

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 03/21/2024
NAME OF PROVIDER OR SUPPLIER MN Veterans Home Minneapolis		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44647</p> <p>Based on observation, interview, and document review the facility failed to assess a resident for the ability to self-administer medications via a nebulizer (machine that aerosolizes medications for inhalation) for 1 of 1 residents (R49) reviewed for self-administration of medications.</p> <p>Findings include:</p> <p>R49's quarterly Minimum Data Set (MDS) dated [DATE], indicated R49 had severe cognitive impairment and diagnoses of chronic obstructive pulmonary disease ([COPD] debilitating lung disease) and dementia.</p> <p>R49's provider order dated 5/5/2023, indicated R49 required levalbuterol inhalation nebulization (medication given via nebulizer to increase airflow to the lungs) solution 1.25 milligrams/3 milliliters four times a day related to COPD.</p> <p>R49's self-administration of medication assessment dated [DATE], indicated R49 did not request to self-administer medications.</p> <p>During observation on 3/18/24 at 5:02 p.m., R49 was in bed with the head of bed elevated. R49's nebulizer machine was running. Staff were not present in the hallway or in R49's room. R49 was holding a nebulizer mask in his right hand away from his face. At 5:02 p.m., R49 held the mask to his face for a moment before removing it again and yelling help help. At 5:03 p.m., R49 put the mask back at his face again for a moment before taking it back off and coughing. Nursing assistant (NA)-B walked by R49's room down towards dining room and let registered nurse (RN)-D know R49 was taking off the nebulizer mask. At 5:05 p.m. NA-B knocked on R49's door and entered to assist to the wheelchair and escort down to dining room for dinner. R49's mask was on the bedside table and the nebulizer machine was still running. At 5:20 p.m., RN-D entered R49's room and turned off nebulizer machine.</p> <p>When interviewed on 3/18/24 at 5:14 p.m., NA-D stated R49 removed the mask himself as the nebulizer medication was completed. NA-D further stated R49 usually knew when the medication was completed.</p> <p>When interviewed on 3/18/24 at 5:46 p.m., RN-D stated some residents require monitoring during a nebulizer treatment, but R49 did not require monitoring. Furthermore, RN-D stated if a resident could not be left alone with their nebulizer, it would be indicated in the order. R49's orders did not indicate R49 could not be left alone. RN-D further stated usually R49 was checked back on in 15 minutes to ensure the medication was completed and acknowledged that was not done tonight.</p> <p>(continued on next page)</p>

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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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>When interviewed on 3/20/24 at 9:19 a.m., RN-E stated residents who self-administer medications require an assessment to ensure they are safe for administration. RN-E further stated R49 should not be left alone when administering the nebulizer as R49 often was anxious and was not cognitively intact.</p> <p>When interviewed on 3/20/24 at 12:18 p.m. the director of nursing (DON) expected staff to be in attendance of all medication administration including nebulizers unless the resident was assessed as safe to self-administer medications.</p> <p>A facility policy titled Self-Administration of Medications dated 7/13/23, directed staff to allow residents to self-administer medications if the resident is determined capable and safe to do so by the interdisciplinary team.</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44647</p> <p>Based on observation, interview and record review the facility failed to comprehensively assess residents food preferences and ensure meal choices were provided for 1 of 1 residents (R146) reviewed for choices.</p> <p>Findings include:</p> <p>R146's significant change Minimum Data Set (MDS) dated [DATE], indicated R146 was cognitively intact and had diagnoses of Parkinson's disease, diabetes, and depression. Furthermore, R146's MDS indicated R146 required set up for meals.</p> <p>R146's dietary care area assessment (CAA) dated 2/28/24, indicated a nutrition care plan would be addressed and to refer to R146's nutrition assessment dated [DATE].</p> <p>R146's nutrition assessment dated [DATE], indicated R146 was recently admitted to hospice and had a liberalized diet. R146 had difficulty chewing and mashed potatoes, cottage cheese, and ice cream were incorporated into the meal plan. R146's assessment stated R146 reviewed menus ahead of time and chose items to ea. R146's assessment lacked indication food preferences were reviewed.