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	07/09/2026

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

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and document review the facility failed to monitor dishwasher temperatures in the main kitchen. This had the potential to increase the risk of food borne illness and affect 293 residents who received food from dietary services. Findings include: The dishwasher temperature log for July of 2026, indicated the required temperatures were 160 degrees (Fahrenheit) for the wash cycle and 180 degrees for the final rinse cycle. It further indicated to report low temperatures to the supervisor immediately which was also highlighted in yellow. The following temperatures and dates were recorded on the log and did not meet the requirements for safe dishwashing temperatures: -7/1/26 wash cycle for supper 154 degrees-7/2/26 wash cycle during lunch 157 degrees-7/4/26 final rinse cycle during dinner 173 degrees-7/5/26 wash cycle for supper 150 degrees, final rinse cycle 179 degrees-7/6/26 wash cycle during breakfast 158 degrees-7/7/26 wash cycle during lunch 159 degrees-7/8/26 wash cycle during breakfast 150 degrees and final rinse cycle 174 degrees-7/9/26 final rinse cycle for lunch 174 degrees During observation with dining supervisor and food service unit supervisor present on 7/9/26 at 10:57 a.m., the dish machine was observed to run, with wash temperature reaching 143 degrees and the final rinse at 177 degrees. The machine was run again and reached a wash temperature of 141 degrees, and the rinse temperature did not register. During interview on 7/9/26 at 11:12 a.m. the dining supervisor stated staff had not notified him regarding low dishwasher temperatures. During interview on 7/9/26 at 11:17 a.m., the food service unit supervisor verified the temperatures recorded on the log did not reach the appropriate temperature and further stated staff had not notified her about it. During interview on 7/9/26 at 11:23 a.m., food service worker (FSW)-A stated when they do the dishes, they look at the temperature for the wash cycle which should be 170 degrees and then they look at the rinse cycle (because that hotter) which should be 180 degrees. Then they record it on the log. If the temperature for the wash and rinse cycle didn't reach 170 and 180 degrees, they would let the supervisor know. During interview on 7/9/26 at 11:27 a.m., FSW-B stated when they are doing the dishes, they watch to see how hot the temperature gets for the wash and rinse cycles and then they record it on a log. DA- further stated the wash cycle should be between 164-167 degrees, and the rinse cycle should be between 182-187 degrees. If it's not, they would let their supervisor know. During interview on 7/9/26 at 12:07 p.m., the administrator stated the food service staff should be writing the dishwasher temperatures on a log which is located on the dishwashers. It should be checked daily to ensure the temperatures are in within range (written on the log). If the temperatures are out of range, they should be notifying the supervisor. The facility policy regarding dishwasher temperatures dated 11/9/24, indicated the following: The dish machine temperatures (wash, dual wash, and final rinse) will be monitored and recorded three times daily. The employee responsible must record the temperatures and initial the log to confirm completion.If any recorded temperatures do not meet the manufacturer's specifications, the issue must be reported immediately to a supervisor, Director, or Administrator.The contracted service vendor will be contacted to address the malfunction.The supervisor or person in charge will decide whether the dish machine can continue to be used or if manual dishwashing is required. If a low-temperature chemical sanitizer is available, the machine may still be used, as the (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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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	product is designed to sanitize at lower temperatures.Once the contracted vendor has completed the repairs, they will notify staff when the dish machine is ready for use, allowing a return to normal operation from manual handwashing if needed.

