



00788

five

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7008 1830 0003 8091 9085

May 11, 2010

Mr. Charles Cox, Administrator
Minnesota Veterans Home Hastings
1200 East 18th Street
Hastings, Minnesota 55033

Re: Enclosed State Boarding Care Home Licensing Orders - Project Number SL00788019

Dear Mr. Cox:

The above facility survey was completed on May 5, 2010 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.

Minnesota Veterans Home Hastings

May 11, 2010

Page 2

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 55160-0900.

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, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 643-2567 Fax: (651) 643-2538

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

L0078s10.rtf

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00788	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/05/2010 <i>CB</i>
NAME OF PROVIDER OR SUPPLIER MN VETERANS HOME HASTINGS		STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>INITIAL COMMENTS</p> <p>*****ATTENTION*****</p> <p>BOARDING CARE HOME LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: On May 3, 4, 5, 2010, 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,</p>	3 000	<p>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.</p>	

Minnesota Department of Health

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00788	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/05/2010
NAME OF PROVIDER OR SUPPLIER MN VETERANS HOME HASTINGS		STREET ADDRESS, CITY, STATE, ZIP CODE 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	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.
3 585	MN Rule 4655.3000 Subp. 1 Tuberculosis esting Employees. Responsibility Subpart 1. Pursuant to Minnesota Rule 4655.1000, and as defined in Minnesota Department of Health Information bulletin 09-03 Tuberculosis Prevention and Control: Nursing Home. Minnesota Rule 4655.3000 Subpart 1 Employee Tuberculosis Program is waived. Conditions of Wavier:	3 585	

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00788	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/05/2010
NAME OF PROVIDER OR SUPPLIER MN VETERANS HOME HASTINGS		STREET ADDRESS, CITY, STATE, ZIP CODE 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
3 585	<p>Continued From page 2</p> <ul style="list-style-type: none"> - Follow the U. S. Centers for Disease Control and Prevention ' s "Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, 2005," Morbidity and Mortality Weekly Report (MMWR) 2005;54 (No. RR-17), and as subsequently amended, for infection control procedures and requirements ("CDC Guidelines"). Refer to this document for complete definitions of terms. - Assign administrative responsibility for the TB infection control program to appropriate personnel. Administrative responsibilities include the establishment of an infection control team (one or more individuals), completion (and periodic update) of a written TB risk assessment, development (and periodic review) of a written TB infection control plan, and screening of health care workers (HCWs) for TB as discussed below. - Conduct a problem evaluation if a case of suspected or confirmed TB disease is not promptly recognized and appropriate measures are not taken. - Perform an investigation in collaboration with the local health department if health-care-associated transmission of M. tuberculosis is suspected. <p>This MN Requirement is not met as evidenced by: Based on record review and interview, the facility</p>	3 585	

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00788	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/05/2010
--	--	--	---

NAME OF PROVIDER OR SUPPLIER MN VETERANS HOME HASTINGS	STREET ADDRESS, CITY, STATE, ZIP CODE 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)	(X6) COMPLETE DATE
--------------------	--	---------------	---	--------------------

