File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

September 10, 2013

Mr. Andrew Burnside, Administrator
Minnesota Veterans Home Hastings
1200 East 18th Street
Hastings, Minnesota 55033

Re: Enclosed Reinspection Results - Project Number SL00788022

Dear Mr. Burnside:

On August 29, 2013 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 18, 2013. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00788	A. Building B. Wing	8/29/2013

Name of Facility	Street Address, City, State, Zip Code
MN VETERANS HOME HASTINGS	1200 EAST 18TH STREET HASTINGS, MN 55033

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix 30395 Reg. # MN Rule 4655.1400 B (5) LSC	08/12/2013	ID Prefix 31040 Reg. # MN Rule 4655.7000 Subp. 1G LSC	08/15/2013	ID Prefix 31165 Reg. # MN Rule 4655.7850 Subp. 3 LSC	08/15/2013
ID Prefix 31305 Reg. # MN Rule 4655.8670 Subp. 1 LSC	08/12/2013	ID Prefix 31995 Reg. # MN Rule 626.557 Subd. 4A LSC	08/30/2013	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	SR/sd	09/10/13	30922	08/29/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
7/18/2013	

SL00788022

Minnesota Department of Health
Licensing and Certification Program

FACILITY MN VETERANS HOME HASTINGS DATE 8/29/13

Indicate the name and title for each surveyor/supervisor on site during the survey, even those not present at the exit.

Surveyors Names and Titles

NAME Please Print	TITLE
Mary Capes RN	HFE Nurs Eval II
Mary Heim LICSW	HPR Sr. SW Spec.
Monodon L. FATTY	HFE Nurs Eval II

Exit Conference Attendees

SIGNATURE	TITLE
Dottie Chamberlain	RN- Senior
Paula Japin RN	RN Senior

File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7012 3050 0000 4830 7932

August 1, 2013

Mr. Andrew Burnside, Administrator
Minnesota Veterans Home Hastings
1200 East 18th Street
Hastings, Minnesota 55033

Re: Enclosed State Boarding Care Home Licensing Orders - Project Number SL00788022

Dear Mr. Burnside:

The above facility survey was completed on July 18, 2013 for the purpose of assessing compliance with Minnesota Department of Health Boarding Care Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Boarding Care Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings is Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me with any questions related to this letter.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

L00788s13.rtf

PRINTED: 08/01/2013
FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00788	A. BUILDING: _____ B. WING _____	07/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME HASTINGS	1200 EAST 18TH STREET HASTINGS, MN 55033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
3 000	INITIAL COMMENTS *****ATTENTION****** BOARDING CARE HOME LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/15/13 to 7/18/13, Surveyors from the Department of Health visited the above provider and the following correction orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health,	3 000	8/19/13 SER RECEIVED AUG 19 2013 Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carlene Bennett TITLE: Administrator (X6) DATE: 8-16-13

STATE FORM 6899 7S2111 If continuation sheet 1 of 20

STATE OF MINNESOTA DEPARTMENT OF VETERANS AFFAIRS
HASTINGS VETERANS HOME
★ ★ ★
1200 EAST 18TH STREET • HASTINGS, MN 55033 • (651)-438-8500 • FAX (651)-437-2203
WWW.MDVA.STATE.MN.US • 1-888-LINKVET

8/19/13 SER

August 15, 2013

Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
MN Dept of Health

Dear Ms. Dietrich,

This letter is in response to the recommendations made by your survey team following our July 18, 2013 survey project number SL00788022.

3395 – MN Rule 4655, 1400 B (5) Responsibilities of Administrator in Charge

1. Nursing management will instruct and monitor for compliance on appropriate management of narcotic medications. Completion Date: Aug 12, 2013
2. A review of the adequacy of narcotic management will be done with collaboration of the Quality Control Committee, the Agency Quality Director, and Agency Pharmacy Director.

