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	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Minnesota Veterans Home - Silver Bay	56 Outer Drive Silver Bay, MN 55614

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to ensure medications weren't left at a resident bedside when the resident was assessed to be unable to self-administer medications. This affected 1 of 1 resident (R41) reviewed for self-administration of medications.Findings include: R41's quarterly Minimum Data Set (MDS) dated [DATE] indicated R41 was cognitively intact. Diagnoses included renal insufficiency, anxiety, and depression R41's Provider Order Summary Report undated, lacked orders to keep medications at bedside. R41's care plan undated, lacked information related to self-administration of medications. R41's Self Administration of Medications &/or Treatments (SAM) dated 3/20/26 indicated R41 did not want to self-administer medications. The SAM also indicated R41 was no longer able to self administration. During an observation on 4/13/26 at 3:45 p.m., two white pills what R41 stated were nicotine throat lozenges were on the bedside table. There were no staff in the room at that time. During an observation on 4/14/26 at 11:10 a.m., two nicotine throat lozenges were again observed on the bedside table and there were no staff present in the room. During an interview on 4/14/26 at 11:12 a.m., trained medication assistant (TMA)-A stated she very rarely leaves medications at bedside. I am not sure what all needs to be in place to be able to keep medications at bedside when staff are not present. TMA-A confirmed R41 had medication left at beside and confirmed they were nicotine throat lozenges. During an interview on 4/14/26 at 11:16 a.m., registered nurse (RN)-A state a SAM assessment and order needed to be in place before medications could be left at bedside so the resident could self-administer.During an interview on 4/16/26 at 7:58 a.m., the director of nursing (DON) stated the SAM assessment needed to be in place and indicate the resident wants to self-administer and is able to self-administer before medications could be left at bedside. An expectation was for staff to confirm the appropriate information was confirmed before medications were left at bedside.Facility policy Self Administration of Medications-Skilled Nursing last revised 2/27/25, indicated a comprehensive assessment would be completed to make sure the resident wanted to, and had the capability to self-administer medications and keep medications at bedside.

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and document review, the facility failed to report an allegation of staff on resident physical abuse within two hours to the State Agency (SA) for 1 of 4 residents (R54) reviewed for abuse. Findings include:Facility incident report dated 6/7/25, identified on the evening of 6/6/25 at approximately 8:00 p.m., R54 was handled roughly by a staff member, coming in contact with R54's left hand causing injury and pain.R54's progress note dated 6/6/25 at 10:39 p.m., identified staff called to room to assist with resident. Resident complained a nurse assistant (NA) in a not gentle manner grabbed the left hand and caused pain and injury.During an interview on 4/15/26 at 2:18 p.m., registered nurse (RN)-C stated R54 reported to her on 6/6/25 around 8:00 p.m., an NA had grabbed his left hand roughly and had caused pain and possible new bruising to the left hand. RN-C could not remember if she notified anybody right away about the concern of abuse.During an interview on 4/16/26 at 7:30 a.m., the infection preventionist (IP) stated she was working as the charge nurse on day shift on 6/7/25. The day nurse had made her aware of the complaint around 10:15 a.m., and that is when it was reported to the SA.Facility policy Vulnerable Adult-Resident Protection Plan dated 6/22/23, indicated all allegations of abuse, neglect, exploitation or mistreatment would be reported no later than two hours after the allegation was made.

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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 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 provider orders and administer medications as ordered for 1 of 2 residents (R41) reviewed for quality of care.Findings include:R41's quarterly Minimum Data Set (MDS) dated [DATE], identified R41 was cognitively intact. Diagnoses included renal insufficiency, anxiety, and depressionR41's Provider Order Summary Report undated, identified an order for nicotine throat lozenge 4 milligrams (mg), give one lozenge by mouth every hour as needed.During an observation on 4/13/26 at 3:45 p.m., two white pills what R41 stated were nicotine throat lozenges were on the bedside table. During an observation on 4/14/26 at 11:10 a.m., R41 stopped registered nurse (RN)-A and requested two nicotine throat lozenges. Trained medication aide (TMA)-A walked into the room at the same time with a medication cup with two nicotine throat lozenges in the cup and gave them to R41.During an interview on 4/14/26 at 11:12 a.m., TMA-A stated medications should only be administered to the resident based on the provider's order and the only way more could be administered is if the provider changed the order. TMA-A confirmed she had given R41 two nicotine throat lozenges, and confirmed the order was only to receive one at a time every hour as needed. TMA-A stated all staff had been giving R41 two lozenges at a time and that is why she did it.During an interview on 4/14/26 at 11:16 a.m., RN-A stated medications should only be administered as per provider orders.During an interview on 4/16/26 at 7:58 a.m., the director of nursing (DON) stated an expectation staff only administered medications as ordered by the provider.Facility policy Medication Administration, last revised 12/4/24, indicated staff would ensure the correct medication and the correct dose was only administered based on the provider

