# *State Veterans' Homes (SVH) Corrective Action Plan*

***Minnesota Veterans Home – Minneapolis, (Annual VA Survey: 01/22-26/2024)***

Important: Attestation by the SVH leadership, including the SVH nurse leader, of actions to assure timely completion of goals and establishment of oversight to assure continued improvement in areas identified for correction. The Corrective Action Plan (CAP) should include input from all levels of staff and affected resident(s), as is applicable and appropriate, impacted by the issue identified. This CAP is intended to become a source towards Quality Assessment and Assurance.

| **State the Issue**<br><br>**Identify the Regulation and Findings** | **Address how corrective action will be accomplished for those residents found to be affected by the deficient practice** (Actions should align with Quality Assessment and Assurance fundamentals) | **Address how the SVH will identify other residents having the potential to be affected by the same deficient practice** | **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur** | **How does the SVH plan to monitor its performance to make sure that solutions are sustained** (Actions should align with Quality Assessment and Assurance) | **Proposed Completion Date** (i.e. when corrective action will be fully implemented and sustained ) |
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| **§ 51.43(e) Drugs and medicines for certain veterans**<br>As a condition for receiving drugs or medicine under this section or under §17.96 of this chapter, the State must submit to the VA medical center of jurisdiction a completed VA Form 10-0460 with the corresponding prescription(s) for each eligible veteran.<br><br>The facility was unable to demonstrate submission of VA Form 10-0460 for Veterans who are be eligible to have medications provided by the VA of jurisdiction. Based on interviews and record reviews, the facility obtained reimbursement for medications from the Veterans Affairs (VA) of jurisdiction for Veterans who meet eligibility under 38 CFR §51.43. During interviews and record reviews, it was identified the facility failed to complete and submit VA Form 10-0460 as required for each eligible Veteran. The SVH did not have on file VA Form 10-0460 for one (1) of four (4) sampled Veterans. | The VA Form 10-0460 for the resident identified was completed on 2/1/2024. | Residents with Service Connection (SC) between 50-60% or with Aid and Assistance (A&A) at MVH-Minneapolis have the potential to be affected. Current MVH-Minneapolis residents with 50-60% SC or A&A will be audited by 4/1/24 for completion of VA Form 10-0460. | Admissions Committee will review prospective residents with 50-60% SC or A&A weekly. Accounts Receivable staff will complete VA Form 10-0460 with these new MVH-Minneapolis residents at the time of admission.<br>3/3 (100%) Accounts Receivable staff educated on completion of VA Form 10-0460 on 3/4/2024. | New admissions with 50-60% SC or A&A will be audited weekly for completion of VA Form 10-0460; auditing will continue for 3 months. These audits will be reported at upcoming Quality Assurance and Performance Improvement (QAPI) meetings monthly for three months and will then be reduced/eliminated per QAPI committee if sustained and successful based on substantial compliance being met.<br>The Director of Finance is responsible. | July 1, 2024 |