31040 – MN Rule 4655, 7000 Subp.1G /Patient or Resident Units; Nurse Call Device

1. In addition to our current preventative maintenance for call lights; which includes performance check upon admission and an annual testing of the entire call light system, we are adding checks during health and safety rounds.
2. Twenty five percent of all call lights will be checked weekly on a rotating basis so that 100% of the call lights are checked per month.
3. During the Resident Council meeting on August 14, 2013 the veterans were notified to not shorten or in any way tamper with call lights. In addition, a letter will be placed in each veteran's mailbox addressing the potential negative safety outcomes when call light cords are tampered with.
4. Upon admission the veterans receive a Residents Expectation Form that highlights expectations related to health and safety concerns. An expectation about call light cord integrity is added to this form. Completion Date: Aug 15, 2013

31165 – MN Rule 4655, 7850 Subp.3 /Disposition of Medications; Records

1. Nursing management will provide on-going instructions to all nursing staff on safe and appropriate accounting and destruction of all narcotic medications upon resident discharge.
2. Monitoring for understanding and compliance will continue on a routine basis as

evidenced by focused audits, currently done twice weekly. If focused audits continue to indicate compliance is meeting the standard of accountability for all controlled medications for three months, the frequency will be altered so as to provide routine monitoring with adequate frequency.

3. The Quality Committee will assist in making recommendations for continued monitoring needs.

31305 – MN Rule 4655, 8670 Subp. 1/Food Supplies; Food

1. Housekeeping staff will be re-educated on the proper cleaning of the refrigerators, and the removal of any expired or non-dated food. The housekeeping supervisor or designee will monitor for compliance on a weekly basis until such time as the results indicate a decrease in frequency is appropriate. Completion Date: Aug 12, 2013
2. During monthly unit meetings veterans will be educated on safe food storage.
3. Housekeeping supervisor or designee will orient new housekeeping staff on proper refrigerator cleaning and safe food storage.

31995 – MN Rule 626.557 Subp. 4A/Reporting Maltreatment of Vulnerable Adults

1. Administration is updating our current Reporting Maltreatment of Vulnerable Adults policy to reflect the immediate nature of reporting to CEP. Completion Date: Aug 16, 2013
2. All staff will be re-educated on the current vulnerable adult policy and the process of reporting to the common entry point and its immediate nature. Completion Date: Sep 1, 2013
3. Semi-annual refresher education and new information related to Reporting of Maltreatment of Vulnerable Adults for supervisory staff and all staff serving in the Officer of the Day (OD) role.

We will hope that you will find these corrections satisfactory. If you have any further questions feel free to contact me.

Sincerely,

Mr. Andrew Burnside, Administrator
MN Veterans Home – Hastings
1200 East 18th Street
Hastings, MN 55033

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00788	A. BUILDING: _____ B. WING _____	07/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME HASTINGS	1200 EAST 18TH STREET HASTINGS, MN 55033

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3 000	INITIAL COMMENTS *****ATTENTION****** BOARDING CARE HOME LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/15/13 to 7/18/13, Surveyors from the Department of Health visited the above provider and the following correction orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health,	3 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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3 000	Continued From page 1 Division of Compliance Monitoring, Licensing and Certification Program PO BOX 64900 St. Paul MN 55164-0900.	3 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
3 395	MN Rule 4655.1400 B (5) Responsibilities of Administrator in Charge The responsibilities of the administrator in charge shall include: B. Formulation of written general policies; admission, discharge, and transfer policies; and personnel policies, practices, and procedures that adequately support sound patient or resident care, including: (5) Orientation for new employees and volunteers and provision of a continuing in-service education program for all employees	3 395		

