Department of Veterans Affairs State Veterans Home Survey Report

This survey report and the information contained herein, resulted from the State Veterans Home (SVH) Survey as a Summary Statement of Deficiencies. (Each Deficiency Must be Preceded by Full Regulatory or applicable Life Safety Code Identifying Information.) Title 38 Code of Federal Regulations Part 51 is applied for SVHs applicable by level of care.

General Information:

Facility Name: Minnesota Veterans Home - Minneapolis

Location: 5101 Minnehaha Ave. South Minneapolis, MN 55417

Onsite / Virtual: Onsite

Dates of Survey: 10/27/2022-10/28/2022

NH / DOM / ADHC: DOM

Survey Class: Annual

Total Available Beds: 50

Census on First Day of Survey: 39

VA Regulation Deficiency	Findings
	Initial Comments: A VA Annual Survey was conducted from October 27, 2022 through October 28, 2022 at the Minnesota State Veterans Home - Minneapolis. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
51.210 (h) Use of outside resources. (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. (2) Agreements pertaining to services furnished by outside resources must specify in writing that the facility management assumes responsibility for— (i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility.	Based on record reviews and interviews, the facility failed to provide a written agreement for services provided to residents by outside resources. Specifically, the facility did not have a written agreement with any dental providers for dental services provided to all 39 residents residing in the domiciliary. The findings include: Review of the admissions document titled, "Services Provided and Made Available to Residents Skilled Nursing Care and Domiciliary," found that: "The following services are made available to Resident (with potential private pay responsibility): •Special Services-not routine and customary •Mental Health Services •Dental Care Services •Podiatric Care Services •Diagnostic Services (i.e., x-rays, laboratory work) •Optometric Care Services

Level of Harm – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Many	•Chiropractic Care Services •Audiology" An interview with Administrative Staff A, on 10/27/22, at 2:17 p.m., revealed that there was never any agreement with any of the dental providers used by the residents. When asked where residents went to receive dental care, they stated that the residents went to the dentist of their choice and transportation was provided if needed since some of the residents did have their own vehicles. Administrative Staff A was unaware that an agreement was required. The facility noted it was under the impression that since dental services were provided, no other action was necessary.
§51.310 (c) (3) Comprehensive care plans. The services provided by the facility must: (i) Meet professional standards of quality; and (ii) Be provided by qualified persons in accordance with each resident's written comprehensive care plan **Level of Harm –** No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on observation, interview, and policy review, the facility failed to secure one (1) of one (1) medication carts when not attended by staff. The findings include: Review of the policy titled, "Medication Storage and Security," dated 4/19, stated: "The (Veterans Home) will store all drugs and biologicals safely, securely, and under proper environmental controls, according to state and federal guidelines, and limit access to authorized nursing personnel only. Procedures: A. All medication storage areas (carts…) are locked whenever the nurse is not in direct sight of the medication storage area." [sic] Observation of Licensed Nurse A, on 10/28/22, at 8:45 a.m., revealed they did not secure the medication cart, leaving medication drawers open when they left the cart to administer medications to a resident. The surveyor remained present at the cart while Licensed Nurse A left the cart unattended and out of their direct sight. An interview with Licensed Nurse A, on 10/28/22, at 8:40 a.m., revealed they should have closed the drawers and locked the medication cart prior to leaving it unattended, even though the surveyor was standing by the cart. An interview with Administrative Nurse A, revealed the nurse should have locked the medication cart when they left the cart unattended due to safety concerns.