Electronically delivered
May 6, 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 17, 2025, a survey was completed at your facility by the Minnesota Department of Health 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 isolated deficiencies that constituted immediate jeopardy (Level J).

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

REMOVAL OF IMMEDIATE JEOPARDY

On April 17, 2025, the situation of immediate jeopardy to potential health and safety cited at F760 was removed.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS location.

- Civil money penalty, (42 CFR 488.430 through 488.444).

You will receive a formal notice from the CMS location only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding

of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective April 17, 2025. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Mn Veterans Home Minneapolis is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective April 17, 2025. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

DEPARTMENT CONTACT

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

Annette Winters, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health

625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245620	A. BUILDING _____ B. WING _____	C 04/17/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 4/17/25 a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following complaint was reviewed: H56202990C/MN112253 and a deficiency was issued at F760 at PAST NON-COMPLIANCE. The immediate jeopardy began on 4/11/25 p.m. when LPN-A administered 20 times the amount of liquid morphine to R1 and was identified on 4/17/25. The director or nursing (DON) and the Administrator were notified of the immediate jeopardy at 3:03 p.m. on 4/17/25. The immediate jeopardy was removed on 4/17/25, and the deficient practice corrected on 4/14/25, prior to the start of the survey and was therefore was issued at past noncompliance. Although the provider had implemented corrective action prior to survey, immediate jeopardy was sustained prior to the survey. No plan of correction is required for a finding of past non-compliance; however, the facility must acknowledge receipt of the electronic documents.	F 000	Past noncompliance: no plan of correction required.	
F 760 SS=J	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility	F 760	Past noncompliance: no plan of	

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 760	Continued From page 1 failed to ensure that a resident was free from a significant medication error for 1 of 3 residents (R1) reviewed for medication errors. This resulted in an Immediate Jeopardy (IJ) citation when licensed practical nurse, (LPN)-A administered morphine, a narcotic medication, 20 times the amount that was ordered by the provider. The immediate jeopardy began on 4/11/25 p.m. when LPN-A administered 20 times the amount of liquid morphine to R1 and was identified on 4/17/25. The director or nursing (DON) and the Administrator were notified of the immediate jeopardy at 3:03 p.m. on 4/17/25. The immediate jeopardy was removed on 4/17/25, and the deficient practice corrected on 4/14/25, prior to the start of the survey and was therefore was issued at past noncompliance. Findings include: R1's quarterly Minimum Data Set (MDS) dated 3/5/25, indicated R1's primary diagnosis was cerebral vascular accident (stroke). Other diagnoses included: diabetes, dementia and atrial fibrillation. R1's Brief Inventory of Mental Status (BIMs) assessment was not conducted as R1 was rarely/never understood. R1 was dependent upon staff for toileting and personal hygiene, dressing, transferring and rolling from side to side in bed. MDH has the MDS printed from ASPEN. R1's progress note dated 4/11/25 at 11:00 p.m. indicated R1's blood pressure (BP) was 158/61, (normal 100/60 - 120/80), pulse (P) was 73 normal (60-100) oxygen saturation (SpO2) was 86% to 91% (normal 90% - 100%). Oxygen levels	F 760	correction required.	

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F 760	Continued From page 2 were fluctuating, the nurse practitioner (NP) was called. The NP advised 2-4 liters (L)of oxygen. If oxygen levels did not improve R1 was to be sent to the hospital. R1's oxygen remained below 88% and his family declined hospitalization. The NP ordered 5 milligrams (mg) of Morphine every hour as needed. R1's order dated 4/11/25 indicated R1 was to take morphine 5 mg (20 mg/1 ml) oral every hour as needed for shortness of breath. R1's individual narcotic record dated 4/11/25, indicated morphine 20 mg/1 ml. Give 5 mg every hour as needed. The quantity of liquid morphine prior to administration was 15 ml and after administration at 11:45 p.m. was 10 ml, indicating R1 received 5 ml (add 100 mg) and not 5 mg as ordered. R1's progress note dated 4/12/25 at 1:49 a.m., indicated a medication error morphine 5 ml given instead of ordered dose of morphine 5 mg. The NP was notified. R1's BP was 160/74, P 74, R 26, and SpO2 93% on 2 L NC. NP advised to hold the morphine for the next few hours and monitor R1. R1's progress note dated 4/12/25 at 3:00 a.m., indicated death at 2:50 a.m. R1 was unresponsive, and vitals had ceased at 2:50 a.m., pupils were fixed, and no pulse was found. Upon interview on 4/17/25 at 10:20 a.m., registered nurse (RN)-A stated the nurse, referring to LPN-A, failed to follow the five rights of medication administration (right medication, right dose, right route, right time and right patient). LPN-A failed to check the correct dose.	F 760		

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F 760	Continued From page 3	F 760		

In addition, she did not verify the dose with another nurse per facility policy. The nurse manager on duty found the medication error around 12:30 a.m. on 4/12/25 in the system because the order had not been verified with another nurse. RN-A immediately reached out to LPN-A to verify the medication error and notified the NP for new orders. RN-A stated all staff had been retrained following the incident.