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3 395	Continued From page 2 and volunteers to give assurance that they understand the proper method of carrying out all procedures. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure nursing staff followed the appropriate procedures to account for medications classified as narcotic drugs. This had the potential to impact 2 of 14 residents (R18, R19) reviewed for disposition of narcotic drugs. Findings include: The facility failed to ensure 120 oxycodone tablets (Schedule II narcotic pain medication) were appropriately documented as destroyed or administered for R18. R18's record contained a physician's order dated 6/18/13, for oxycodone 5 mg (milligram) tablets, take 5 mg-10 mg. every four hours as needed for pain, dispense 240 tablets. R18's Individual Narcotic Record showed the facility received 120 oxycodone 5 mg tablets on 6/28/13, all with the same prescription number. No administration or disposition of the 120 tablets for this prescription number was documented in the Individual Narcotic Record, and observation revealed no medication with this prescription number was found in the narcotic bins of the facility. When interviewed on 7/17/13, at 5:00 p.m., registered nurse (RN)-A stated she believed the documentation for the medication with this prescription number had been transferred to other pages in the several narcotic log books in	3 395		

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3 395	Continued From page 3	3 395		

the facility, but could not locate an entry with the same prescription number. There were other pages in narcotic log books listing oxycodone 5 mg for R18, but none of these entries contained this prescription number; some contained no prescription number, and some contained no date, or the date of 7/12/13.

An interview conducted on 7/18/13, at 9:35 a.m. RN-A and the facility administrator stated they believed they could account for most or all of the medication with this prescription number by reviewing the medication administration records in the facility, but there was not definitive documentation of the administration or disposition of the medication with this prescription number in the Individual Narcotic Record of R18.

The facility failed to ensure 30 Percocet tablets (Schedule II narcotic pain medication) were appropriately documented as destroyed or administered for R19.

R19's record contained a Physician's Order form with an order, dated 8/10/10, for oxycodone 5 mg/APAP 325 mg take one tablet by mouth every morning as needed for pain. R19's Individual Narcotic Record showed the facility received 30 of these tablets on 6/6/13, all with the same prescription number. No administration or disposition of the 30 tablets of this prescription number was documented in the Individual Narcotic Record, and observation revealed no medication with this prescription number was found in the narcotic bins of the facility.

When interviewed on 7/17/13, at 5:00 p.m., RN-A stated she believed the documentation for the medication with this prescription number had been transferred to other pages in the several

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3 395	Continued From page 4 narcotic log books in the facility, but could not locate an entry with the same prescription number. There was another page in a narcotic log book listing oxycodone 5 mg/APAP 325 mg for R19; one by mouth every morning as needed for pain, received on 6/6/13, but no prescription number was listed. An interview conducted on 7/18/13, at 9:35 a.m. RN-A and the facility administrator stated they believed they could account for all of the medication with this prescription number by reviewing the medication administration records in the facility, but there was not definitive documentation of the administration or disposition of the medication with this prescription number in the Individual Narcotic Record of R19. The policy for Controlled Drugs/Narcotic Receipt, Counting, Label Changing, Descrepancies [sic] and Discontinuation, last revised November 2000, directed staff "Schedule II Drugs: Nursing will enter the medication into the Individual Narcotic Record Book with the following information. a. In the index: 1. Resident name 2. Name of drug. 3. Prescription number 4. Name of ordering physician 5. Directions for usage. 6. Initials of receiving 7. Date Received 8. Quantity received. H. Any Schedule II drug that is not used due to change in orders, discontinuation, or becoming outdated will be removed from the resident's drawer. 1. Record on the MAR that the Schedule II medication is being placed in the double locked metal cabinet for disposition. 2 Record in the narcotic book that the Schedule II medications being placed in the narcotic book that the Schedule II medication is being placed in the double locked metal cabinet for disposition. IV Shift -to Shift- Counting A. Two licensed nurses will count all narcotics at the end of each shift. C.	3 395		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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3 395	Continued From page 5 The count is completed as follows. Following the index: . a. Both nurses visualize the medication and compare the amount in the container with the amount listed on the corresponding page in the narcotic/card record. b. The two previous entries are noted to ensure correct math that the proceeding doses were signed out, etc. c. After medications are counted and verified by both nurses as correct, both nurses sign the shift to shift book, listing the date and time of the count." On 7/18/13, at 9:35 a.m. the administrator acknowledged the procedures to account for narcotic medication would need to be revised. Nursing staff required further training on accounting for narcotics. These procedures would need to be more closely monitored by nursing and medical record management staff. Upon investigation, management staff concluded nursing staff were not utilizing two nurses (one from the ending shift and one from the starting shift) to count narcotic medications, as it was not efficient. Nursing staff would be trained that two nurses (one from the ending shift and one from the starting shift) need to account for all narcotics. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and nursing management could instruct nursing staff on a system for safely and appropriately accounting for all narcotic medications. This system could be regularly monitored by the DON, nursing management and medical record management staff. The administrator could ensure this system is implemented and discrepancies are reported immediately to the appropriate authority. TIME PERIOD FOR CORRECTION: Three (3) days	3 395		

