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MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1780 0001 4939 8937

October 5, 2011

Ms. Kari Everson, Administrator
Mn Veterans Home Hastings
1200 East 18th Street
Hastings, Minnesota 55033

Re: Enclosed State Boarding Care Home Licensing Orders - Project Number SL00788020

Dear Ms. Everson:

The above facility survey was completed on September 21, 2011 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, PO 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.

Please feel free to call me with any questions.

Sincerely,

Susanne Reuss

Susanne Reuss, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3793 Fax: (651) 201-3790

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

L00788s11lic.rtf

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 _____	09/21/2011

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 September 19, 20, 21, 2011, surveyors of this Department's staff, visited the above provider and the following correction orders are 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 Boarding Care Homes.	

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3 000	Continued From page 1 Division of Compliance Monitoring, Licensing and Certification Program; Complaints; 85 East Seventh Place, Suite 220; P.O. Box 64900, St. Paul, Minnesota 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 is 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.	
3 945	MN Rule 4655.6400 Subp. 1 Adequate Care; Care in General Subpart 1. Care in general. Each patient or resident shall receive nursing care or personal and custodial care and supervision based on individual needs. Patients and residents shall be encouraged to be active, to develop techniques for self-help, and to develop hobbies and interests. Nursing home patients shall be up and out of bed as much as possible unless the attending physician states in writing on the patient ' s medical record that the patient must remain in	3 945		

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3 945	Continued From page 2 bed. This MN Requirement is not met as evidenced by: Based on observation, staff interview and record review the facility did not provide nursing care based on individual needs related to infection control for 4 of 4 residents (R9, R14, R20, R21) who used the facility glucometer (machine to check a blood glucose), and assess a resident who was at risk for falls and had a fall with a fracture. Findings include: The facility failed to ensure disinfection of a multi use glucometer according to the facility policy. On 9/19/11 at 4:30 p.m. the registered nurse (RN), in charge, stated the staff clean the facility multi use glucometer (a device used to measure blood glucose) weekly with two alcohol wipes. The RN stated the residents were encouraged to clean the glucometer after each use, report blood spills, and to notify staff the spill was cleaned up. On 9/21/11 at 6:45 a.m. a tissue covered tray with a glucometer was observed on the counter of the resident's blood glucose testing area. The tissue was stained with what appeared to be a small spot of blood. Signage was posted directing residents to immediately report blood drips on equipment, counter, etc. At 7:20 a.m. R20 approached the glucometer counter, performed the blood test, and replaced the soiled tray tissue with a clean tissue. The glucometer was not disinfected. At 7:25 a.m. R21 performed the blood test and did not disinfect the glucometer. At 7:25 a.m. R14 and at 7:35 a.m. R9 performed the	3 945		

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3 945	Continued From page 3 blood test and did not disinfect the glucometer. On 9/21/11 at 7:45 a.m. the facility infection control nurse stated the glucometer should be disinfected with a Sani-Cloth after each use and there should be a directive posted for the residents. There was no directive posted related to disinfecting the glucometer and no Sani-Cloths were available at the glucometer counter on 9/19/11, 9/20/11, and 9/21/11. On 9/22/11 the facility policy and procedure for blood glucose monitoring was reviewed. The procedure directed staff and residents to wipe the glucometer with a Sani-Cloth after completing the blood glucose monitoring procedure and allow time for drying as indicated by the manufacturer (two minutes). R3 was not comprehensively assessed following a fall, which resulted in a hip fracture. R3 suffered a fall on 9/13/11 at 7:00 a.m. and before the nurse completed an assessment the resident was lifted from the floor and placed in a wheelchair. The resident had a fractured hip. On 9/13/11 at 7:00 a.m. a resident called the nurses station to report that R3 was lying on the floor in the bathroom. R3 had been exiting the bathroom stall and another resident entering the bathroom accidentally knocked R3 down when the bathroom door hit R3. The Licensed Practical Nurse (LPN) responded to the 2 east bathroom to find R3 lying on the floor. The LPN notes written at 7:57 a.m., indicated R3 was asked, " if he was hurt anywhere and if he could move. He said yes and just demanded a wheelchair." The LPN brought a wheelchair and R3 was asked again if	3 945		

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3 945	Continued From page 4 was able to move. R3 replied "he could move and nothing hurt except he fell on his keys which were in his pocket." The security guard and the LPN lifted the resident from the floor into the wheelchair and took the resident to the nursing office. No comprehensive assessment of injuries was done prior to moving the resident from the floor nor was a comprehensive assessment completed once R3 arrived in the nursing office other than vital signs and oxygen saturation. The resident was transferred out by 911 to the hospital and at 9:14 a.m. the hospital called to state R3 had a fractured hip and would require surgery. The policy and procedure "Resident Falls Prevention Program" dated 10/24/08 indicated once a fall occurs the resident would be given immediate attention, and assessed by nursing (to include orthostatic blood pressure, oxygen saturation levels, accucheck etc). When interviewed on 9/21/11 at 11:00 a.m. the director of nursing agreed the LPN should have done a comprehensive assessment of the resident before moving him.. She further indicated there was no RN on duty that morning so the LPN did the assessment. Two fall risk assessments were completed for R3 on 6/30/10 and 9/13/11. Both indicated the resident was not at risk for falls. When interviewed on 9/21/11 at approximately 1:30 p.m. the administrator acknowledged the fall risk assessment was inaccurate and indicated the staff had been utilizing the wrong assessment tool. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing could ensure that staff	3 945		

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3 945	Continued From page 5 are re-inserviced as to the use of the glucometer and completeing assessments after an incident, and then audit this service to ensure that it care is being provided as indicated and take action as needed. TIME PERIOD FOR CORRECTION: Thirty (30) days.	3 945		
32000	MN Rule 626.557 Subd. 14 Reporting Maltreatment of Vulnerable Adults Subd. 14. Abuse prevention plans. (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency. (b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person ' s susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse.	32000		

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32000	Continued From page 6 (c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility ' s ongoing assessments of the vulnerable adult. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility did not develop and implement an individual resident vulnerable adult plan for the residents. Findings include: Sixteen resident records were reviewed. A plan to address the resident's vulnerability was not found in the medical record. During an interview on 9/20/11 at 11:35 a.m., the Director of Nursing (DON) indicated residents were assessed for areas of vulnerability, but that individual vulnerability plans were not developed. The DON indicated the different areas of vulnerability would be noted on the individual resident's care plans, in the social service notes and in the nursing notes. Review of the plan of care did not include the resident's vulnerability. The DON indicated	32000		

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32000	Continued From page 7 the facility was working on an assessment that would pull the information together, but nothing had been completed, and no vulnerability assessments would be found in the charts. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure all residents were assessed for vulnerability and individualized vulnerability plans were developed. The Director of Nursing or designee could educate all the appropriate staff on the polices/procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Thirty (30) days	32000		