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| **§ 51.110 (e) (3) Comprehensive care plans**<br>The services provided or arranged by the facility must—<br>(i) Meet professional standards of quality; and<br>(i) (ii) Be provided by qualified persons in accordance with each resident's written plan of care.<br><br>Based on observations, interviews, and record review, the facility failed to implement interventions to prevent dialysis complications in accordance with each resident's Plan of Care for one (1) of one (1) resident reviewed for dialysis. | Upon notification of the concern of the identified resident's dialysis access site not specified on the dialysis care plan, MVH-Minneapolis updated the resident's care plan on 1/24/24 to include dialysis access site. | Residents receiving dialysis at MVH-Minneapolis have the potential to be affected. MVH-Minneapolis reviewed the three other residents receiving dialysis on 1/24/24 and found the three care plans addressed dialysis access site. | MVH-Minneapolis dialysis care plan template updated 2/23/24 to include prompting documentation of dialysis access site.<br>Assistant Directors of Nursing (ADON), Registered Nurse Managers (RNM), Registered Nurse Seniors (RNS), and MDS Nurses will be educated on identifying dialysis access site in dialysis care plans by 4/1/2024.<br>As of 3/13/24, 23/33 (70%) staff have been educated. | Dialysis care plans will be audited monthly, starting 3/4/24, by nursing to verify dialysis access site is identified in 100% of the dialysis care plans; auditing will continue through 7/1/24.<br>These audits will be reported at upcoming Quality Assurance and Performance Improvement (QAPI) meetings monthly for four months and then will be reduced/eliminated per QAPI committee based on substantial compliance being met.<br>The Director of Nursing (DON) is responsible. | July 1, 2024 |
| **§ 51.120 (a) (3) Reporting of Sentinel Events**<br>The facility management must report sentinel events to the director of VA medical center of jurisdiction within 24 hours of identification. The VA medical center of jurisdiction must report sentinel events by calling VA Network Director (10N 1-22) and Office of Geriatrics and Extended Care in VA Central Office within 24 hours of notification.<br><br>Based on interview and record review, the facility failed to report sentinel events to the Veterans Administration (VA) Medical Center of Jurisdiction within 24 hours for one (1) of one (1) sampled residents (Resident #28) who had a sentinel event. | The Sentinel Event for the resident identified was reported on 2/27/23 to the director of VA medical center of jurisdiction. | Residents with potential Sentinel Events at MVH-Minneapolis have the potential to be affected. On 1/25/24, 29 other residents with the potential for Sentinel Events were reviewed with none found to qualify as a Sentinel Event. | Education on requirements for Sentinel Event reporting and notification of resident changes/deaths after hours, on weekends, and on holidays will be provided to Assistant Directors of Nursing (ADON), Registered Nurse Managers (RNM), Registered Nurse Seniors (RNS), and Officer of the Day (OD) Nurses by 4/1/2024. The list of residents with the potential to have a Sentinel Event will be updated/referenced by ADONs.<br>As of 3/13/24, 23/33 (70%) staff have been educated. | Future Sentinel Events will be audited by ADONs following VA notification for timely (within 24 hours) reporting; audits will be completed monthly. Auditing will continue for 3 months.<br>These audits will be reported at upcoming Quality Assurance and Performance Improvement (QAPI) meetings monthly for three months and reporting will then be reduced/eliminated per QAPI committee recommendation based on substantial compliance being met.<br>The Director of Nursing (DON) is responsible. | July 1, 2024 |
| **§ 51.200 (a) Life safety from fire**<br>(a) Life safety from fire. The facility must meet the applicable provisions of NFPA 101, Life Safety Code and NFPA 99, Health Care Facilities Code.<br><br>**Means of Egress**<br>1. Based on observations and interview, the facility failed to ensure doors to hazardous areas were not held open with devices that did not have an automatic release device. The deficient practice affected zero (0) of seven (7) smoke compartments in Building #19, one (1) of 10 smoke compartments in | No resident was affected.<br><br>The affected door was unpropped. | All residents are potentially affected by propped open doors.<br><br>All doors with closers that did not have an automatic release were identified and inspected for compliance. | Staff education will be provided to all staff on not holding doors open with devices that do not have an automatic release. | Audits will be conducted weekly in all departments weekly for 4 weeks on all doors with automatic closers. Director of Physical Plant / designee responsible.<br><br>Results of audits will be presented to QAPI. Director of Physical Plant Responsible. | April 30, 2024.<br><br>Weekly audit compliance will occur through April 26,2024 or until 100% compliance is |