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31040	MN Rule 4655.7000 Subp. 1G Patient or Resident Units; nurse call device Subpart 1. Requirements. The following items shall be provided for each patient or resident: G. A device for signaling nurses and attendants which shall be kept in working order at all times. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a call light was available for use for both residents in 1 of 5 randomly reviewed resident rooms. The facility also failed to ensure the call system worked consistently in 5 of 20 randomly checked rooms on all 3 floors in building 25. The non functioning call system had the potential to affect all 38 residents living in the building. Findings include: During the environmental tour on 7/15/13, at 10:45 a.m. one of the personal bathrooms on fourth floor was observed with a call light not within reach when the resident was on the toilet. The call system in the bathroom was on the wall where the bathtub was located. The toilet was opposite the bathtub and no call system was located by the toilet. In the same room, the call light cord for bed 2 was not long enough to reach the bed. R22, who was in the room, indicated the cord had never been long enough. The environmental supervisor on tour agreed the call system in the bathroom was not available for the resident on the toilet and agreed the call light cord for bed 2 was not long enough for the resident to	31040		

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31040	Continued From page 7 reach. Random rooms in building 25 were checked for a functioning call system. Building 25 was located across the street from the main building. It was not routinely staffed. The call system in four rooms on first floor (101, 103, 105, 113) did not work consistently and one room on ground floor (G3) did not work consistently. The call system when activated would alert staff at the nursing station in building 23 of the need for assistance from residents. When tested during the enviornmental tour the call light on the system would immediately deactivate and the staff at the nursing station were not alerted. The environmental specialist immediately called the engineer who came to check the system. However, he was unable to repair it. On 7/19/13, at approximately 10:30 a.m. the engineer and environmental supervisor indicated the system was checked on an annual basis. Review of testing documentation indicated the last time the call system was checked was in March 2012. At 2:15 p.m. on 7/15/13, the engineer indicated there was most likely a problem with the system because all of the affected rooms were on the same floor (with the exception of one room) and all were on the same side of the hall. A plan was immediately put into place to assure the safety of the residents in building 25 until the company could come and fix the problem the following morning. SUGGESTED METHOD OF CORRECTION: The enviornmental services supervisor could implement a system to regularly audit call light availability and function for resident rooms.	31040		

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31040	Continued From page 8 TIME PERIOD FOR CORRECTION: Ten (10) days	31040		
31165	MN Rule 4655.7850 Subp. 3 Disposition of Medications; Record Subp. 3. Recording of disposition. A notation of such destruction giving date, quantity, name of medication, and prescription number shall by recorded on the resident's personal care record. Such destruction shall be witnessed and the notation signed by both persons. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to account for the administration or destruction of medications for 2 of 14 residents (R18, R19) reviewed to accounting for narcotic medication and 4 of 5 residents discharged (RD1, RD2, RD4 and RD3) reviewed for disposition of medications upon discharge. The facility failed to ensure 120 oxycodone tablets (Schedule II narcotic pain medication) were appropriately documented as destroyed or administered for R18. R18's record contained a physician's order dated 6/18/13, for oxycodone 5 mg (milligram) tablets, take 5 mg-10 mg. every four hours as needed for pain, dispense 240 tablets. R18's Individual Narcotic Record showed the facility received 120 oxycodone 5 mg tablets on 6/28/13, all with the same prescription number. No administration or disposition of the 120 tablets for this prescription number was documented in the Individual	31165		