Upon interview on 4/17/25 at 11:01 the NP stated on 4/11/25 he was informed that R1 was having difficulty eating, breathing and was agitated. He ordered R1 to have oxygen and if his breathing did not improve to send him to the hospital. R1's family did not want him sent to the hospital, so the NP ordered liquid morphine 5 mg (20 mg/1 ml). He ordered the morphine in liquid form because that was available in the emergency medication kit. At around 12:30 a.m. he was notified that R1 received an incorrect dose of morphine. The NP gave the orders to hold the morphine and monitor R1 frequently. The NP was under the impression R1 received 20 mg of morphine and was not told until the following day that R1 instead received 100 mg of morphine. The NP stated he was not certain if the overdose caused R1's death. He stated the Medical Examiner will make that determination.

Upon interview on 4/17/25 at 1:42 p.m. RN-B stated she worked as the facility manager the night of 4/11/25. She was given report by the outgoing manager RN-C that R1 had a change in condition, the NP was notified and had placed an order for oxygen and morphine. RN-B stated she received the hard copy verbal order of the morphine. She checked the order to ensure there were two signatures on the order. She got the

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F 760	Continued From page 4 medication out of the emergency (e)-kit and delivered it to LPN-A around 11:30 p.m. RN-B handed the medication vial to LPN-A and another LPN staff member signed the managers book that the medication was delivered. RN-B left the unit and went to complete other assignments. At approximately 12:30 p.m. RN-B noticed R1's morphine order had not been confirmed in R1's electronic chart (e-chart). She was concerned because medications were not to be given until two nurses had confirmed the ordered dose in the e-chart. RN-B went to the unit and asked LPN-A why she had not administered R1's morphine. LPN-A told RN-B she had administered the morphine at 11:45 p.m. RN-B noticed that LPN-A had written down 5 ml administered. RN-B asked LPN-A how much morphine R1 received, and LPN-A told her 5 ml. RN-B stated she knew it was the wrong dose and calculated the error. RN-B's calculation indicated R1 received 20 mg of morphine. RN-B called the NP and reported R1 had been given 20 mg of morphine instead of 5 mg. The NP ordered staff to hold the morphine and to monitor R1. RN-B told the family, who was in R1's room that R1 had been given 20 mg of morphine instead of 5 mg and the facility would be holding the morphine and monitoring R1 frequently. The family still wanted R1 to stay at the facility and not be sent to the hospital. RN-B brought in cots for the family to spend the night with R1. At approximately 2:15 a.m. RN-B received a call from LPN-A stating R1's oxygen saturations were trending down in the 70's. RN-B elevated R1's head of bed and got him a face mask for the oxygen instead of the nasal cannula. At approximately 2:40 a.m. LPN-A told RN-B that she thought she may have given R1 more than 20 mg of Morphine. RN-B looked at the morphine bottle again and what LPN-A had given and	F 760		

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F 760	Continued From page 5	F 760		

realized she had given him 100 mg of Morphine instead of the 20 mg they had thought prior. RN-B paged the NP, as she was paging him, she was told R1 had passed away. After confirming R1's passing and consoling the family, RN-B met with the family and told them R1 received more morphine than they originally thought he received, it was 100 mg of morphine at 11:45 p.m. and 20 mg was previous reported to the family. RN-B stated the facility provided training to all licensed staff following the error.