</p> <p>R146's care plan revised 2/26/24, indicated R146 was at nutritional risk related to poor dentition, weight loss, and hospice. R146 was expected to have weight loss. R146's goal was to accept food as desired and able to tolerate for comfort. R146's care plan lacked indication of food preferences and indicated R146 was independent in making food choices.</p> <p>R146's lunch meal ticket dated 3/19/24, indicated R146 would have ice cream, crumbled cottage cheese, tomato soup, soft shell pork carnitas, extra gravy on food and mashed potatoes with beef gravy.</p> <p>An observation on 3/19/24 at 12:31 p.m., R146 was lying in bed when licensed practical nurse (LPN)-A entered with R146's lunch tray. R146 was repositioned to eat lunch and LPN-A set up R146's meal tray. When R146 was asked what was for lunch R146 replied I don't know about to find out. LPN-A then removed the food cover and ensured R146 did not need anything else before leaving the room. R146 picked up the meal ticket and reviewed it. R126's tray had a soft-shell taco, beans, mashed potatoes and a light gravy and chicken noodle soup. R146 stated does this look like beef gravy .I hate chicken. They give me chicken every meal. R146 was frustrated with the meal and further stated I can't eat this food as I only have three teeth left. I tell them I want pastas, but it doesn't seem to matter. Review of R146's meal ticket listed R146 was supposed to have tomato soup and mashed potatoes with beef gravy, extra gravy on food, cottage cheese, and ice cream. However, R146's lunch tray was not the same.</p> <p>When interviewed on 3/18/24 at 1:57 p.m., R146 stated they were not a fan of chicken and liked pasta and carbohydrate like foods but there was not much of that. Furthermore, R146 stated they were not asked about food choices at meals.</p> <p>(continued on next page)</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>When interviewed on 3/19/24 at 1:38 p.m., nursing assistant (NA)-A stated residents attend a group meeting to make menu selections. If a resident was not able to go, the dietician reviewed the menu for selections. NA-A stated changes can be made at any time and given to the dietician to enter. NA-A further stated R146 had gotten weaker and no longer was able to walk. R146 remained in bed most of the time now as it was becoming difficult to get out of bed.</p> <p>When interviewed on 3/19/24 at 2:24 p.m., LPN-A stated R146 did not like the meal today and didn't really eat. Furthermore, LPN-A stated the dietary staff completed meal choices and orders for residents. LPN-A verified R126's meal ticket and lunch tray served did not match and stated if it was different, the kitchen must be out of the other items.</p> <p>When interviewed on 3/19/24 at 2:44 p.m., registered nurse (RN)- A stated residents have weekly menu selections on Wednesdays. Residents then go down and meet to review the menu for the upcoming week and make their choices. RN-A further stated if a resident did not go down, the dietician would review the menu and place their choices with the resident. RN-A stated likes or dislikes would be on the care plan to alert staff and assist in offering something else. RN-A verified no preferences had been included in R146's care plan.</p> <p>When interviewed on 3/19/24 at 4:15 p.m., dining service supervisor (DSS)-A stated meal tickets should be completed 2 days ahead of time but can be changed the day of as well. If a resident wanted to change something, nursing staff would let the dietician know as nursing staff cannot change the meal tickets. If the change was made at the time of the meal, all efforts were done to make the request happen. If a meal ticket and tray did not match, the server should be notified. Servers were expected to ensure the tickets match the tray and to correct or call to the kitchen if something was not available on the unit. DSS-A further stated resident preferences were coordinated with the dietician and was included in the meal plan.</p> <p>When interviewed on 3/20/24 at 7:40 a.m., dietician (D)-A stated residents meal preferences or likes/dislikes were assessed during the initial nutrition assessments and could be updated during future assessments. D-A stated residents were also informed of a menu section group that meets weekly and all are encouraged to attend. D-A further stated if residents did not attend the menu selection meeting, the choices may be gathered by family or nursing staff. If family or nursing staff were not able to complete, nursing staff would let the dietician know. If there had been no selections made, the meal tickets were generated by the list of dislikes in the computer. The meal ticket would automatically choose the other option if a disliked item was the main choice. D-A stated R146's meals have been difficult due to R146's dental issues and the food was not always been what R146 loves. D-A was aware of some dislikes with the food texture and was not aware of the meal ticket not matching what R146 was served or any other problems. D-A expected the tickets to match up and if not, servers or nursing should attempt to correct it. D-A stated R146's disliked food list was not given and reviewed at the last nutrition assessment and was aware of R146 requesting pasta. D-A further stated special requests could be passed along, but it was then up to the culinary team to make it work. D-A was not sure if R146 reviewed the menus in advance or if any special request for pasta had been made.