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31165	Continued From page 9 Narcotic Record, and observation revealed no medication with this prescription number was found in the narcotic bins of the facility. When interviewed on 7/17/13, at 5:00 p.m., registered nurse (RN)-A stated she believed the documentation for the medication with this prescription number had been transferred to other pages in the several narcotic log books in the facility, but could not locate an entry with the same prescription number. There were other pages in narcotic log books listing oxycodone 5 mg for R18, but none of these entries contained this prescription number; some contained no prescription number, and some contained no date, or the date of 7/12/13. An interview conducted on 7/18/13, at 9:35 a.m. RN-A and the facility administrator stated they believed they could account for most or all of the medication with this prescription number by reviewing the medication administration records in the facility, but there was not definitive documentation of the administration or disposition of the medication with this prescription number in the Individual Narcotic Record of R18. The facility failed to ensure 30 Percocet tablets (Schedule II narcotic pain medication) were appropriately documented as destroyed or administered for R19. R19's record contained a Physician's Order form with an order, dated 8/10/10, for oxycodone 5 mg/APAP 325 mg take one tablet by mouth every morning as needed for pain. R19's Individual Narcotic Record showed the facility received 30 of these tablets on 6/6/13, all with the same prescription number. No administration or disposition of the 30 tablets of this prescription	31165		

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31165	Continued From page 10 number was documented in the Individual Narcotic Record, and observation revealed no medication with this prescription number was found in the narcotic bins of the facility. When interviewed on 7/17/13, at 5:00 p.m., RN-A stated she believed the documentation for the medication with this prescription number had been transferred to other pages in the several narcotic log books in the facility, but could not locate an entry with the same prescription number. There was another page in a narcotic log book listing oxycodone 5 mg/APAP 325 mg for R19; one by mouth every morning as needed for pain, received on 6/6/13, but no prescription number was listed. An interview conducted on 7/18/13, at 9:35 a.m. RN-A and the facility administrator stated they believed they could account for all of the medication with this prescription number by reviewing the medication administration records in the facility, but there was not definitive documentation of the administration or disposition of the medication with this prescription number in the Individual Narcotic Record of R19. The policy for Controlled Drugs/Narcotic Receipt, Counting, Label Changing, Descrepancies [sic] and Discontinuation, last revised November 2000, directed staff "Schedule II Drugs: Nursing will enter the medication into the Individual Narcotic Record Book with the following information. a. In the index: 1. Resident name 2. Name of drug. 3. Prescription number 4. Name of ordering physician 5. Directions for usage. 6. Initials of receiving 7. Date Received 8. Quantity received. H. Any Schedule II drug that is not used due to change in orders, discontinuation, or becoming outdated will be removed from the resident's	31165		

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31165	Continued From page 11	31165		

drawer. 1. Record on the MAR that the Schedule II medication is being placed in the double locked metal cabinet for disposition. 2 Record in the narcotic book that the Schedule II medications being placed in the narcotic book that the Schedule II medication is being placed in the double locked metal cabinet for disposition. IV Shift -to Shift- Counting A. Two licensed nurses will count all narcotics at the end of each shift. C. The count is completed as follows. Following the index: . a. Both nurses visualize the medication and compare the amount in the container with the amount listed on the corresponding page in the narcotic/card record. b. The two previous entries are noted to ensure correct math that the proceeding doses were signed out, etc. c. After medications are counted and verified by both nurses as correct, both nurses sign the shift to shift book, listing the date and time of the count."

On 7/18/13, at 9:35 a.m. the administrator acknowledged the procedures to account for narcotic medication would need to be revised. Nursing staff required further training on accounting for narcotics. These procedures would need to be more closely monitored by nursing and medical record management staff. Upon investigation, management staff concluded nursing staff were not utilizing two nurses (one from the ending shift and one from the starting shift) to count narcotic medications, as it was not efficient. Nursing staff would be trained that two nurses (one from the ending shift and one from the starting shift) need to account for all narcotics.

