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: 10/24/22-10/27/22

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 340

Census on First Day of Survey: 257

VA Regulation Deficiency	Findings
	Initial Comments: A VA Annual Survey was conducted from October 24, 2022 through October 27, 2022 at the Minnesota Veterans Home - Minneapolis. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§ 51.110 (e) (3) Comprehensive care plans. The services provided or arranged by the facility must- (i) Meet professional standards of quality; and (ii) Be provided by qualified persons in accordance with each resident's written plan of care. **Level of Harm –** No Actual Harm, with potential for more than minimal harm **Residents Affected** – Many	Based on interview, record review, and policy review, the facility failed to perform weekly calibrations on the glucometer machine for 38 of 38 sampled machines and failed to report a significant weight gain to the [Consultant Staff A] for one (1) of 28 sampled residents (Resident # 15). The findings include: 1. Review of the policy titled, "Glucometer Quality Control Check Standard of Work," dated 12/16/21, stated: "Performing quality control check on the meter and test strips verify the meter and test strips are calibrated and working properly. Glucose control solution is used to validate the accuracy of the meter. It is important to run periodic control tests to ensure that the meter and test strips are functioning and giving reliable results. It is essential that people with diabetes keep their blood sugar levels in their target range." Review of the Glucometer Calibration Logbook, on 10/26/22, at 11:00 a.m., revealed the glucometer machines (used to monitor

	resident glucose numbers) had not been calibrated since [DATE]. An interview with Administrative Nurse A, on 10/26/22, at 11:20 a.m., revealed the glucometer machine(s) were to be calibrated every Tuesday during the night shift (11:00 p.m., to 7:00 a.m.) and the findings documented in the glucometer log. An interview with Administrative Nurse B, on 10/27/22, at 8:30 a.m., revealed staff should be calibrating each glucometer whenever a new bottle of glucose strips was opened, as well as weekly. They stated weekly calibration should be done to ensure resident glucose readings were accurate. 2. Review of the clinical record revealed Resident #15 was admitted to the facility on [DATE], with diagnoses including: Chronic Heart Failure, Chronic Kidney Disease, Chronic Obstructive Pulmonary Disease, Atrial Fibrillation and Chest Pain. Review of the Physician Orders revealed an order dated [DATE], for weekly weights in the morning on Mondays, and to update the provider of five (5) pound (lb) weight gain in a week. Further review revealed the last four (4) weights to be as follows: [DATE] 299 lbs. [DATE] 281.8 lbs. [DATE] 280.6 lbs. [DATE] 281 lbs. In an interview, on 10/26/22, at 2:00 p.m., Dietary Staff A confirmed Resident #15 had gained 18 lbs., (6.10%), for the week as of [DATE]. They also confirmed the resident was not reweighed to verify the weight. In an interview, on 10/26/22, at 2:40 p.m., Administrative Nurse C verified that the provider had not been notified of the resident's weight gain. In an interview, on 10/26/22, at 3:00 p.m., Administrative Nurse B stated that it was their expectation that Resident #15's weight gain should have been verified and the provider notified as per the order.
§ 51.120 (i) Accidents. The facility management must ensure that	Based on observation, interview, record review, and policy review, the facility failed to ensure the residents' environment remained as free of accidents and hazards as possible, and failed to provide adequate supervision for two (2) of twenty-eight (28) sampled residents (Resident #1 and Resident #11).

