continued From page 32 The facility's 2025 Grievance Complaint Log failed to document R232's grievance. The facility's missing item tracker identified R232's with a missing item on 2/28/25. During an interview on 4/7/25 at 4:19 p.m., R232 stated, a black long sleeve shirt was on his chair as he entered his room and while his back was turned a staff member removed the shirt and left the room. R232 stated, when he turned around the staff member and the shirt were gone. The missing item was reported to the nurse manager on 2/28/25. R232 stated "the investigation was lacking". The nurse manager waved him down in the hallway to discuss the camera footage and informed him that staff member would no longer float to his unit, but never came to my room to discuss the results of the investigation or that they were done looking for the shirt. During an interview on 4/8/25 at 11:37 a.m., licensed practical nurse (LPN)-A stated anytime a resident reported a missing item staff checked the resident's room first, then talked with aids and other residents, called laundry and charted a general progress note. LPN-A stated family would be called only if it was necessary. The next shift would be notified of any new missing items during a huddle meeting and the nurse manager was always notified. LPN-A confirmed the unit was equipped with security cameras. During an interview on 4/8/25 at 12:04 p.m., registered nurse manager (RN)-C stated when a resident reported a missing item, a missing item form was completed and sent to laundry, the safety officer, assisted director of nursing (ADON), and the unit social worker. If it was a	21880			

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21880	Continued From page 33 housekeeping item, such as laundry, that item usually turned up and that documentation would be found under progress notes. RN-C stated during R232's investigation the security camera footage was reviewed, and the staff member was not seen holding any item as he exited the room. RN-C verified a report was filed with OHFC. RN-C stated a claim was filed with the social worker on 2/28/25. During observation and interview on 4/8/25 at 1:31 p.m., social services (SS)-A stated the resident had the right to complete a Tort claim if an item could not be recovered. To prove monetary value, the resident would need a receipt. If the resident did not have a receipt a similar item could be found online, and that value would be used to complete the Tort claim. Once the form was completed it was given to legal department and sent to Saint Paul where a committee approved the claim. SS-A stated a copy of the claim was not kept on file, and then confirmed R232 never came back to file a Tort claim. SS-A provided a blank settlement of claims-not exceeding \$7,000 form. SS-A confirmed no completed forms were kept on file for R232. During an interview on 4/8/25 at 2:30 p.m., assistant director of nursing (ADON-RN)-D stated a report was submitted to the Department of Health, OHFC specifically for R232's black long sleeve shirt that was reported stolen by the nurse on 2/28/25. RN-D confirmed all completed grievance forms were filed and kept with the director of social services and confirmed there was no follow up with the resident after the report was filed. During an interview on 4/8/25 at 3:00 p.m. RN-C	21880			

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21880	Continued From page 34 recalled having a conversation with R232 regarding the investigation and referred to the spreadsheet for missing items. RN-C confirmed the tracker failed to show results of the investigation in that only demographic information was completed. RN-C also confirmed not going to the resident's room to discuss the investigation, but did confirm the shirt was discussed in passing while R232 visited across the hall with the social worker. During an interview on 4/9/25 at 9:37 a.m., R232 stated the nurse manager never came back to discuss how the investigation ended. He stated she saw him in front of the social workers office and would say, "I will get back in touch" with him. R232 stated it was dismissed at that point, but he was not satisfied because she never clarified if the investigation was ongoing. R232 confirmed he was not offered the Resident Property Damage/Loss Form and SS-A never offered a Tort or settlement claim for reimbursement on 2/28/25 or anytime thereafter. During an interview on 4/9/25 at 9:40 a.m., RN-C could not provide the resident property damage/loss form completed for R232 that is directed to be completed in step 1 of 4 in the Minnesota Veteran's Home-Minneapolis Stand of Work Resident Lost/Missing Items protocol. RN-C also confirmed there was no follow up progress note to document an investigation or conversations with R232 after 3/6/25 regarding the missing item. Minnesota Department of Veterans Affairs Policy dated 6/22/23 indicated (A) 1. A claimant will be provided with a claim report and demand form upon request and the claimant has suffered personal injury or negligent loss, damage, or	21880			

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21880	Continued From page 35 destruction of property. SUGGESTED METHOD OF CORRECTION: The Director of Nursing and/or designee could review and revise policies pertaining to handling resident grievances, educate staff on these policies and perform audits to ensure each resident grievance has been addressed by the facility. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21880			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 3, 2025

Administrator
MN Veterans Home Minneapolis
5101 Minnehaha Avenue South
Minneapolis, MN 55417

RE: CCN: 245620
Cycle Start Date: April 10, 2025

Dear Administrator:

On June 16, 2025, we notified you a remedy was imposed. On July 2, 2025 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of July 1, 2025.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective July 10, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of May 6, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from April 17, 2025. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping'.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 3, 2025

Administrator
MN Veterans Home Minneapolis
5101 Minnehaha Avenue South
Minneapolis, MN 55417

Re: Reinspection Results
Event ID: VNCO12

Dear Administrator:

On June 5, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 10, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping'.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us