The facility failed to document destruction of medication for RD1, upon discharge.

RD1 was discharged on 7/3/13, to a correctional

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31165	Continued From page 12 facility according to a Discharge Summary form in the record dated 7/10/13. A physician's order dated 7/3/13, directed that RD1 would be discharged involuntarily without medications. The 7/10/13, Discharge Summary form indicated RD1's scheduled drugs were destroyed per facility policy. There was no record of the medication destruction. The Physician's Order form dated 5/8/12, showed RD1 was taking one medication at the time of discharge (ranitidine). The facility failed to document destruction of medications upon discharge for RD2. RD2 was discharged on 10/26/12, to acute care and then to a nursing home. The discharge record dated 10/28/12, indicated scheduled medications were destroyed per the facility policy. However, no record was available to indicate they were destroyed. The medications to be destroyed were: simvastatin (a cholesterol lowing medication), multivitamins, vitamin D3, combivent inhaler (used to prevent bronchospasm), albuterol inhaler (relaxes muscles in the airways and increases air flow to the lungs), digoxin (used to treat heart failure and abnormal heart rhythms), metoprolol (used to treat high blood pressure), and warfarin (blood thinner). The facility failed to document destruction of medications upon discharge for RD4. RD4 was discharged on 4/10/13, to independent living. The physicians order dated 4/8/13, indicated R4 should be sent a 14 day supply of medications. The discharge summary dated 4/10/13, indicated scheduled medications were sent with RD4 however the summary also indicated scheduled drugs were destroyed by the facility. There was no destruction record available	31165		

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31165	Continued From page 13 and no record of what medications were sent with RD4. The medications were: vitamins, mirtrazapine (antidepressant), olanzapine (anitpsychotic), HCTZ (hydrochlorothiazide used to treat high blood pressure and edema), divalproex ER (use to treat seizures), sennosides/DSS (Docusate Sodium used to treat constipation), EC aspirin, omeprazole (used to treat reflux), lisinopril (used to treat hypertension), levothyroxine (used to treat thyroid), monetasone (used topically to reduce inflammation of the skin or in the airways), vitamin D3, fish oil (used to lower triglyceride levels in the blood), metoprolol (used to treat hypertension), hydroxyzine (used to treat anxiety), ibuprophen (used for pain relief), ondanestron (used to prevent nausea and vomiting that may be caused by surgery or by medicine to treat cancer, and albuterol inhaler. When interviewed on 7/17/13, at 1:25 p.m. RN-A indicated all medications (other than narcotics) were documented on the medication record as to when they were destroyed. The medical record should also indicate what medications were sent with RD4. RN-A was unable to locate any information regarding the disposition of the above medications and indicated the documentation must not have been completed. The facility failed to produce a record showing destruction of non-controlled medications for RD3. Discharge Summary dated 11/23/12, indicated scheduled medications were destroyed per facility policy. A corresponding note indicated no medications were sent with RD3. Physician orders dated 11/23/12, indicated RD3 was prescribed the following medications: Tamsulosin HCL Extended Release (used to treat benign prostatic hyperplasia), omeprazole (used for	31165		