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| Building #21, zero (0) of 11 smoke compartments in Building #22, staff, and no residents. The facility had a capacity for 341 beds with a census of 260 on the first day of the survey. | | | | | achieved over 4 consecutive weeks, whichever is later. |
| **Smoke Barriers and Sprinklers**<br><br>1. Based on records reviews, observation, and interviews, the facility failed to properly maintain the sprinkler system. The deficient practice affected seven (7) of seven (7) smoke compartments in Building #19, 10 of 10 smoke compartments in Building #21, 11 of 11 smoke compartments in Building #22, staff, and all residents. The facility had a capacity for 341 beds with a census of 260 on the first day of the survey. | 1.Complete 5-year sprinkler riser inspection(s) and 5-year sprinkler gauge inspection(s). Replace gauges as necessary.<br><br>2. The 3-year full trip testing & dry pipe sprinkler valve inspection, testing, maintenance, and documentation. Was completed of December 2, 2021.<br><br>3.Complete the 5-year internal pipe inspection(s), testing, maintenance, and documentation as per NFPA 25, 14.2. | All residents are potentially affected. | 1. The five-year fire riser inspection and gauge inspection will be scheduled in Archibus. Preventative Maintenance record to ensure compliance and safety for residents in the Skilled Nursing Facility.<br><br>2.Complete 3-year full trip testing & dry pipe sprinkler valve inspection, testing, maintenance, will be scheduled in Archibus Preventative Maintenance record to ensure compliance and safety for residents in the Skilled Nursing Facility<br><br>3.The five-year fire internal pipe inspection will be scheduled in Archibus Preventative Maintenance record to ensure compliance and safety for residents in the Skilled Nursing Facility.<br><br>Director of Physical Plant will complete by April 30, 2024. | Provide documentation that an Archibus Preventative Maintenance record exists to schedule automatically for the next date of inspection to occur and review with QAPI.. | April 30, 2024 |
| **Building Services (Elevators, Escalators, Laundry Chutes, etc.)**<br><br>1. Based on record review and interview, the facility failed to inspect and test the fire dampers installed throughout the facility. The deficient practice affected seven (7) of seven (7) smoke compartments in Building #19, 10 of 10 smoke compartments in Building #21, 11 of 11 smoke compartments in Building #22, staff, and all residents. The facility had a capacity for 341 beds with a census of 260 on the first day of the survey. | Documentation was located that indicates that the inspection and testing of the fire dampers located throughout the facility was completed on December 2, 2021. | All Residents are Potentially affected. | Fire damper inspection and testing will be scheduled in Archibus Preventative Maintenance record to ensure compliance and safety for residents in the Skilled Nursing Facility. | Provide documentation that an Archibus Preventative Maintenance record exists to schedule automatically for the next date of inspection to occur and review with QAPI. | Building 19 fire damper inspections completed? Yes: 4-year inspection completed on 12/02/2021. Next inspection due in 2025. |

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| **Electrical Systems**<br><br>1. Based on records review, observation, and interview, the facility failed to maintain documentation of inspections on the Patient-Care Related Electrical Equipment (PCREE). The deficient practice affected seven (7) of seven (7) smoke compartments in Building #19, 10 of 10 smoke compartments in Building #21, 11 of 11 smoke compartments in Building #22, staff, and all residents. The facility had a capacity for 341 beds with a census of 260 on the first day of the survey. | Complete PCREE testing and maintenance of facility resident lift systems, and the portable suction units, vital signs, beds, nebulizers, oxygen concentrators, air pump(s) for mattresses, and other medical equipment present at the facility to be annually inspected, maintained, and documented as per NFPA 99, Health Care Facilities Code.<br><br>Implement testing program for PCREE to include elements specified in NFPA 99 Chapter 10: cord physical integrity, touch current & resistance tests, and lead leakage current tests. Central Office Facilities to provide testing setup diagrams and documentation forms. Testing required prior to being placed in service, following repair/modification, and recommendation is for annual frequency thereafter. | All Residents are potentially affected. | PCREE testing and maintenance of facility resident lift systems, and the portable suction units, vital signs, beds, nebulizers, oxygen concentrators, air pump(s) for mattresses, and other medical equipment present at the facility to be annually inspected, maintained, and documented as per NFPA 99, Health Care Facilities Code. will be scheduled in Archibus Preventative Maintenance record to ensure compliance and safety for residents in the Skilled Nursing Facility. Director of Physical Plant responsible.<br><br>Implement testing program for PCREE to include elements specified in NFPA 99 Chapter 10: cord physical integrity, touch current & resistance tests, and lead leakage current tests. Central Office Facilities to provide testing setup diagrams and documentation forms. Testing required prior to being placed in service, following repair/modification, and recommendation is for annual frequency thereafter.<br><br>Director of Physical Plant to review and present to QAPI. | Documentation on the PCREE inspections will be presented to QAPI for review. | March 8, 2024, target completion date |
| **§ 51.200 (b) Emergency power**<br><br>An emergency electrical power system must be provided to supply power adequate for illumination of all exit signs and lighting for the means of egress, fire alarm and medical gas alarms, emergency communication systems, and generator task illumination.<br><br>(2) The system must be the appropriate type essential electrical system in accordance with | 1. A monthly test of the specific gravity and conductance of the lead acid batteries has been conducted since February 2024.<br><br>2. The facility conducts inspections and monthly Load Testing of generator and has | All residents are potentially affected. | Monthly Load Testing of generators will continue to be conducted monthly.<br><br>Schedules and documentation of the emergency power system are set up in Archibus Preventative Maintenance record to ensure compliance and safety for residents in the Skilled Nursing Facility. | Power Plant Operations<br>1. Weekly generator inspections to be completed weekly by Director of Physical Plant or designee.<br><br>2. Monthly inspection (specific gravity batteries), load testing of 30% or more for a 4-hour period to be completed by Director of Physical Plant or | Completion date: April 30th, 2024 |