(1) The resident environment remains as free of accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. **Level of Harm –** No Actual Harm, with potential for more than minimal harm **Residents Affected** - Some	The findings include: 1. Review of the policy and procedure titled, "Safety Programs," dated 2/25/2020, revealed: "the [LOCATION] is committed to providing a safe environment for all …residents…all staff share in the responsibility of maintaining a safe workplace." Observation, on 10/24/22, at 11:00 a.m., on the [LOCATION] revealed Resident #1 carrying a closed container of PDI Sani-Hands Instant Hand Sanitizing Wipes 70 percent (%) alcohol. Resident #1 was admitted to the facility on [DATE], with the following diagnoses: Alzheimer's Disease, Dementia, and Falls. Review of the Quarterly Minimum Data Sheet (MDS), dated [DATE], revealed Resident #1 had been assessed to have a Brief Interview for Mental Status (BIMS) score of six (6), and the resident was not able to be interviewed. Review of the "Safety Data Sheet," dated 11/30/17, stated "1.1 Product Identified: Product name Sani-Hands ® Instant Hand Sanitizing Wipes 1.2 Relevant Identified Uses of the Substance or Mixture and Uses Advised Against: Recommended Use: Antiseptic. 2. Hazards Identification: This product is a clear, colorless liquid with an alcohol odor impregnated a wipe in a single packet or on multiple wipes in a pack/canister 4. First-Aid Measures: Eye: Flush eyes with large quantities of water for 15 minutes. Remove contact lenses if easy to do so. Continue rinsing. Get medical attention if irritation persists. Inhalation: If symptoms develop move victim to fresh air. Get medical attention if irritation or other symptoms persists. 4.2 Most important symptoms and effects, both acute and delayed: Direct contact with liquid may cause moderate eye irritation. Inhalation of high concentration of vapors may cause upper respiratory tract irritation and central nervous system effects." An interview with Licensed Nurse A, on 10/24/22, at 11:40 a.m., revealed that the hand sanitizing wipes should not have been out on the resident tables and freely accessible to the residents without staff supervision. They revealed that when the wipes were not in use, they were to be kept in the nursing station area. Licensed Nurse A could not state that a resident would eat or drink the hand wipes, but did reveal chemicals should not be accessible to residents without the proper supervision. An interview with Administrative Nurse B, on 10/24/22, at 11:55 a.m., revealed the hand sanitizer wipes should not have been

	accessible to the residents on the [LOCATION] and should have been stored in the nursing station when not in use. An interview with Certified Nurse Aide A, on 10/26/22, at 10:00 a.m., revealed the hand sanitizer wipes should only be used during mealtimes, and with staff supervision. Certified Nurse Aide A revealed that when the wipes were not in use, they should be kept in the kitchen cabinets. An interview with Administrative Nurse D, on 10/26/22, at 10:10 a.m., revealed chemicals should not be left out and accessible to the residents with dementia. They revealed the hand sanitizer wipes should have been kept locked up in the nursing station or the medication cart when not in use due to safety concerns. 2. Review of Resident #11's clinical record revealed the resident was admitted to the facility on [DATE], with diagnoses including: Unspecified Dementia with Behavioral Disturbance, Anxiety, Depression, Atrial Fibrillation, and Anger. Review of the Annual Minimum Data Set (MDS) assessment, dated [DATE], determined the resident's Brief Interview for Mental status (BIMS) score to be 15, indicating intact cognitive status. Resident #11 was assessed as exhibiting angry behaviors, and when angry, threatened to leave the facility. According to the assessment, the resident was able to self-transfer from the bed to the wheelchair and propel themself throughout the [LOCATION]. Resident #11 had been assigned a court appointed guardian, as they needed guidance to make life decisions. Review of Resident #11's Care Plan titled, "Cognition," revised [DATE], indicated the resident displayed memory impairment, poor insight and judgment regarding situations that could place them at risk. An intervention was in place to provide the resident with education and information to make safe choices when expressing unsafe plans. Review of Resident #11's Care Plan titled, "Safety," revised [DATE], indicated the resident was a risk for elopement related to exit seeking attempts. An intervention in place was to direct them from the front doors and, if seen outside wheeling away from the premises unsupervised, to call security and staff to assist resident back to the [LOCATION]. Review of Resident #11's Incident Reports indicated the following:

	"On [DATE] at 2:46 p.m., Resident #11 was observed at the front door wanting to leave the facility. The resident left and was headed for the bridge with staff following behind. When the resident reached the bridge staff persuaded [them] to return to the facility. Resident #11 was assessed and sustained no injuries. An intervention in place after the incident was to have staff regularly monitor [their] whereabouts." "On [DATE] at 7:49 a.m., staff was heading to the facility to work for the day shift and spotted Resident #11 on the bridge and called security and staff who persuaded the resident to return to the facility. Resident#11 was assessed and sustained no injuries. An intervention after the incident was to place the resident on hourly checks." "On [DATE] at 2:30 p.m., Resident #11 was spotted by [Certified Nurse Aide B] attempting to wheel [themself] across the bridge. Security and staff were notified and returned the resident to the facility. Resident #11 was assessed and sustained no injuries. An intervention after the incident was to place the resident on 15-minute checks." Following the last incident, Resident #11 was assigned to wear an Accutech bracelet (would alarm when entering the elevator) and moved to the [LOCATION], where when entering the elevator, the resident would need to enter a pass code to make the elevator move. On 10/25/22, at 2:00 p.m., Administrative Nurse C confirmed Resident #11 had poor decision making, would become angry, threaten to leave the facility, and had made several attempts to do so. They stated, "We tried to monitor [them] to keep [them] safe while trying to give [them] some independence." On 10/25/22, at 2:20 p.m., Administrative Nurse B stated Resident #11 was assessed to not be safe to exit the facility unsupervised. On 10/26/22, at 10:05 a.m., Licensed Nurse B stated Resident #11 would become upset, swear, and make threats to leave the facility. They stated, "The resident now wears a bracelet and does not know the passcode to the elevator. [They were] not able to make good decisions and had no plan where to go if [they] left."
§51.140 (h) Sanitary conditions. The facility must: (1) Procure food from sources approved or considered satisfactory by Federal, State, or local authorities;	Based on observation, interview, and facility policy review, the facility failed to ensure food was stored in accordance with professional standards for food service safety. The sanitation concerns had the potential to affect residents living in five (5)

(2) Store, prepare, distribute, and serve food under sanitary conditions; and (3) Dispose of garbage and refuse properly. **Level of Harm –** No Actual Harm, with potential for more than minimal harm **Residents Affected** –Some	out of eleven floors with kitchenettes, out of the three (3) skilled care buildings. The findings include: Review of the facility's policy, "Food from Outside Sources," dated 10/2020, documented: "All food items from outside sources will follow required health department food storage practices. Food and Beverages that are brought in from the outside will be monitored by nursing staff or designee for spoilage, contamination, and safety… Procedures: D. All items must be marked with the resident name, room number, and dated by nursing staff or designee with the date the item was brought into the facility. 1. All cooked and prepared foods brought in for a resident and stored in the resident refrigerator will be dated when accepted for storage and discarded after 72 hours. 2. Items that have manufacturers expiration dates on the container should be disposed of according to the expiration dates on the container. The date when the item was opened shall be written on the outside of the container." A tour of the [LOCATION] on the [LOCATION] was conducted on 10/25/22, at 1:00 p.m. Concerns identified included: [LOCATION]: On the [LOCATION], in the resident's refrigerator, there was a bottle of Heinz 57 steak sauce that was not dated when opened. [LOCATION]: On the [LOCATION], in the resident's refrigerator, there was an item, not labeled or dated, that appeared to have black fuzz on it. Dietary Staff B stated, "It doesn't look good," and threw it out. On the [LOCATION], in a resident's refrigerator, there was a package of deli meat with an expiration date of 10/11/22. Dietary Staff A threw the package out. There was also an undated/unlabeled open cup of an unknown substance. [LOCATION]: On the [LOCATION], in the resident's refrigerator, there was an open bottle of cocktail sauce, without a date to indicate when it was first opened. Dietary Staff B threw it out and stated it went against their policy to have opened containers without a date it was opened. On the [LOCATION], in the resident's refrigerator, there was an opened bottle of chili sauce with an expiration date of 9/27/22, and an opened bottle of A1 sauce with an expiration date of