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure as-needed (PRN) psychotropic medication orders had a defined stop date and were limited to 14 days without a documented rationale for extension for 1 of 5 residents (R279) reviewed for unnecessary medications. Findings include: R279's quarterly Minimum Data Set (MDS) dated [DATE], indicated R279 was severely cognitively impaired, and had diagnoses of non-traumatic brain dysfunction, Alzheimer's disease, non-Alzheimer's dementia, anxiety, and depression. R279 had verbal behavioral symptoms (such as threatening or screaming) directed toward others, behavioral symptoms not directed at others (such as disruptive sounds, pacing, ect.), and wandering. R237 used a wheelchair for mobility. R279's Mood/Behavior care plan focus revised 6/11/26, directed staff to administer prescribed medications per MD/NP orders, monitor for side effects of medications, notify provider with concerns, and refer to behavioral services as needed. R279's Order Review History Report dated 7/7/26, included Haloperidol (an antipsychotic) Oral Tablet 1 milligram (mg), give 1 tablet by mouth every 4 hours as needed for 14 days starting 4/28/2026. The order lacked an order end date. R279's Haloperidol Order Details dated 4/28/26, identified the end date as Indefinite. R279's Medication Administration Record (MAR) dated 6/1/26 - 6/30/26, indicated R279 received PRN Haloperidol 16 times during the month. R279's MAR dated 7/1/26 - 7/7/26, indicated R279 received PRN Haloperidol one time during the first six days of the month. During interview on 7/7/26 at 3:02 p.m., nursing assistant (NA)-C stated sometimes R279 became violent with staff during cares and sometimes they needed to call the nurse to help with de-escalation. During interview on 7/7/26 at 3:10 p.m., licensed practical nurse (LPN)-B stated staff tried to redirect and distract R279 with coloring or other things to do when he demonstrated behaviors, and gave him PRN Haloperidol if the redirection did not work and when the behaviors were disturbing other residents. LPN-B stated it was not very often, one or two times a shift. Upon review of R279's medical record, LPN-B verified the order for Haloperidol was for 14 days, however, was entered as indefinite and had been mistakenly given far beyond the 14-day end date. During interview on 7/7/26 at 3:19 p.m., unit manager registered nurse (RN)-H stated PRN psychotropic medications should have an end date and were limited to 14 days. If PRN psychotropic medications were being used on a frequent or regular basis, they would ask the provider to have them scheduled. Upon review of R279's medical record, RN-H confirmed R279's Haloperidol order did not have an end date and had been given many times after the order should have been discontinued. During interview on 7/7/26 at 5:15 p.m., the director of nursing (DON) stated PRN psychotropic medications should have an end date and were expected to be re-evaluated by a provider after 14 days. The provider could then continue, discontinue, or change the order based on the resident's needs. The facility Psychotropic Medications policy dated 4/11/25, indicated PRN orders for psychotropic and antipsychotic medication are limited to 14 days. 1. If the prescriber believes it appropriate to extend the order for the psychotropic medication, excluding antipsychotics, the provider must document the clinical rationale for the extended period in the resident's medical record.2. PRN orders for antipsychotic medications are only effective for 14 days. If the provider wants to write a new or another order, they must first evaluate the resident to determine if the new order for the PRN antipsychotic medication is appropriate and document the evaluation in the resident's medical record.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to follow doctor's orders for 1 of 1 resident (R87) reviewed who required daily weights. In addition, the facility failed to ensure services were coordinated with the hospice agency for 1 of 1 resident (R265) reviewed who received hospice services. Finding include: R87's significant change Minimum Data Set (MDS) dated [DATE], indicated severely impaired cognition and diagnoses of congestive heart failure (CHF), chronic kidney disease, and dementia. R87's physician's orders dated 5/18/26, indicated daily weight for CHF, in the morning and to update the provider if the resident gains +2 pounds (lbs.) per day or +5 lbs. per week R87's treatment administration record (TAR) indicated the following weights: -6/1/26 229.5 lbs. -6/2/26 236.2 lbs. R87 gained 6.7 lbs. between 6/1/26 and 6/2/26. R87's care plan dated 6/22/26, indicated R87 had CHF and indicated the following interventions: -Apply oxygen 2-5 liters per minute for desaturation, titrate to comfort via nasal cannula for CHF. Apply at bedtime per order and as needed (PRN) during waking hours for comfort. -Check breath sounds and monitor/document for labored breathing. Monitor/document for the use of accessory muscles while breathing. -Give cardiac medications as ordered. -Monitor Lab work: potassium, sodium, blood urea nitrogen (BUN), Creatinine -Monitor/document/report to medical doctor (MD) PRN any signs or symptoms of CHF: dependent edema of legs and feet, periorbital edema, shortness of breath upon exertion, cool skin, dry cough, distended neck veins, weakness, weight gain unrelated to intake, crackles and wheezes upon auscultation of the lungs, orthopnea, weakness and/or fatigue, increased heart rate (Tachycardia) lethargy and disorientation.