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31165	Continued From page 14 heartburn relief), calcium + D (dietary supplement), metformin HCL (used for management of blood sugars) Digoxin (used to treat congestive heart failure), Fluticasone-Salmeterol, Tiotropium Bromide Mononohydrate (used to treat chronic obstructive pulmonary disease), lisinopril, metroprolol succinate (used for treatment of high blood pressure), Nitrogylcerin (treatment for chest pain), Ambien (sleep aid), albuterol and albuterol sulfate (for relief of wheezing and shortness of breath), docusate sodium (treat constipation), simvastain (treatment of hyperlipidemia), ferrous sulfate (used to treat iron deficiency), Lasix (treatment of fluid retention), aspirin (pain reliever), clindamyacin HCL (antibiotic), Percocet (a schedule II controlled substance for treatment of severe pain). A review of the medication administration record for November did not indicate destruction of medications. When interviewed on 7/17/13, at 1:25 p.m. RN-A, indicated all medications (other than controlled substances) were documented on the medication administration record as to when they were destroyed. RN-A reviewed the medical record and medication administration record and determined no record existed to prove destruction of medications that were not controlled substances for RD3. A record of destruction of Percocet was produced. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and nursing management could instruct nursing staff on a system for safely and appropriately accounting for all narcotic medications and destruction of medications upon resident discharge. This system could be regularly monitored by the DON, nursing management and medical record	31165		

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31165	Continued From page 15 management staff. The administrator could ensure this system is implemented and discrepancies are reported immediately to the appropriate authorities. TIME PERIOD FOR CORRECTION: Three (3) days	31165		
31305	MN Rule 4655.8670 Subp. 1 Food Supplies; Food Subpart 1. Food. All food shall be from sources approved or considered satisfactory by the commissioner of health, and shall be clean, wholesome, free from spoilage, free from adulteration and misbranding, and safe for human consumption. No hermetically sealed, nonacid, or low-acid food which has been processed in a place other than a commercial food-processing establishment shall be used. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain 3 of 5 common refrigerators in building 23 in a sanitary manner. This had the potential to affect all 118 residents living in the facility. Findings include: Accompanied by the environmental specialist, the environmental tour was conducted on 7/15/13, at 10:45 a.m. Three common use refrigerators in building 23 were observed to contain spoiled, and/or out dated food. The fourth floor refrigerator contained a spoiled watermelon, bologna open and not dated, peanut	31305		

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31305	Continued From page 16 butter with a best by use date of 2/10, seven jello dated use by 1/13. The third floor refrigerator contained a undated open jar of homemade pickles with a yellow-milky white liquid substance in the bottom, mustard with a use by date of 5/1/13, cocktail sauce with a use by date of 4/5/13. The second floor refrigerator contained cocktail sauce with a use by date of 7/12/11, homemade jelly with an open date of 2010, spicy cocktail sauce with a use by date of 9/26/08, hotdog's with a use by date of 4/24/13. In all three lounges there were numerous packets of mayonnaise, miracle whip,and ranch dressing, none of these packets were dated.. The environmental specialist indicated all refrigerators were to be checked daily and cleaned every week by housekeeping staff. The refrigerator checklists were reviewed and indicated staff should remove outdated and expired items. However, when reviewed, the check lists indicated temperature, that refrigerator was cleaned, and condition of freezer. Although the third and fourth floor checklists were all signed the environmental specialist indicated the refrigerators obviously were not checked for outdated food and items were not discarded. The environmental specialist also indicated the residents bring up all the condiments and place them in the drawer. The environmental specialist indicated there was no system in place to monitor for expiration of condiments. SUGGESTED METHOD OF CORRECTION: The environmental supervisor or designee could develop and implement a system to monitor resident refrigerators and food storage area for cleanliness and expired food. Refrigerators and food storage areas could be regularly cleaned and expired food discarded. The dietary manager	31305		

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31305	Continued From page 17 or designee could educate residents and staff on basic food safety. TIME PERIOD FOR CORRECTION: Ten (10) days	31305		
31995	MN Rule 626.557 Subd. 4A Reporting Maltreatment of Vulnerable Adults Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. This MN Requirement is not met as evidenced by: Based on interview, and document review, the facility failed to immediately report to the Common Entry Point (CEP) potential neglect of care for 2 of 4 residents (R20, R21)reviewed for incidents. Findings include: The facility failed to immediately report to the CEP an attempted suicide, resulting in hospitalization for R20. Review of Committee Meeting Minutes, dated 10/30/12, indicated "This incident occurred at 0309 [3:09 a.m.] on the morning of 10-7-12. The resident called the nurses' station via his call	31995		