</p> <p>The Director of Culinary Services was off and unavailable for interview.</p> <p>A facility policy regarding resident choices was requested however not received.</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925</p> <p>Based on interview and document review, the facility failed to ensure a voiced grievance of a missing electric toothbrush was acted upon timely to help facilitate prompt resolution for 1 of 1 resident (R187) who reported such item as missing with no follow-up.</p> <p>Findings include:</p> <p>R187's quarterly Minimum Data Set (MDS), dated [DATE], identified R187 had intact cognition and demonstrated no delusional behavior and/or thinking.</p> <p>R187's care plan, last reviewed 1/23/24, identified R187 was alert and oriented to person, place and time; and could become upset or frustrated . when I do not feel like I am being heard or when technology is not working in a way that I would like it to. The care plan lacked evidence R187 had delusional thinking or any associated behaviors.</p> <p>On 3/18/24 at 3:24 p.m., R187 was interviewed and expressed frustration as his electric toothbrush had gone missing the week prior. R187 stated he reported it to the nursing assistant (NA) and nurse working who seemed to more argue with him about ever having one instead of helping to look for it which R187 voiced was bullshit. R187 stated he still had not had any follow-up (i.e., plan to address it, replace it) about the missing item since reporting it to the nurse the week prior.</p> <p>When interviewed on 3/19/24 at 2:00 p.m., registered nurse (RN)-B stated they recalled R187 had reported to them a missing electric toothbrush the week prior and staff were unable to locate it with a quick search. RN-B stated they visited with another NA about it, too, who also had not seen the device. RN-B verified R187 had intact cognition and added R187 was pretty alert and orientated. RN-B explained when a missing item was reported, the staff should complete a green form and route it to the social worker. However, RN-B stated they did not do this as they were hopeful we would find it. RN-B stated they would put it on my list and act on it now (3/19/24). When questioned on expected timeframe for reporting missing items using the identified form, RN-B stated the right answer would be to complete the form and route it right away but reiterated they did not do such as they were hoping the device would be found in his room. RN-B stated the form, had it been completed, would have likely been routed to social worker (SW)-A but added they were likely unaware of the missing item as I'd never spoke to her [SW-A] about it.</p> <p>R187's medical record was reviewed and lacked evidence the reported missing electric toothbrush had been acted upon including what, if any, actions were taken to locate the item or report it as missing to the management team for resolution. In addition, no evidence was provided to demonstrate the voiced grievance of a missing item had been acted upon to determine what, if any, follow-up actions were wanted or needed to resolve the issue for R187.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/19/24 at 3:59 p.m., SW-A was interviewed and verified they helped cover R187's unit. SW-A explained a reported missing item should have a corresponding form completed which is then routed onward to be addressed. SW-A stated the timeliness of a response kind of varies adding, I don't know there's a set parameter. However, SW-A acknowledged, The sooner the better is just good practice. SW-A verified they were unaware R187 had reported a missing electric toothbrush and expressed, had they been told or received a completed form with the item listed, they would have followed up with it. SW-A stated it was important to ensure missing items were acted upon as the items belong to that person and it's their home and their belongings.</p> <p>A provided Settlement of Claims - Not Exceeding \$7,000 policy, dated 6/2023, identified the person reporting the missing item would be provided a Claim Report and Demand form upon request and if they've suffered personal injury, negligent loss, damage or destruction of property. The form would then be routed and reviewed via designated staff members. The policy included an attached, Resident Property Damage/Loss Form, which outlined it was to be completed . by the first staff person [<u>underlined</u>] to be notified of missing resident property, then the safety officer and immediate supervisor was to be notified.