-Monitor/document/report to MD PRN any signs/symptoms of digitalis toxicity: fatigue, muscle weakness, anorexia, nausea, yellow halos around objects. -Monitor/document/report to MD PRN any signs/symptoms of hypokalemia in residents receiving diuretic therapy: fatigue, muscle, weakness, diminished appetite, nausea and vomiting and dysrhythmias, Monitor potassium levels. R87's progress notes for the months of May and June of 2026 lacked indication the provider was notified of a weight gain between 6/1/26 and 6/2/26. During interview on 7/7/26 at 2:15 p.m., registered nurse (RN)-E verified R87 had gained 6.7 lbs. between 6/1/26 and 6/2/26 and there was no documentation the provider was notified and should have been. During interview on 7/7/26 at 2:25 p.m., RN-F stated the provider should have been notified when R87 had a weight gain of 6.7 lbs. from 6/1/26 to 6/2/26. RN-F further stated there also should have been a progress note so that other staff are aware the provider had been notified. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 7/9/26 at RN-D stated the provider should have been notified when R87 had a weight gain of 6.7 lbs. from 6/1/26 to 2/2/26. RN-D further stated, each time R87 had a weight gain the nurses were expected to notify the provider and document in a progress note to let the other nurses know what happened, the steps they took and how they followed through. This was important because a resident with CHF requires their weight to be monitored in order to prevent a fluid imbalance/fluid overload which could then cause shortness of breath (SOB) and problems with endurance. It was also important to monitor weights and labs to ensure the medications R87 was taking were working and they were the right ones. During interview on 7/9/26 at 1:05 p.m. The director of nursing (DON) stated nurses should be following doctor's orders. A facility policy on following doctor's orders was requested but not received. R265 R265's quarterly Minimum Data Set (MDS) dated [DATE] identified R265 with impaired cognition, dependent on staff for all cares including eating, toileting, personal hygiene, and dressing. R265 had diagnoses of Parkinsons, dementia, and depression and was on hospice (end of life) services. During review of R265's hospice binder on nursing station on 7/7/26 at 9:10 a.m., the calendar for July 2026 identified one home health aide visit on July 1, 2026, and social services visit on July 31, 2026. July 5-30 was left blank of visit notes from nursing, home health aide, social services, chaplain services, massage therapy services, and music therapy services. In addition, the hospice plan of care (POC) dated 7/1/26 to 8/29/26 that was in the binder identified start of hospice services on 1/2/26 and included diagnoses, allergies, activity level, functional limitations, mental status, psychosocial status, safety measures, supplies, nutrition, medications, care plan goals and interventions for home health aide, chaplain, massage therapy, social services, music therapy, and nursing. The POC failed to identify visit orders for the services for nursing, home health aide, chaplain, massage therapy, social services, and music therapy. During interview with registered nurse (RN)-A on 7/7/26 at 1:21 p.m., RN-A stated she was not aware of when hospice visited R265 and had no knowledge of what the visit orders were. RN-A stated expectation of R265's hospice binder to have an updated calendar and visit orders. During interview with health services technician (HST)-A on 7/7/26 at 1:26 p.m., stated, we do not know when and who comes from hospice. There is no calendar or notice to staff here on who is coming and when. In addition, HST-A stated he was not aware of visit notes in R265's hospice binder for updates and information. HST-A stated missing calendar and visit orders was not ideal. During interview with RN-B on 7/7/26 at 1:39 p.m., RN-B reviewed R265's hospice binder and verified calendar for July 2026 missed visits for month from July 5-30, 2026. RN-B stated he believed the hospice nurse visited once a week and the hospice home health aide visited once per week. RN-B also verified R265's POC failed to identify visit orders for the services for nursing, home health aide, chaplain, massage therapy, social services, and music therapy. RN-B stated importance of facility and hospice services to collaborate and communicate regarding visit orders and update the calendar, so facility would be aware of what services were scheduled and when. During interview with hospice nurse RN-C on 7/7/26 at 2:31 p.m., RN-C stated she was R265's nurse (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	case manager for hospice. RN-C verified the July 2026 calendar and POC, are not updated at this time. RN-C stated the home health aide was scheduled twice per week to visit R265 and nursing visits once per week. RN-C verified information facility had was incomplete. RN-C stated it was important for facility to have an accurate calendar of visits and updated POC with visit orders. Staff there would not know who is coming and when by looking at an empty calendar and incomplete POC. During interview with director of nursing (DON) on 7/9/26 at 9:03 a.m., DON stated expectation of hospice binders to include updated and accurate monthly calendars and plan of care to include visit orders for each discipline. DON reviewed R265's July 2026 calendar and POC dated 7/1/26 and verified they were both incomplete. DON stated importance of hospice and facility to collaborate and communicate regarding visit orders. Hospice contract with effective date of April 29, 2026, identified the POC to include details concerning frequency of hospice services and details regarding which provider is responsible for performing the services. Facility policy titled End of life, Hospice, and Comfort Care Services, revised 12/04/2024, identified, The hospice and MVH [Minnesota Veterans Home] will ensure that each residents' written plan of care includes the most recent hospice plan of care, intervention and services furnished.