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31995	Continued From page 18 light." "When they [nursing and security staff] entered the resident's room, they saw that he had a black garbage bag over his head and a pair of scissors on the bed. There was a small amount of blood on the resident's shirt and a scant amount of blood on the resident's neck." Nursing staff bandaged the superficial neck wound and removed the scissors while security removed the bag from the resident's head. The resident expressed feelings that "he couldn't even do this right" and "told the nurse that he was DNR/DNI (Do not resuscitate. Do not intubate) so she should not be helping him" while waiting for further assistance. Emergency services responded to the facility call and transported R20 to the hospital. R20 was subsequently admitted to the hospital. The facility determined the incident was "catastrophic" in severity level. Review of Internal Notification of Vulnerable Adult Report to the CEP revealed the incident was reported to CEP on 10/8/12 at 10:40 a.m. The facility failed to immediately report to the CEP a medication error that caused harm to R21 and required medical intervention. Review of the Medication Error Report, undated, indicated R21 was given Trazadone (antidepressant)100mg (milligrams) instead of Tramadol (pain reliever)100mg on 10/11/12. R21 suffered an "allergic reaction" as a result the nurse practitioner ordered a 50 mg dose of Benadryl to be given to R21 on 10/12/12. Investigation notes dated 10/23/12, indicated "[R21] received Trazadone 100 mg instead of Tramadol 100 mg. He had a noted allergy to Trazadone and recognized the symptoms he started to experience." A letter to the Office of Health Facility Complaints dated 11/5/12, indicated "[R21] sustained moderate skin	31995		

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31995	Continued From page 19 irritation, namely reddened rash localized to upper extremities and one area below the lip." Internal Notification of Vulnerable Adult Report to the CEP indicated the incident was reported on 10/16/12 at 4:00 p.m. On 7/17/13, at approximately 2:00 p.m. the director of nursing (DON) explained typically the management staff reported incidents of potential abuse, neglect and financial exploitation to the CEP on the first business day after the event. The DON acknowledged incidents should be reported immediately. The Vulnerable Adults Act policy for the Minnesota Veterans Home-Hastings, dated 2/02/96, directed staff "After determining that a VA (vulnerable adult) incident occurred or may have occurred, telephone the Vulnerable Adult incident to the Common Entry Point [contact information] as soon as possible, within 24 hours of initial knowledge of the incident and complete the "Notification of VA Report to the CEP" (Attachment B). SUGGESTED METHOD OF CORRECTION: The administrator or designee could educate all staff on vulnerable adult mandated reporter laws, including immediate internal and external reporting responsibilities. The administrator or designee could develop and implement procedures to audit compliance with reporting procedures. TIME PERIOD FOR CORRECTION: Ten (10) days	31995		

3201 MOH LLC

SENDER: *COMPLETE THIS SECTION*

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- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Mr. Andrew Burnside, Administrator
Minnesota Veterans Home Hastings
1200 East 18th Street
Hastings, MN 55033

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) Ben Eggersdorfer

C. Date of Delivery 8-5-13

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Minnesota Department of Health
Licensing and Certification Program

FACILITY MN VETERANS HOME HASTINGS DATE 7-18-13

Indicate the name and title for each surveyor/supervisor on site during the survey, even those not present at the exit.

Surveyors Names and Titles

NAME Please Print	TITLE
Mary Heim LICSW	HPR Sr. Social Work Spec
Robyn Wadley RN	Nurse Evaluator II
Karen Beskar RN	"

Exit Conference Attendees

SIGNATURE	TITLE
Cadence Bramside	Administrator
W Kon	Medical Director
Kim Glass	psychologist
Nancy Satern	Benefits Coord.
Mary Glaser	RN CNP
Vickie Davidson	Admissions Coord.
Paula Zajac	QA RN
Eric Zuercher	Dietitian, Registered
[illegible]	HIM supervisor
Dottie Chamberlain	RN - Services
[illegible]	psychology
Mary Johnson	Pharmacy