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925</p> <p>Based on interview and document review, the facility failed to ensure assessed and care-planned interventions for skin monitoring were consistently implemented to reduce the risk of complication (i.e., infection, breakdown) for 1 of 3 residents (R246) reviewed for non-pressure skin impairments.</p> <p>Findings include:</p> <p>R246's quarterly Minimum Data Set (MDS), dated [DATE], identified R246 had intact cognition and needed substantial assistance with bathing or showering. Further, the MDS outlined R246 was at risk for pressure ulcer development and had current moisture-associated skin damage (MASD) present.</p> <p>On 3/18/24 at 3:01 p.m., R246 was interviewed and expressed concern with a rash on his bilateral legs. R246 stated the rash seemed to come and go and described it as really bumpy and just itchy. R246 stated the staff (i.e., nursing assistants) were applying lotion to his legs but not everyday. R246 stated the nurses, to his knowledge, were aware of it but was unsure what, if any, monitoring of it was being done.</p> <p>R246's care plan, last reviewed 1/19/24, identified R246 was scheduled for Thursday evening bathing and required assistance to complete it. The care plan outlined R246 had potential for skin breakdown and a history of open areas adding, [R246] has fragile skin and has a history of bruises. The care plan listed a goal which read, Skin will be free from s/s [signs, symptoms] of infection through next review period, along with several interventions including, Licensed nurse to assess/document skin condition weekly per facility protocol.</p> <p>R246's Treatment Administration Record (TAR), dated 2/2024 to 3/2024, identified an intervention which read, Weekly: Open and complete Weekly Skin Assessments on bath day ., with a listed start date of 11/30/23. This had a refusal marked on 3/7/24, and the intervention was signed as completed on 3/14/24; however, R246's last completed Weekly Skin Check (under the ASSMNTS section) was dated 2/22/24 (nearly a month prior) which outlined R246 had, No new findings noted. There were no other recorded skin checks, or refusals of one, identified since 2/22/24.</p> <p>When interviewed on 3/19/24 at 2:03 p.m., registered nurse (RN)-B explained R246 had current moisture-associated skin impairment along his abdominal or groin folds and, as a result, staff were applying a fabric-type, moisture wicking treatment to them. RN-B explained during bath day the residents, including R246, were to have a weekly skin check completed and documented in the medical record. RN-B verified this was done using the 'Weekly Skin Check' form in the EMR, and reviewed R246's medical record with the surveyor present. RN-B acknowledged the last completed form was on 2/22/24, and expressed R246 had potentially refused bathing but was unsure adding any rationale for not completing the weekly skin evaluation should have been outlined in the medical record. RN-B stated they were unsure exactly where the facility wanted refusals, if any, recorded in the medical record and expressed the skin checks might get dropped [not done] if the nurses weren't telling the management R246 had been, potentially, refusing them.</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R246's medical record was reviewed and lacked a completed Weekly Skin Check for 2/29/24 and 3/14/24, despite being scheduled for bathing on these days. Further, there was no evidence R246 had been offered and refused a skin check on these dates.</p> <p>On 3/20/24 at 8:26 a.m., registered nurse manager (RN)-A was interviewed and verified they had reviewed R246's medical record. RN-A explained there was no documentation to support a 'Weekly Skin Check' had been completed or attempted on 2/29/24, and the nurse had signed off as completing the skin check on 3/14/24 but there was none located so, as a result, RN-A stated they have to follow up with her. RN-A stated they felt R246's skin was still being looked at on regular intervals due to his other various treatments (i.e., foot checks, abdominal fold treatments) but verified the weekly skin checks should be done and explained they helped to catch un-noticed bruises or un-noticed concerns. RN-A stated the nursing leadership had identified the skin checks were not always getting completed so, as a result, they had developed education and were going to complete it but had to delay it due to survey arrival. RN-A stated they would get the needed education done as soon as possible and added the weekly skin checks were important as they helped ensure residents' were not coming down with an infection or skin concern.</p> <p>A provided Resident Assessment - Care Plan policy, dated 2/2023, identified all residents would have a care plan developed from the comprehensive assessment process. The policy outlined, The care plan will be implemented to assist the resident to attain the highest practicable level of functionality and wellness and will promote and support the resident's care choices .