Upon interview on 4/17/25 at 6:22 p.m., family member (FM)-A stated she had spoken with RN-A a few days prior to R1's death regarding R1's change in condition. FM-A was told R1 required more assistance with feeding and was sleeping more. A plan was made that R1 would stay at the facility and not be hospitalized if he declined further. On 4/11/, FM-A and FM-B were with R1 at dinner time and assisted with his feeding. They left the facility around 7:00 p.m. At approximately 10:00 p.m. FM-A received a call from the facility stating R1 was agitated, and his oxygen saturations were under 90% and they wanted to send R1 to the hospital. FM-A stated not to send him to the hospital that she and FM-B were on their way to the facility to see him. They arrived at the facility around 10:30 p.m. R1 was anxious, pulling at his blankets and his breathing "seemed more labored." R1 was wearing oxygen when they arrived, however his saturations continued to be below 90%. RN-C told FM-A that the NP ordered some morphine to relax R1 and assist with the breathing. FM-A was agreeable. At 11:45 p.m. LPN-A administered the morphine to R1. LPN-A had to awaken R1 to administer the morphine. R1 stayed awake and was breathing harder, "sounded like sleep apnea although he

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F 760	Continued From page 6 was awake" FM-A asked staff to please leave the O2 monitor on R1, which they did. R1's saturations continued to drop. At approximately 12:30 p.m. LPN-A told the family she had accidentally given R1 20 mg of morphine instead of 5 mg, that the NP had been notified, and the staff would be monitoring R1 frequently. At approximately 12:40 p.m. RN-B entered the room and explained the medication error to the family again. RN-B recommended the family spend the night and brought in cots to sleep on. FM-A stated over the next few hours R1 became worse, his saturations continued to drop, he was agitated and then he went into a coma state where his pupils looked to be pinpoint. He still had a pulse at 1:50 a.m. At approximately 2:00 a.m. FM-A stated R1 started the "death rattle" which was confirmed by RN-B. RN-B told FM-A she thought R1 was dying and to notify the rest of the family. After R1's passing at 2:50 a.m. RN-B told the family R1 had received 100 mg of morphine. Attempts to contact LPN-A were unsuccessful. A facility protocol titled Medication Administration Protocol with a revision date of 4/2025 indicated: Medication/Treatment Administration Procedure: A. Perform hand hygiene. B. Unlock medication cart. C. Open resident's electronic health record (HER) and choose eMAR. D. Identify medication/treatment to be administered. E. Check for resident allergy. F. Locate medication card/container and compare the label with the eMAR directions. 1. Check the label for: a) Right resident	F 760		

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F 760	Continued From page 7 b) Right drug - check label description for color and shape c) Right dosage d) Right route e) Right time In addition: Special instructions: a) Liquid narcotic medication: two nurses must verify the amount to be given. Liquid narcotic medication requiring a dosage calculation must be transcribed in PCC order in ml and verified at time of transcription by two nurses. A facility policy titled Medication Administration with a revision date of 12/4/2024 indicated: Staff administering medication must ensure the correct medication is administered in the correct dose, in accordance with the manufacturer's specifications or provider's order, to the correct person via the correct route in the correct dosage form and at the correct time. Medication incidents that result in certain types of medication errors for the resident (Such as the wrong person, drug, dose, route, frequency, lack of clinical justification, or charting omissions) must be documented and reported by staff to nursing leadership as applicable. Following survey the DON sent the policy and protocol which were in the investigative file. The IJ that began on 4/11/25, was corrected on 4/14/25. The IJ was issued at past noncompliance due to the actions the facility implemented prior to survey, including: The facility identified the error on 4/11/25 and completed a thorough investigation identifying the root cause that LPN-A did not follow the	F 760		

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F 760	Continued From page 8 medication right or right dose and did not verify the dose with another nurse. LPN-A was placed on a leave pending the investigation on 4/14/25. All nursing staff were educated on the medication order transcription process, order confirmation process, ensuring orders are confirmed and appear on the electronic medication record prior to administration, double noting of liquid narcotics to ensure correct dosing on order and in the narcotic book. This was completed on 4/14/25. IDT meeting was held to discuss the use of liquid narcotics in the facility vs. sublingual morphine to propose the change to the pharmacy for emergency medication kit use on 4/14/25.	F 760		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 6, 2025

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

Re: Event ID: 9ZG211

Dear Administrator:

The above facility survey was completed on April 17, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any 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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MN VETERANS HOME MINNEAPOLIS	5101 MINNEHAHA AVENUE SOUTH MINNEAPOLIS, MN 55417

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/17/25 a complaint investigation was conducted by surveyors from the Minnesota Department of Health (MDH) to investigate complaint H56202990C/MN112253. No correction order were issued. The facility is enrolled in ePOC and therefore a	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00233	A. BUILDING: _____ B. WING _____	C 04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 000	Continued From page 1 signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction in required, it is required that you acknowledge receipt of the electronic documents.	2 000		