	8/26/22, and Redi Whip with an expiration date of 1/25/22. The following items were not dated with the date they were opened: Worcestershire Sauce, Kikkoman Sauce, Hellman's Mayo, Sriracha Sauce, and Dill pickles. Dietary Staff B removed the items from the refrigerator and acknowledged the policy was not being followed. On 10/25/22, at 3:30 p.m., in an interview with Dietary Staff B, they stated they were aware of the nursing staff not adhering to the policy and they had been working with them to have better compliance with the policy.
51.200(a) Life safety from fire. The facility management must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public. (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. **Level of Harm –** No Actual Harm, with potential for more than minimal harm **Veterans Affected -** Some	**<u>Smoke Barriers and Sprinklers</u>** Based on observation and interview, the facility failed to maintain corridor walls to resist the transfer of smoke in accordance with the code. The deficient practice affected two (2) of 12 smoke compartments in [LOCATION], staff, and 33 residents. The facility had a capacity for 340 beds with a census of 257 on the day of the survey. The findings include: Observation during the [LOCATION] inspection tour, on 10/25/22, from 10:56 a.m., to 1:45 p.m., revealed penetrations in the following areas which would not resist the transfer of smoke, as required by sections 8.4.1, 8.4.2, and 19.3.6.2 of NFPA 101, Life Safety Code.: 1) [LOCATION] area on [LOCATION] with a 3 X 3-inch square unsealed penetration in the corridor wall 2) Four (4) unsealed penetrations in the [LOCATION] (conduit annular spaces) 3) Four (4) unsealed penetrations on the corridor wall opposite of the entry point in the [LOCATION] 4) Two (2) ceiling tiles missing in the [LOCATION] The census of 257 was verified by Administrative Staff A on 10/25/22. The findings were acknowledged by Administrative Staff A and verified by Maintenance Staff A during the exit interview on 10/27/22, at 10:00 a.m. **Actual NFPA Standard: NFPA 101, Life Safety Code (2012)** **19.3.6.2 Construction of Corridor Walls.** **19.3.6.2.1** Corridor walls shall be continuous from the floor to the underside of the floor or roof deck above; through any concealed spaces, such as those above suspended ceilings;

	and through interstitial structural and mechanical spaces, unless otherwise permitted by 19.3.6.2.4 through 19.3.6.2.8. **19.3.6.2.2*** Corridor walls shall have a minimum 1⁄2-hour fire resistance rating. **19.3.6.2.3*** Corridor walls shall form a barrier to limit the transfer of smoke. **19.3.6.2.4*** In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.7, a corridor shall be permitted to be separated from all other areas by non-fire-rated partitions and shall be permitted to terminate at the ceiling where the ceiling is constructed to limit the transfer of smoke. **19.3.6.2.5** Existing corridor partitions shall be permitted to terminate at ceilings that are not an integral part of a floor construction if 60 in. (1525 mm) or more of space exists between the top of the ceiling subsystem and the bottom of the floor or roof above, provided that all the following criteria are met: **(1)** The ceiling is part of a fire-rated assembly tested to have a minimum 1-hour fire resistance rating in compliance with the provisions of Section 8.3. **(2)** The corridor partitions form smoke-tight joints with the ceilings, and joint filler, if used, is noncombustible. **(3)** Each compartment of interstitial space that constitutes a separate smoke area is vented, in a smoke emergency, to the outside by mechanical means having the capacity to provide not less than two air changes per hour but, in no case, a capacity less than 5000 ft3/min (2.35 m3/s). **(4)** The interstitial space is not used for storage. **(5)** The space is not used as a plenum for supply, exhaust, or return air, except as noted in 19.3.6.2.5(3). **19.3.6.2.6*** Existing corridor partitions shall be permitted to terminate at monolithic ceilings that resist the passage of smoke where there is a smoke-tight joint between the top of the partition and the bottom of the ceiling. **Chapter 8 Features of Fire Protection** **8.4 Smoke Partitions.**

	8.4.1* General. Where required elsewhere in this *Code*, smoke partitions shall be provided to limit the transfer of smoke. **8.4.2** Continuity. Smoke partitions shall comply with the following: **(1)** They shall extend from the floor to the underside of the floor or roof deck above, through any concealed spaces, such as those above suspended ceilings, and through interstitial structural and mechanical spaces. **(2)*** They shall be permitted to extend from the floor to the underside of a monolithic or suspended ceiling system where all of the following conditions are met: **(a)** The ceiling system forms a continuous membrane**.** **(b)** A smoke-tight joint is provided between the top of the smoke partition and the bottom of the suspended ceiling. **(c)** The space above the ceiling is not used as a plenum. **(3)** Smoke partitions enclosing hazardous areas shall be permitted to terminate at the underside of a monolithic or suspended ceiling system where all of the following conditions are met**:** **(a)** The ceiling system forms a continuous membrane**.** **(b)** A smoke-tight joint is provided between the top of the smoke partition and the bottom of the suspended ceiling. **Building Services (Elevators, Escalators, Laundry Chutes, etc.)** Based on observation and interview, the facility failed to ensure electrical junction boxes were covered as required. The deficient practice affected two (2) of twelve (12) smoke compartments in [LOCATION], staff, and no residents. The facility had a capacity for 340 beds with a census of 257 on the day of the survey. The findings include: Observation during the [LOCATION] inspection tour, on 10/25/22, from 10:20 a.m., to 1:45 p.m., revealed four (4) open junction boxes in the [LOCATION] on [LOCATION], two (2) open junction boxes located in the [LOCATION] located on the [LOCATION], and one (1) open junction box located in the [LOCATION] in the [LOCATION] located on the [LOCATION], as