3 585	<p>Continued From page 3</p> <p>failed to complete a tuberculosis risk assessment per state requirement. Findings include:</p> <p>During facility record and policy review on 5/5/10, a tuberculosis risk assessment for the facility was not located. When interviewed that same date, the facility's infection control nurse stated that this assessment had not been done, and she would complete it immediately.</p> <p>SUGGESTED METHOD FOR CORRECTION: The Director of Nursing or designee(s) may review or revise policies and procedures to assure the tuberculosis risk assessment is completed yearly.</p> <p>PERIOD FOR CORRECTION: Fourteen (14) days.</p>	3 585		
3 590	<p>MN Rule 4655.3000 Subp. 2 Tuberculosis Testing of Employees; TB test</p> <p>Subp. 2. Pursuant to Minnesota Rule 4655.1000, and as defined in Minnesota Department of Health Information bulletin 09-03 Tuberculosis Prevention and Control: Nursing Home. Minnesota Rule 4655.3000 Subpart 2 Employee Tuberculosis Program is waived.</p> <p>Conditons of Waiver:</p> <p>- All paid and unpaid HCWs (as defined in the "CDC Guidelines") must receive baseline TB screening. This screening must include a written assessment of any current TB symptoms, and a two-step tuberculin skin test (TST) or single interferon gamma release assay (IGRA) for M. tuberculosis (e.g., QuantiFERON® TB Gold or TB Gold - In Tube, T-SPOT® .TB).</p>	3 590		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00788	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/05/2010
NAME OF PROVIDER OR SUPPLIER MN VETERANS HOME HASTINGS		STREET ADDRESS, CITY, STATE, ZIP CODE 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
3 590	<p>Continued From page 4</p> <p>- All paid and unpaid HCWs (as defined in the "CDC Guidelines") must receive serial TB screening based on the facility 's risk level: (1) low risk - not needed; (2) medium risk - yearly; (3) potential ongoing transmission - consult the Minnesota Department of Health's TB Prevention and Control Program at 651-201-5414.</p> <p>This MN Requirement is not met as evidenced by: Based on review of employee records, facility policies and staff interview, the facility failed to ensure 1 of 6 employees (Employee- A), prior to employment, received accurate screening of tuberculosis. Findings include:</p> <p>Employee A was offered a position on 9/24/09 with a start date of October 1, 2009 and would work as a Medical Records Technician. Employee A received a tuberculin test on 9/14/09, however, the employee record lacked documentation that an initial first step tuberculin test was received prior to the start date. The employee lacked evidence of another second step had been administered after the test on 9/14/09.</p> <p>The policy, adopted by the facility on 9/1/09, indicated a first step Mantoux test must be read prior to the actual starting date of employment and if the test result was not positive, a second test would be administered one to three weeks following the reading of the first test.</p> <p>When interviewed on 5/4/10, the Human Resource Director reported remembering the staff person received both steps, however, verified the employee record lacked documentation that supported the employee received a</p>	3 590	

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00788	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/05/2010
NAME OF PROVIDER OR SUPPLIER MN VETERANS HOME HASTINGS		STREET ADDRESS, CITY, STATE, ZIP CODE 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
3 590	Continued From page 5 two-step screening. SUGGESTED METHOD FOR CORRECTION: The Administrator or designee(s) may review or revise policies and procedures to ensure that new employees receive a two-step tuberculin skin test. PERIOD FOR CORRECTION: Fourteen (14) days.	3 590	



fre

Protecting, Maintaining and Improving the Health of Minnesotans

May 11, 2010

Mr. Charles Cox, Administrator
Minnesota Veterans Home Hastings
1200 East 18th Street
Hastings, Minnesota 55033

Re: Enclosed Reinspection Results - Project Number SL00788018

Dear Mr. Cox:

On May 5, 2010 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 March 12, 2009, with orders received by you on March 27, 2009. 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,

Susanne Reuss

Susanne Reuss, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 643-2567 Fax: (651) 643-2538

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

L0078r109.rtf

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number
00788

(Y2) Multiple Construction
A. Building
B. Wing

(Y3) Date of Revisit
5/5/2010 **CG**

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	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix 30945	05/05/2010	ID Prefix 31105	05/05/2010	ID Prefix 31155	05/05/2010
Reg. # MN Rule 4655.6400 Subp. LSC	Correction Completed	Reg. # MN Rule 4655.7810 LSC	Correction Completed	Reg. # MN Rule 4655.7850 Subp. LSC	Correction Completed
ID Prefix 31810	05/05/2010	ID Prefix		ID Prefix	
Reg. # MN Rule 144.651 Subd. 6 LSC	Correction Completed	Reg. # LSC	Correction Completed	Reg. # LSC	Correction Completed
ID Prefix		ID Prefix		ID Prefix	
Reg. # LSC	Correction Completed	Reg. # LSC	Correction Completed	Reg. # LSC	Correction Completed
ID Prefix		ID Prefix		ID Prefix	
Reg. # LSC	Correction Completed	Reg. # LSC	Correction Completed	Reg. # LSC	Correction Completed
ID Prefix		ID Prefix		ID Prefix	
Reg. # LSC	Correction Completed	Reg. # LSC	Correction Completed	Reg. # LSC	Correction Completed

Reviewed By
State Agency
Reviewed By
CMS RO

Reviewed By
SP/ SNL
Reviewed By

Date: *5/11/10*
[Signature]
Date:

Signature of Surveyor:
19200
Signature of Surveyor:

Date: *5/5/10*
Date:

Followup to Survey Completed on:
3/12/2009

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

**Minnesota Department Of Health
Division of Compliance Monitoring
Licensing and Certification Program**

INFORMATIONAL MEMORANDUM

PROVIDER: Mn Veterans Home Hastings
1200 East 18th Street
Hastings, MN 55033

DATE OF SURVEY: May 3, 2010 through May 5, 2010

BEDS LICENSED:

HOSP: _____ NH: _____ BCH: 200 SLFA: _____ SLFB: _____

CENSUS:

HOSP: _____ NH: _____ BCH: 172 SLF: _____

BEDS CERTIFIED:

SNF/18: _____ SNF 18/19: _____ NFI: _____ NFII: _____ ICF/MR: _____ OTHER: _____

NAME(S) AND TITLE(S) OF PERSONS INTERVIEWED:

Connie Ball, Director of Nursing	Diane Eide, RN
Dorothy Chamberlain, Infection Control	Mary Glaeser, Nurse Practitioner
Nancy Delmore, Human Resources	Kelly Kaiser, TMA
Patricia Gosz, LicSW	Sue Klein, Dietary
Sharon Smith, Registered Dietician	Eleanor Mattson, LPN
Joseph Alawode, LPN	Melissa Tschida, LPN
Robert Walker, LicSW	
Patricia Werner, Cash Office	

SUBJECT: Annual Licensing Survey

ITEMS NOTED AND DISCUSSED:

An unannounced visit was made to determine compliance with state licensing regulations. The results of the survey were delineated during an exit conference. Refer to Exit Conference Attendance Sheet (HR116) for the names of the individuals attending the exit conference.

**Minnesota Department Of Health
Division of Compliance Monitoring
Licensing and Certification Program**

INFORMATIONAL MEMORANDUM

PROVIDER: Mn Veterans Home Hastings
1200 East 18th Street
Hastings, MN 55033

DATE OF SURVEY: May 3, 2010 through May 5, 2010

BEDS LICENSED:

HOSP: _____ NH: _____ BCH: 200 SLFA: _____ SLFB: _____

CENSUS:

HOSP: _____ NH: _____ BCH: 172 SLF: _____

BEDS CERTIFIED:

SNF/18: _____ SNF 18/19: _____ NFI: _____ NFII: _____ ICF/MR: _____ OTHER: _____

NAME(S) AND TITLE(S) OF PERSONS INTERVIEWED:

Connie Ball, Director of Nursing	Diane Eide, RN
Dorothy Chamberlain, Infection Control	Mary Glaeser, Nurse Practitioner
Nancy Delmore, Human Resources	Kelly Kaiser, TMA
Patricia Gosz, LicSW	Sue Klein, Dietary
Sharon Smith, Registered Dietician	Eleanor Mattson, LPN
Joseph Alawode, LPN	Melissa Tschida, LPN
Robert Walker, LicSW	
Patricia Werner, Cash Office	

SUBJECT: Licensing Revisit

ITEMS NOTED AND DISCUSSED:

An onsite re-visit was made to follow up state licensing deficiencies issued as a result of a survey completed on May 5, 2010. The results of this visit were delineated during an exit conference which was tape recorded.. Refer to Exit Conference Attendance Sheet (HR116) for the names of individuals attending the exit conference. Refer to the CMS-2567L and/or CMS-2567B for the status of federal deficiencies. Refer to the State-2567B for the status of state licensing deficiencies.



Track & Confirm

FAQs

Track & Confirm

Search Results

Label/Receipt Number: **7008 1830 0003 8091 9085**

Service(s): **Certified Mail™**

Status: **Delivered**

Your item was delivered at 9:11 AM on May 13, 2010 in HASTINGS, MN 55033.

Track & Confirm

Enter Label/Receipt Number.

Go >

Detailed Results:

- Delivered, May 13, 2010, 9:11 am, HASTINGS, MN 55033
- Arrival at Unit, May 13, 2010, 8:49 am, HASTINGS, MN 55033

Notification Options

Track & Confirm by email

Get current event information or updates for your item sent to you or others by email. [Go >](#)

U.S. Postal Service™
CERTIFIED MAIL™ RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)

For delivery information visit our website at www.usps.com

OFFICIAL USE

Postage	\$	Postmark Here
Certified Fee		
Return Receipt Fee (Endorsement Required)		
Restricted Delivery Fee (Endorsement Required)		

Tot
 Sent to: **Mr. Charles Cox, Administrator**
Minnesota Veterans Home Hastings
 Street: **1200 East 18th Street**
 City: **Hastings, Minnesota 55033**

PS Form 3800, August 2006 See Reverse for Instructions

7008 1830 0003 8091 9085