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to implement and follow interventions in place for a resident who needed assistance with meals. This had the potential to affect 1 of 1 resident (R1) reviewed who required assistance with feeding.Findings include:R1's quarterly Minimum Data Set (MDS) dated [DATE], identified R1 was cognitively intact. Diagnoses included stroke, hemiplegia and dysphagia. R1's Care plan undated, identified a current diet of regular with thin liquids. All foods needed to be cut into bite size pieces. The care plan also indicated and assist of one with meals.The facility East Dining Assistance Roster identified R1 was an assist of one for meals.R1's care conference notes dated 3/4/26 at 12:39 p.m., identified R1 had agreed to a bite size diet and assist of one with meals and the care plan was updated.During an observation on 4/14/26 at 12:34 p.m., R1 was given a plate that consisted of mashed potatoes with gravy and a piece of meatloaf. The resident then began feeding himself. The meatloaf was not cut up into bite size pieces and there were no staff with him, assisting with the meal.During an observation on 4/15/26 at 8:29 a.m., R1 received a piece of coffee cake with his breakfast. It was not cut up and again he ate it without any staff around to assist him.During an interview on 4/15/26 at 9:00 a.m., cook (CK)-A stated R1 was supposed to have his food cut up into bite size pieces and the cooks were responsible for cutting up the food. CK-A stated the coffee cake was not cut up because she felt the coffee cake was soft enough, and he could cut it himself. CK-A also stated the nurse assistants were responsible for assisting residents who needed assistance with meals.During an interview on 4/15/26 at 10:02 a.m., nursing assistant (NA)-A stated she was not aware NA-A was an assist for all meals and did not stay with him while he ate his meal. There should be somebody trained in feeding assistance with all residents that need assistance with meals.During an interview on 4/15/26 at 10:43 a.m., registered nurse (RN)-B stated R1 had agreed to bite sized food and having assistance with meals during the last care conference. The care plan had been updated, and the staff should follow the care plan when a resident needed assistance with meals.During an interview on 4/16/26 at 7:58 a.m., the director of nursing (DON) stated an expectation the staff would follow the care plan and provide care based on the care plan.The facility policy Resident Assessment-Care Plan dated 4/22/25, indicated the care plan would be implemented to assist the residents reach the highest practical level of functionality and wellness.

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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 and interview, the facility failed to complete appropriate hand hygiene during cares for 1 of 1 resident (R1) reviewed for infection control. Findings include:R1's quarterly Minimum Data Set (MDS) dated [DATE], identified R1 was cognitively intact. Diagnoses included stroke and cancer. The MDS indicated R1 was frequently incontinent of bladder and always incontinent of bowel. R1 needed maximum assistance with toileting needs.R1's care plan undated, identified R1 had an alteration in elimination due to incontinence of urine and bowel. interventions included to check and change brief and provide perineal care.During an observation on 4/15/26 at 8:29 a.m., nurse assistant (NA)-A entered R1's room and told R1 she was going to check to see if the brief was dirty, and if so, change his brief, clean him up, and get him dressed for the morning. NA-A washed her hands and donned gloves. NA-A gathered wipes, cream, and a new brief from the R1's closet. R1's brief was undone and NA-A confirmed R1's brief was saturated with urine. NA-A removed R1's dirty brief and washed the front of his peri area with wipes. R1 was rolled to the right side and NA-A cleaned the buttock region. The dirty brief was rolled halfway under R1, and the clean brief was rolled to the other half of the R1, coming in contact with the soiled brief. R1 was then rolled to the left, the dirty brief was removed, and the clean brief was rolled the rest of the way under R1 with the dirty disposable chuck still under R1. The disposable chuck was observed to have wet areas on the pad where the peri-area would be located. With the contaminated gloves still on, NA-A then placed the new brief on R1 and secured it in place. NA-A proceeded to transfer R1 to the wheelchair and place R1's clean clothes on him. Lastly NA-A was observed placing the peri area cleaning supplies back into R1's closet, touching several items, with the contaminated gloves still on. The gloves were removed, hands washed, and R1 was taken to the dining hall.During an interview on 4/15/26 at 10:01 a.m., NA-A stated gloves would be changed if there was visible soiling noted or any time they went from a dirty area to clean area.During an interview on 4/15/26 at 10:43 a.m., registered nurse (RN)-B stated when doing cares gloves should always be changed when going from dirty parts, such as cleaning the peri area, to clean parts such as placing a new brief or clean clothes on the resident.During an interview on 4/16/26 at 7:30 a.m., the infection preventionist (IP) stated not following appropriate hand hygiene and not changing gloves when going from dirty to clean can increase the resident's risk of getting an infection.During an interview on 4/16/26 at 7:58 a.m., the DON stated all staff should change gloves when doing cares anytime they change from dirty parts of the process to clean parts of the process.Facility policy Hand Hygiene last revised 9/17/24, indicated staff would only perform hand hygiene before and after resident cares.