</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44647</p> <p>Based on interview and document review the facility failed to comprehensively assess and develop a program to maintain bowel continence was implemented for 1 of 1 residents (R146) reviewed for bowel management.</p> <p>Findings include:</p> <p>R146's significant change Minimum Data Set (MDS) dated [DATE], indicated R146 was cognitively intact and had diagnoses of Parkinson's disease, diabetes, and depression. Furthermore, R146's MDS indicated R146 was dependent on toileting and always continent of bowel.</p> <p>R146's urinary incontinence care area assessment (CAA) dated 2/28/24, indicated R146 was admitted to hospice services and required physical assist with all cares and was incontinent of bowel.</p> <p>R146's bladder and bowel assessment dated [DATE], indicated R146 was continent of bowel, was able to turn on call light when needing to have a bowel movement, wore an incontinence brief, and required 1-2 staff and a transfer belt to toilet. Furthermore, R146's assessment lacked a 3-day bowel assessment summary.</p> <p>R146's care plan revised 3/4/24, indicated R146 was incontinent of bowel with frequent continent episodes and required physical assist for toileting. Interventions indicated R146 was able to call for assistance when needed and wore an incontinent product. Furthermore, a revision on 3/19/24, indicated R146 required assist of 2 for a check and change.</p> <p>When interviewed on 3/18/24 at 1:53 p.m., R146 stated I have to poop in my pants and am unable to use a toilet as a mechanical lift was needed. R146 had not been offered a bed pan and was not aware of any bowel program options.</p> <p>During a follow up interview on 3/19/24 at 3:42 p.m., R146 verified he was able to tell when he had to have a bowel movement and had not been offered anything like a bedpan. R146 stated having a bowel movement in the brief bothered him, but if he didn't want to go to the bathroom, he wasn't aware of any other choices.</p> <p>When interviewed on 3/19/24 at 1:38 p.m., nursing assistant (NA)-A stated R146 was continent of both bladder and bowel. NA-A further stated R146 wants independence but can't get out of bed like they used to. NA-A stated R146 will let staff know when he had a bowel movement and needed to be changed.</p> <p>When interviewed on 3/19/24 at 2:24 p.m., licensed practical nurse (LPN)-A stated R146 used to walk independently. With a recent decline, it was harder for R146 to get out of bed. LPN-A stated R146 was normally continent of bowels but with recent changes, usually did not want to get out of bed. R146 let staff know when he had gone and needed to be changed. LPN-A was not aware of any concerns R146 had with going in a brief and further stated bedpans were not used in the facility.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>When interviewed on 3/19/24 at 2:44 p.m., registered nurse (RN)-A stated R146 was more incontinent now and did not want to get up as often. RN-A further stated R146's care plan had just been updated to a check and change intervention (staff were directed to check for incontinence and change as needed). RN-A further stated staff should offer toileting and assistance with R146 as wanted. RN-A further stated bed pans were not commonly used in the facility and was not aware if one had been offered or if R146 would even want to use a bedpan.</p> <p>When interviewed on 3/20/24 at 12:18 p.m., the Director of Nursing (DON) stated staff were expected to assess continence accurately and to revise interventions to reflect individualized needs of the residents and this would include bedpan or commode use. Furthermore, DON stated if residents are continent of bowels, staff were expected to provide care to maintain continence levels.</p> <p>A facility policy titled Bowel and Bladder Management Program dated 6/22/23, directed staff to assess residents for bowel and bladder function based on cognitive and physical limitations and current toileting patterns/abilities and a toileting care plan will be individualized to maintain the resident's highest level of function with toileting and independence.</p>		

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 03/21/2024