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| the applicable provisions of NFPA 101, Life Safety Code and NFPA 99, Health Care Facilities Code.<br><br>(3) When electrical life support devices are used, an emergency electrical power system must also be provided for devices in accordance with NFPA 99, Health Care Facilities Code.<br><br>(4) The source of power must be an on-site emergency standby generator of sufficient size to serve the connected load or other approved sources in accordance with NFPA 101, Life Safety Code and NFPA 99, Health Care Facilities Code.<br><br>Based on records review and interview, the facility failed to properly inspect and test all components of the emergency generator. The deficient practice affected seven (7) of seven (7) smoke compartments in Building #19, 10 of 10 smoke compartments in Building #21, 11 of 11 smoke compartments in Building #22, staff, and all residents. The facility had a capacity for 341 beds with a census of 260 on the first day of the survey. | been completed since March 2023. | | | designee.<br><br>3. Annual and quarterly servicing and inspections by contract services Cummins Diesel.<br><br>Director of Physical Plant responsible and will report compliance to QAPI. | |
| **§ 51.210 (g) Staff qualifications**<br>(1) The facility management must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements.<br><br>(2) Professional staff must be licensed, certified, or registered in accordance with applicable State laws.<br><br>Based on interviews and record review, the facility failed to ensure the Veterans Administration VA 10-3567 Staffing Profile form was completed to accurately reflect the professional staff employed necessary to carry out the provisions of these requirements. | The completion of Veterans Administration VA 10-3567 Staffing Profile was incorrect. The form has been corrected for all MVH-Minneapolis residents. | Does not affect any residents. | Administrative staff of MVH-Minneapolis responsible for the completion of the Veterans Administration VA 10-3567 Staffing Profile have been educated on the requirements of the VA concerning the accuracy of the information that needs to be provided on Veterans Administration VA 10-3567. Samples of a correctly competed form will be maintained in the MVH-Minneapolis administrative offices to assure compliance with future VA surveys. | The VA 10-3567 will be monitored during the survey preparation process monthly to ensure that all consultant and licensed professionals are listed accurately on the form. The Administrator or Director of Nursing will be responsible. | Completed on 01/25/2024. |

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| **§ 51.210 (h) Use of outside resources**<br>(1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility management must have that service furnished to residents by a person or agency outside the facility under a written agreement described in paragraph (h)(2) of this section.<br>(2) Agreements pertaining to services furnished by outside resources must specify in writing that the facility management assumes responsibility for—<br>(i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and<br>(ii) The timeliness of the services.<br>(3) If a veteran requires health care that the State home is not required to provide under this part, the State home may assist the veteran in obtaining that care from sources outside the State home, including the Veterans Health Administration. If VA is contacted about providing such care, VA will determine the best option for obtaining the needed services and will notify the veteran or the authorized representative of the veteran.<br><br>Based on interview and record review, the facility's management failed to obtain a sharing agreement that governed mental health services provided to 54 of 260 residents by the Veterans Administration Medical Center (VAMC). | The new agreement, effective 02/01/2024 provides mental health services to all residents residing in the MVH-Minneapolis facility. The term of the agreement is up to a maximum of 5 years. | The new agreement provides the availability of mental health services to all residents residing in the MVH-Minneapolis facility. | MVH-Minneapolis will review the agreement annually to validate that it meets the mental health services needs of the organization. | The term of the Agreement is one year which began on February 1, 2024 and continues until January 31, 2025. The Agreement may be extended at the option of the VA for an additional four (4) ordering periods by providing written notice to Sharing Partner no less than thirty (30) days prior to expiration of the initial term. If all additional ordering periods are exercised, this Agreement will end on January 31, 2029. | Completed on 02/01/2024. |



- This Corrective Action Plan is to be electronically submitted to the Pod-specific National SVH Program Manager for Quality and Oversight