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure enhanced barrier precautions (EBP) were followed for 1 of 1 resident (R11) reviewed for EBP.Findings include:R11's quarterly Minimum Assessment Data (MDS) dated [DATE], indicated R11 had moderate cognitive impairment, was incontinent of bowel and bladder, required moderate assistance to transfer to the toilet, and was dependent on staff for toileting hygiene. R11's Clinical Diagnosis form dated 7/9/26 indicated a diagnosis of carrier of methicillin resistant staphylococcus aureus (MRSA). R11's Clinical Profile dated 7/9/26 indicated R11 was on EBP.R11's care plan dated 7/9/26, included a care plan focused on EBP. The EBP care plan indicated R11 required enhanced barrier precautions due to history/diagnosis of MRSA in nares and directed staff to wear gown and gloves when in room providing personal cares.During observation on 7/9/26 at 11:07 a.m., a sign on R11's door indicated he was on EBP. The sign directed staff to wear a gown and gloves when aiding with transfers and personal cares. R11 walked into his room followed by a health support technician (HST)-B. HST-B directed R11 to the bathroom. HST-B assisted R11 to use the toilet and changed his incontinent brief. HST-B wore gloves but did not wear a gown.During interview on 7/9/26 at 11:12 a.m., HST-B stated he was rushing and didn't have time to put on a gown. HST-B said he needed to wear gown and gloves to assist R11 with personal cares. HST-B stated R11 was on infection precautions because R11 had a skin rash before. HST-B stated he needed to wear a gown to protect his clothes from R11's urine. During interview on 7/9/26 at 11:03 a.m., licensed practical nurse (LPN)-A stated R11 was on EBP due to MRSA on the nose. LPN-A stated the sign on R11's door directed staff to wear gloves and gowns to provide personal cares. LPN-A stated the nursing staff received annual infection control training, and as needed whenever they had a new resident with an infection.During interview on 7/0/26 at 11:12 a.m., senior nurse/registered nurse RN-G stated the EBP signs were in place to alert staff of some kind of communicable disease. RN-G stated the EBP signs directed staff to wear gown and gloves when personal cares were provided to residents on EBP. RN-G stated all the staff received annual infection control training and as needed.During interview on 7/9/26 at 3:42 p.m., director of nursing (DON) stated he expected staff to follow the instructions on the signs. DON said the EBP signs had pictograms and indicated what personal protection equipment (EPP) the staff needed to wear when they were in contact with the residents. DON stated the facility provided a PPE bin containing all necessary equipment for every resident. DON added that the essence of an EBP sign is to identify residents that had an infection or were susceptible to infections and prevent infection from being transmitted to other residents. Facility's policy titled Infection Prevention and Control Program dated 4/22/25, indicated EBP is an intervention designed to reduce transmission of multidrug-resistant organisms during high contact resident care activities in which opportunities exist for the transfer of MDROs to staff hands and clothing. EBP, in conjunction with standard precautions, includes staff use of gowns and gloves during high contact resident care activities.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure that recommended pneumococcal vaccinations were offered and/or that shared clinical decision-making regarding pneumococcal vaccinations occurred, as outlined by the Centers for Disease Control (CDC), to reduce the risk of severe disease for 1 of 5 residents (R11) reviewed for immunizations.Findings include:A CDC Pneumococcal Vaccine Timing for Adults chart dated 3/2025, included a table identifying when each (or all) of the pneumococcal vaccinations should be obtained for adults 50 years and older. The chart indicated that when a resident had received the 13-valent pneumococcal conjugate vaccine (PCV13) at any age and the pneumococcal polysaccharide vaccine 23 (PPSV23) at greater than 65 years, the resident and provider may choose to administer the 20-valent pneumococcal conjugate vaccine (PCV20) or the 21-valent pneumococcal conjugate vaccine (PCV21). R11's quarterly Minimum Data Set (MDS) dated [DATE], indicated R11 was [AGE] years old at the time of assessment, had moderately impaired cognition, and was diagnosed with kidney disease, dementia, and diabetes. R11's Resident Vaccinations record dated 10/30/25, indicated R11 had received the PPSV23 on 4/15/20 (was greater than [AGE] years old) and the PCV13 on 4/11/19. The record indicated R11 had refused pneumovax dose 1 on 1/10/13. R11's medical record was reviewed and did not indicate shared clinical decision-making had occurred or the PCV20/21 had been offered or administered to R11.During an interview on 7/9/26 at 8:26 a.m., the infection preventionist (IP, a registered nurse) confirmed she had reviewed R11's medical record and stated that R11 should have been offered an additional pneumococcal vaccination. The IP stated she did not see that this had occurred before the survey start. The facility Vaccine for Residents policy dated 4/22/25, indicated vaccinations would be offered to residents according to the current CDC guidance.