NAME OF PROVIDER OR SUPPLIER MN Veterans Home Minneapolis		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely, quality laboratory services/tests to meet the needs of residents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44647</p> <p>Based on interview and document review, the facility failed to ensure a provider order for a throat culture had been obtained in a timely manner for 1 of 1 residents (R124) reviewed for infection.</p> <p>Findings include:</p> <p>R124's quarterly Minimum Data Set (MDS) dated [DATE], indicated R124 was cognitively intact and had diagnoses of heart failure and depression.</p> <p>R124's provider order dated 3/16/24, indicated R124 required a STAT (immediate) throat culture to test for streptococcal bacteria (bacteria found in strep throat).</p> <p>A review of R124's progress notes indicated the following:</p> <ul style="list-style-type: none"> -on 3/16/24 at 5:30 p.m., R124 had complained of a sore throat since the morning and was painful when swallowing fluids. R124's provider was notified, and an order was received for throat culture to rule out strep throat. -on 3/16/24 at 8:26 p.m., R124's throat culture was obtained and waiting pick up from the lab. -on 3/17/24 at 2:44 p.m. R124's throat culture results were pending. -on 3/20/24 at 10:49 a.m., the lab was called to inquire about R124's throat culture. The throat culture order had been canceled due to an error with labeling of the specimen. Provider was notified and no new orders obtained. R124's throat was feeling better and pain was likely from an abscessed tooth. No repeat test was needed. <p>When interviewed on 3/18/24 at 1:24 p.m., R124 stated they recently had an infected tooth pulled last week and now has strep throat. Furthermore, R124 stated their throat still hurts and mouth does too. R124 verified he had been on antibiotics since the weekend for the tooth infection.</p> <p>When interviewed on 3/20/24 at 8:21 p.m., licensed practical nurse (LPN)-B stated the electronic medical record flags when labs were result. LPN-B stated different labs will take different amounts of time to result. LPN-B verified there had not been a result of R124's throat culture. LPN-B asked registered nurse (RN)-F about the pending culture and stated RN-F was calling the lab determine where the result was as it should have been back. LPN-B further stated there was no communication from the night shift about R124's pending lab work. Furthermore, the test results were not communicated in the red communication book where LPN-B stated pending labs were usually communicated.</p> <p>When interviewed on 3/20/24 at 11:21 a.m., RN-F stated the lab was called to check on R124's throat culture results. RN-F stated there was a problem with the label and the lab canceled the test. RN-F stated lab test results vary depending on what the test was, so timelines will vary. RN-F stated, staff receive notification from the medical record and providers usually watch for results as well. RN-F stated the lab does not call when orders were canceled and when something was missed there wasn't any notification from lab and staff had to be aware of pending results.</p> <p>(continued on next page)</p>		

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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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<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>When interviewed on 3/20/24 at 12:18 p.m., the director of nursing (DON) verified the lab would not notify the facility if a specimen was not able to be processed. Nursing staff were expected to follow the communication process of shift-to-shift report between floor nurses and unit charge nurses. DON further stated there is a red binder that was used to document and track lab tests that should be utilized as well. If lab results are not seen within 48 hours, the nurse should contact the lab to check the status.</p> <p>A facility procedure/process for lab collection was requested however was not received.</p> <p>33925</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49034</p> <p>Based on interview and document review, the facility failed to ensure recommended pneumococcal vaccinations, as outlined by the Centers for Disease Control (CDC), were offered and/or provided to reduce the risk of severe disease for 1 of 5 residents (R148) reviewed for immunizations. In addition, the facility failed to ensure 5 of 5 residents (R24, R48, R49, R148, R243) medical records included documentation that the resident or resident representative was provided education regarding influenza immunization benefits and potential side effects.</p> <p>Findings include:</p> <p>Pneumococcal Vaccination</p> <p>A CDC Pneumococcal Vaccine Timing for Adults chart dated 3/15/2023, identified various tables when each (or all) of the pneumococcal vaccinations should be obtained for adults [AGE] years and older. The chart indicated when a resident had received the Pneumococcal 13-valent Conjugate Vaccine (PCV13) at any age, greater or equal to one year ago, they should receive the pneumococcal polysaccharide vaccine 23 (PPSV23) or the pneumococcal 20-valent Conjugate Vaccine (PCV20).</p> <p>R148's quarterly Minimum Data Set (MDS) dated [DATE], indicated R148 had intact cognition, was [AGE] years old at time of assessment, and was diagnosed with Parkinson's disease, depression, and chronic obstructive pulmonary disease (COPD- incurable lung disease causing breathlessness, frequent coughing, and chest tightness).