STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245620	A. Building B. Wing	09/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN Veterans Home Minneapolis	5101 Minnehaha Avenue South Minneapolis, MN 55417

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. (continued on next page)

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview and document review, the facility failed to follow R1's Physician Orders for Life-Sustaining Treatment (POLST) do not attempt resuscitation (DNR), do not intubate, and to allow natural death for 1 of 3 residents (R1) when R1 became unresponsive after a fall and licensed practical nurse (LPN)-A initiated cardiopulmonary resuscitation (CPR). The immediate jeopardy began on [DATE] when R1 became unresponsive after a fall, licensed practical nurse (LPN)-A initiated cardiopulmonary resuscitation (CPR), and was identified on [DATE]. The campus administrator, director of nursing, and nurse manager of facility staff were notified of the immediate jeopardy at 3:20 p.m. on [DATE]. The immediate jeopardy was removed on [DATE] and the deficient practice corrected on [DATE], prior to the start of the survey and was therefore Past Noncompliance. Findings include: R1's Physician Orders for Life-Sustaining Treatment (POLST) dated [DATE], indicated he was a DNR. R1's progress note dated [DATE] at 10:17 a.m., indicated R1 was found on the floor by a nursing assistant (NA) at 6:07 a.m. R1 became unresponsive while staff were cleaning him up after a bowel movement. His skin color changed, and he stopped talking to them. CPR was initiated. The ambulance staff continued lifesaving efforts and transported R1 to the hospital. Facility investigation interview with LPN-A note dated [DATE], indicated when R1 became unresponsive she left the room to update the officer on duty (OD) and retrieve R1's medical chart. She indicated while holding the POLST document her finger covered up the check mark for the DNR option. She interpreted his code status as a full code and initiated CPR. During an interview on [DATE] at 1:42 p.m., LPN-B stated she would go to the computer to look up the resident's code status or read the POLST located in their chart at the nursing station. During an interview on [DATE] at 3:10 p.m., LPN-C stated she would look for the POLST in the resident's chart and make sure it was signed. The label on the chart spine would be white if they were a full code. During an interview on [DATE] at 3:17 p.m., LPN -D stated she would go to the chart to find the code status documented on the POLST. During an interview on [DATE] at 3:25 p.m., registered nurse (RN)-A stated she would expect the nurses to look for the CPR status on the POLST. The second nurse arriving during a cardiac arrest would verify the code status. Interview on [DATE] at 2:14 p.m. family member (FM)-A stated his father had Alzheimer's disease, and he was the appointed healthcare representative. R1 had been a DNR since admission to the facility on [DATE]. He received a phone call on [DATE], notifying him his father was pulseless, and staff were doing CPR. He thought to himself why are they doing CPR, but he didn't say anything to the staff and just wanted to get to the facility. On the way to the facility, he received a phone call from the hospital. He was told they were only able to get his pulse back for a few minutes before his heart stopped again. They wanted to stop CPR. FM-A told them they should have never started CPR because his father was a DNR. Interview on [DATE] at 10:47 a.m. LPN-A stated while they were cleaning him up after a bowel movement, he became unresponsive, and his color changed. She left the room to call the OD and to look up his code status. She still had her gloves on, and she only saw attempt resuscitation. She started CPR when she returned to the room. The next day staff told her she read the POLST wrong. She looked again and saw the check mark for Do not resuscitate. Since she had training on how to read a POLST. She now knows the chart spine label is colored white for a full code and blue for a DNR. In addition, the POLST was located inside the chart. The facility policy Medical Emergency Protocol dated [DATE], indicated the nurse would first identify absence of breathing and circulation. Before starting CPR, the resident's code status would be reviewed in the electronic medical record, or the POLST found in the residents chart. The past noncompliance immediate jeopardy began on [DATE]. The immediate jeopardy was removed and he deficient practice corrected on [DATE] after the facility implemented a systemic plan that included the following actions: 1. Health unit coordinator (HUC), nurse manager, and registered nurses would check all resident's charts to ensure POLST matched the electronic medical record banner and the charts spine color. 2. Staff were educated on emergency protocols. a. Where to check code status.b. Two people verify the POLST. 3. Completed audits with staff and verified the training. 4. Completed monthly Code drills where staff would read the POLST and correctly identify if a full code or DNR. 5. Ongoing audit schedule to evaluate staff knowledge regarding the POLST and where to find the code status.