Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 31 2025

Administrator
Minnesota Veterans Home - Silver Bay
56 Outer Drive
Silver Bay, MN 55614

Re: Event ID: HLCI11

Dear Administrator:

The above facility survey was completed on January 15, 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,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245628	A. BUILDING _____ B. WING _____	C 01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNESOTA VETERANS HOME - SILVER BAY	56 OUTER DRIVE SILVER BAY, MN 55614

(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 1/14/25 through 1/15/25, a standard abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found IN compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were reviewed: H56284349C (MN00109568) H56284382C (MN00109649) with a deficiency cited at F760 at PAST NON-COMPLIANCE. The facility is enrolled in ePOC, therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, the facility must acknowledge receipt of the electronic documents.	F 000	Past noncompliance: no plan of correction required.	
F 760 SS=G	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 document review, the facility failed to ensure medications were administered to the correct resident for 1 of 3 residents (R1) reviewed for medication errors. This failure resulted in actual harm for R1 when she developed bradycardia (abnormally slow heart rate) and became hypotensive (abnormally low blood pressure) which required ongoing monitoring in the emergency department (ED). The facility had implemented appropriate corrective action prior to the onsite investigation, so the deficiency is being cited at past non-compliance.	F 760	Past noncompliance: no plan of correction required.	

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 Findings include: R1's quarterly Minimum Data Set (MDS) dated 12/11/24, indicated R1 had intact cognition, and had diagnoses of chronic kidney disease stage 3b (moderate to severe loss of kidney function), hypertension (high blood pressure), heart failure (heart muscle does not pump blood effectively), hyponatremia (low blood sodium), anemia (low red blood cells), and polymyalgia rheumatica (inflammatory disorder that causes muscle pain and stiffness) . A facility report to the State Agency (SA) on 1/7/25 indicated on 1/6/25 at 7:45 a.m. R1 received another resident's medications, and had been sent to the hospital. On 1/6/25 at 9:14 a.m., a progress note written by nurse practitioner (NP)-A, indicated R1 had symptomatic hypotension and bradycardia following a medication error. R1 reported severe dizziness. Order written for evaluation and treatment at the ED. R1's Weights and Vitals Summary dated 1/6/25, indicated R1 had a blood pressure of 67/40 and pulse was 47 at 9:14 a.m. At 9:39 a.m. R1's blood pressure was 61/40 and her pulse was 41 bpm. R1's Emergency Department Note dated 1/6/25, indicated R1 was given the following medications the morning of 1/6/25: acetaminophen 650 milligrams (mg), apixaban (blood thinner) 5 mg , carvedilol (heart medication) 25 mg, divalproex sodium (seizure medication) 125 mg, furosemide (diuretic) 40 mg, metformin (diabetic medication) 1000 mg, sacubitril-valsartan (heart medication)	F 760		

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F 760	Continued From page 2 97-103 mg, allopurinol (uric acid reducer) 100 mg, amlodipine (blood pressure medication) 100 mg, empagliflozin (diabetic medication) 10 mg, ferrous sulfate (iron) 234 mg, isosorbide mononitrate extended release (heart medication) 60 mg, paroxetine (antidepressant) 20 mg, tamsulosin (prostate medication) 0.4 mg, and zinc sulfate 220 mg. R1's hospital History and Physical Summary dated 1/6/25, indicated R1 was accidentally given the wrong medications on the morning of 1/6/25. R1 had the following symptoms: lightheadedness, weakness, hypotension, and sinus bradycardia with rate in the mid to upper 40s. Poison control was contacted and didn't have further recommendations other than monitoring R1's blood pressure and heart rate. R1 was placed on telemetry, vital signs were completed every 2 hours, intravenous (IV) therapy was started with normal saline at 100 cubic centimeters per hours (cc/hr). Creatinine level (indicates how well the kidneys are functioning) was within baseline at 1.6 milligrams per deciliter (mg/dL). Hemoglobin (a protein in red blood cells) was stable at 9.4 grams per deciliter (g/dL). Orders were placed to recheck hemoglobin on 1/7/25. Electrolytes were within normal limits. On 1/14/25 at 11:52 a.m., R1 stated on 1/6/25 in the morning, she was told by staff that she got the wrong medications. R1 stated she felt dizzy and weak in her legs a few hours after taking the wrong medications. R1 stated she had to go to the hospital overnight because she was not feeling well. On 1/15/25 at 8:46 a.m., registered nurse (RN)-A stated on 1/6/25 during the morning medications	F 760		

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F 760	Continued From page 3 pass, she set up three different residents' medication in the medication room, and placed them on a tray. She took the tray and went into R1's room to give R1 her medications. She gave R1 the wrong medications, but did not realize until she went to the second resident's room and his medications were not on the tray, but R1's medications were still on the tray. She went and told the charge nurse right away. The charge nurse then took over caring for R1. RN-A was removed from passing medications to being a nursing assistant for the day. During her lunch, she was told she needed to leave the facility pending investigation, and has not been back to the facility since the incident. She had since been re-educated, and was now aware that pre-preparing medications was not an acceptable practice, and she would not be doing it in the future. On 1/15/25 at 9:56 a.m., consultant pharmacist (P)-A stated after she reviewed the medications R1 received in error, she was concerned about R1's blood pressure as she received high doses of blood pressure medications. It would not be acceptable for nurses to prepare more than one person's medications at one time ever. On 1/15/25 at 11:48 a.m., NP-A stated she found out R1 was given the wrong medications on the morning of 1/6/25, and became worried about R1's blood pressure, pulse, alertness, and level of consciousness. She told the facility to send R1 to the ED when her blood pressure and pulse dropped, and she was complaining of dizziness. She would expect staff to complete one resident's medications at a time. It would never be accepted to do set up multiple resident medications at one time.	F 760		

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F 760	Continued From page 4 On 1/15/25 at 12:04 p.m., the director of nursing (DON) stated the process of staff passing medications was to follow the medication rights, and do prepare medications for one resident at a time. The policy was not followed by RN-A on 1/6/25. The facility had reviewed the medication administration and medication incident policy, revised the medication administration standards policy, reviewed R1's care plan, started medications administration audits, provided education to nurses in regards to medication pass expectations, and P-A would be coming on 1/30/25 to do more education on medication administration. The facility Medication Administration policy revised 12/4/24, identified staff administering medication would ensure the correct medication was administered 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. The facility implemented corrective action to prevent recurrence by 1/14/25 when the facility completed the following: Reviewed and revised medication administration policies, provided education to all staff members responsible for medication administration, which included administration of medications and ensuring the six rights of medication administration was being followed, and completed medication administration audits. Verification of corrective action was confirmed by observation, interview, and document review on 1/14/25 and 1/15/25.	F 760		

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January 31 2025

Administrator
Minnesota Veterans Home - Silver Bay
56 Outer Drive
Silver Bay, MN 55614

RE: CCN: 245628
Cycle Start Date: January 15, 2025

Dear Administrator:

On January 15, 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 actual harm that was not immediate jeopardy (Level G),

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).

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 $12,924; 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 January 15, 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.

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:

Terri Ament, Regional Operations Supervisor RR
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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.

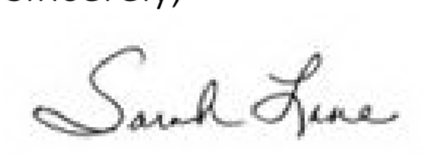
INFORMAL DISPUTE RESOLUTION (IDR)

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,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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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 1/14/25 through 1/15/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure. The following complaints were reviewed during	2 000		

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2 000	Continued From page 1 the survey: H56284349C (MN00109568) H56284382C (MN00109649) Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		