</p> <p>R148's immunization record dated 11/8/23, indicated that R44 had received the PCV13 on 12/28/16. The record did not indicate that R44 had received or been offered a pneumococcal PCV20 or PPSV23 dose. The record indicated R148 had received the influenza vaccination on 10/25/23 but did not indicate that education regarding benefits and potential side effects had been completed.</p> <p>During an interview on 3/20/24 at 9:43 a.m., R148 stated that he did not recall anyone discussing an updated pneumococcal vaccination with him or ever receiving one, but if one was available, he would have wanted it. R148 stated that he did not recall receiving any education regarding the influenza vaccination.</p> <p>Influenza Education</p> <p>R24's significant change MDS dated [DATE], indicated R24 had intact cognition with a diagnosis of kidney disease, diabetes, and a heart dysrhythmia.</p> <p>R24's immunization record dated 10/25/23, indicated R24 had received the influenza vaccination but did not indicate education regarding benefits and potential side effects had been completed.</p> <p>R48's quarterly MDS dated [DATE], indicated R48 had intact cognition with dementia, depression, and anxiety.</p> <p>(continued on next page)</p>		

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<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R48's immunization record dated 10/25/23, indicated R48 had received the influenza vaccination but did not indicate education regarding benefits and potential side effects had been completed.</p> <p>R49's quarterly MDS dated [DATE], indicated R49 had moderate cognitive impairment and was diagnosed with heart failure, diabetes, and dementia.</p> <p>R49's immunization record dated 10/25/23, indicated R49 had received the influenza vaccination but did not indicate education regarding benefits and potential side effects had been completed.</p> <p>R243's quarterly MDS dated [DATE], indicated R243 had severely impaired cognition with a diagnosis of Alzheimer's disease and a seizure disorder.</p> <p>R243's immunization record dated 10/25/23, indicated R243 had received the influenza vaccination but did not indicate education regarding benefits and potential side effects had been completed.</p> <p>During interview and document review on 3/20/24 at 1:42 p.m., the medical records for R24, R48, R49, R148, and R243 were reviewed with the infection preventionist (IP) and documentation indicating education had been completed with the resident or resident representative regarding the influenza vaccine was not found. The IP stated that when a resident had a resident representative, the facility would mail influenza vaccination education and a consent refusal form to that representative, but it was not part of their practice to document this occurrence in the medical record. The IP stated that she expected the nurses who were administering the vaccination to educate the residents on the benefits and potential side effects of the influenza vaccination but after reviewing the medical record, she was unsure if this was occurring. The IP stated that after reviewing R148's vaccination record, it looked like his pneumococcal vaccinations were not up to date and she did not see that the vaccination had been offered or refused, so it must have been missed but she would look into it further.</p> <p>During an interview on 3/20/24 at 2:23 p.m., the DON stated that a Vaccine Information Statement (VIS) was sent via certified mail to the family members every flu season along with a consent refusal form. If the representative did not consent to influenza vaccination, they would mail back the refusal form and that was scanned into the medical record. The DON was unsure if education regarding influenza vaccination was documented in the medical record if the vaccination was given. The DON stated he thought this same packet was given to residents who were their own representative every flu season but was unsure where this was documented. Any documentation in the medication record indicating education had been given regarding the influenza vaccination was requested from the DON at this time. The DON stated that it was important the residents receive this education so they can have informed decision making and maintained dignity.</p> <p>No further documentation regarding R24, R48, R49, R148, R243 or their representatives receiving influenza vaccination education was received from the facility. Documentation regarding R148 having been offered, refused, or received an updated pneumococcal vaccination was not received from the facility.</p> <p>The facility Vaccines for Residents policy dated 2/1/23, indicated the facility will ensure adequate vaccine coverage for each resident. The policy indicated that the VIS would be provided to the resident, the residents representative, and the residents family prior to the vaccination.</p>		