	prohibited in article 314.28(c) of NFPA 70, National Electrical Code. An interview, on 10/25/22, at 10:20 a.m., with Maintenance Staff A revealed the facility was not aware the junction boxes were uncovered but would get them corrected to comply. The census of 257 was verified by Administrative Staff A on 10/25/22. The findings were acknowledged by Administrative Staff A and verified by Maintenance Staff A during the exit interview on 10/27/22, at 10:00 a.m. **Actual NFPA Standard: NFPA 101 Life Safety Code (2012)** **Chapter 19 Existing Health Care Occupancies** **19.5 Building Services.** **19.5.1 Utilities.** **19.5.1.1** Utilities shall comply with the provisions of Section 9.1. **Chapter 9 Building Service and Fire Protection Equipment** **9.1 Utilities.** **9.1.2 Electrical Systems.** Electrical wiring and equipment shall be in accordance with *NFPA 70*, *National Electrical Code*, unless such installations are approved existing installations, which shall be permitted to be continued in service. **Actual NFPA Standard: NFPA 70 National Electrical Code (2011)** **ARTICLE 314** **Outlet, Device, Pull, and Junction Boxes; Conduit Bodies; Fittings; and Handhole Enclosures** **314.28 Pull and Junction Boxes and Conduit Bodies.** **(C) Covers.** All pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. Where used, metal covers shall comply with the grounding requirements of 250.110. **Electrical Systems** Based on observation and interview, the facility failed to ensure transfilling locations had required signage. The deficient practice affected one (1) of twelve (12) smoke compartments in [LOCATION], staff, and no residents. The facility had a capacity for 340 beds with a census of 257 on the day of the survey. The findings include:

	Observation during the [LOCATION] room inspection tour, on 10/25/22, at 11:15 a.m., revealed an [LOCATION] on the [LOCATION] labelled room [LOCATION]. The room was observed to have a liquid oxygen tank with eye protection, gloves, two (2) small oxygen concentrators, and several E cylinders stored without the required transfilling signage, as required in section 11.5.2.3.1(3) of NFPA 99, Health Care Facilities Code. An interview, on 10/25/22, at 11:15 a.m., with Maintenance Staff A revealed the room was used for oxygen transfilling but was not aware of the signage requirement. Maintenance Staff A revealed they would get the proper sign posted to comply. The census of 257 was verified by Administrative Staff A on 10/25/22. The findings were acknowledged by Administrative Staff A and verified by Maintenance Staff A during the exit interview on 10/27/22, at 10:00 a.m. **Actual NFPA Standard: NFPA 101 Life Safety Code (2012)** **Chapter 19 Existing Health Occupancies** **19.3.2.4 Medical Gas.** Medical gas storage and administration areas shall be in accordance with Section 8.7 and the provisions of NFPA 99, *Health Care Facilities Code*, applicable to administration, maintenance, and testing. **Actual NFPA Standard: NFPA 99, Health Care Facilities Code (2012)** **11.5.2.3 Transfilling Liquid Oxygen.** Transfilling of liquid oxygen shall comply with 11.5.2.3.1 or 11.5.2.3.2, as applicable. **11.5.2.3.1** Transfilling to liquid oxygen base reservoir containers or to liquid oxygen portable containers over 344.74 kPa (50 psi) shall include the following: **(1)** A designated area separated from any portion of a facility wherein patients are housed, examined, or treated by a fire barrier of 1 hour fire-resistive construction. **(2)** The area is mechanically ventilated, is sprinklered, and has ceramic or concrete flooring. **(3)** The area is posted with signs indicating that transfilling is occurring and that smoking in the immediate area is not permitted. **(4)** The individual transfilling the container(s)