

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7015 0640 0003 5695 6436 November 4, 2016

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

# \*\*This letter and 2567amends and replaces the previous 2567 and letter dated October 18, 2016. Please shred the 2567 and letter dated October 18, 2016. \*\*

Re: Enclosed State Boarding Care Home Licensing Orders - Project Number SL00788025

Dear Mr. Burnside:

The above facility survey was completed on September 29, 2016 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, Health Regulation 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.

Mn Veterans Home Hastings November 4, 2016 Page 2 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 MN, 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,

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure(s) cc: Licensing and Certification File

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ND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	ECONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00788	B. WING		09/29/2016
IAME OF PR	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST/	ATE, ZIP CODE	00/20/2010
IN VETER	RANS HOME HASTINGS		ST 18TH STREE GS, MN 55033	т	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLET
3 000	INITIAL COMMENTS		3 000		
	*****ATTENTION	V*****			
	BOARDING CARE	HOME CTION ORDER			
	144A.10, this correction	innesota Statute, section on order has been issued If, upon reinspection, it is	11/17/10 SER	· · · · · · · · · · · · · · · · · · ·	
	found that the deficien herein are not correct not corrected shall be	ncy or deficiencies cited ed, a fine for each violation assessed in accordance es promulgated by rule of	JEK		
	corrected requires con requirements of the runumber and MN Rule When a rule contains comply with any of the lack of compliance. L re-inspection with any result in the assessme	ther a violation has been mpliance with all ule provided at the tag number indicated below. several items, failure to e items will be considered ack of compliance upon r item of multi-part rule will ent of a fine even if the item ng the initial inspection was			· ·
	that may result from n orders provided that a	aring on any assessments on-compliance with these written request is made to 15 days of receipt of a for non-compliance.			
	above Licensed Board following licensing orc corrections are compl make a copy of these	9/28/16 and 9/29/16, artment's staff visited the d and Care provider and the lers were issued. When eted, please sign and date.		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal softwa Tag numbers have been assigned to Minnesota state statutes/rules for Nur- Homes.	

11-16-16 If continuation sheet 1 of 56

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00788	B. WING		09/29/2016	
AME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
	RANS HOME HASTINGS		ST 18TH STREET			
		HASTING	GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLET	
3 000	INITIAL COMMENTS		3 000			
	*****ATTENTION	<b>****</b>				
	BOARDING CARE					
	144A.10, this correction pursuant to a survey. found that the deficient herein are not correct not corrected shall be	innesota Statute, section on order has been issued If, upon reinspection, it is ney or deficiencies cited ed, a fine for each violation assessed in accordance es promulgated by rule of ment of Health.				
	corrected requires correquirements of the runumber and MN Rule When a rule contains comply with any of the lack of compliance. L re-inspection with any result in the assessme	ther a violation has been mpliance with all ule provided at the tag number indicated below. several items, failure to e items will be considered ack of compliance upon vitem of multi-part rule will ent of a fine even if the item ng the initial inspection was				
	that may result from n orders provided that a	earing on any assessments non-compliance with these a written request is made to a 15 days of receipt of a for non-compliance.				
	above Licensed Board following licensing or	9/28/16 and 9/29/16, artment's staff visited the d and Care provider and the ders were issued. When eted, please sign and date,		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal softw Tag numbers have been assigned to Minnesota state statutes/rules for Nu Homes.		

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

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00788	B. WING		09/29/2016
	ROVIDER OR SUPPLIER	1200 EAS	DDRESS, CITY, ST ST 18TH STREE 3S, MN 55033		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLET
3 000	original to the Minness Health Regulation Div Certification Program Minnesota Department the State Licensing C federal software. Tag assigned to Minneso Boarding Care Home The assigned tag nur column entitled "ID F statute/rule number a the state statute/rule in the "Summary Stat column and replaces the correction order. the findings which ar statute after the state as evidenced by." Fo findings is the Time P PLEASE DISREGAR FOURTH COLUMN V "PROVIDER'S PLAN APPLIES TO FEDER THIS WILL APPEAR THERE IS NO REQU PLAN OF CORRECT MINNESOTA STATE MN Rule 4655.3300 S Contents of record Subpart 1. Content record shall be initiate	tota Department of Health, vision, Licensing and ; Int of Health is documenting correction Orders using numbers have been ta state statutes/rules for s. Inber appears in the far left Prefix Tag." The state nd the corresponding text of out of compliance is listed ement of Deficiencies" the "To Comply" portion of This column also includes e in violation of the state ment, "This Rule is not met ollowing the surveyors 'eriod For Correction. D THE HEADING OF THE VHICH STATES, OF CORRECTION." THIS AL DEFICIENCIES ONLY. ON EACH PAGE. IIREMENT TO SUBMIT A ION FOR VIOLATIONS OF	3 000	The assigned tag number appears in far left column entitled " ID Prefix Tag The state statute/rule out of complian listed in the "Summary Statement of Deficiencies" column and replaces th Comply" portion of the correction orde This column also includes the finding which are in violation of the state stat after the statement, "This Rule is not as evidence by." Following the survey findings are the Suggested Method o Correction and Time period for Correct PLEASE DISREGARD THE HEADIN THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. TH WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION VIOLATIONS OF MINNESOTA STAT STATUTES/RULES.	g." ce is e "To er. s ute met /ors f ction. G OF

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CON: A. BUILDING:		(X3) DATE SURVEY COMPLETED 09/29/2016	
		00788	B. WING			
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE, ZI	P CODE		
IN VETE	RANS HOME HASTINGS		ST 18TH STREET GS, MN 55033			
(X4) ID	SUMMARY ST			PROVIDER'S PLAN OF		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	COMPLET
3 620	contain identifying info previous address, soo marital status, age, da previous occupation, name, address, and to nearest relative, and ta an emergency or dear arrangements, if avail pastor; and the name resident's attending p This MN Requirement by: Based on interview ar facility failed to ensure admission record for 8 R117, R23 and R92). Findings include: Review of admission R23 and R92 revealed one of the following of address, birthplace, p affiliation and pastor. On 9/29/16 between 9 health information sup accuracy of admission SUGGESTED METHO health information sup could review and revis admission record and	brmation including: name, cial security number, sex, ate and place of birth, date and hour of admission; elephone number of the the person to be notified in th; information as to funeral able; church affiliation and of the patient's or hysician. t is not met as evidenced and document review, the e a complete and accurate 5 of 5 residents (R37, R14, components: previous revious occupation, church D a.m. and 11 a.m. the pervisor verified the	3 620	DEFICIEN		

	a Department of Health OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00788	B. WING		09	0/29/2016
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE	• • • •	
NN VETER	RANS HOME HASTINGS		ST 18TH STREET GS, MN 55033			
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3 620	Continued From page	9 3	3 620			
	TIME PERIOD FOR ( (21) days.	CORRECTION: Twenty-one				
3 830	MN Rule 4655.4700 S Examinations and Or		3 830			
	Each patient or reside medical history and c examination performe physician within five of hours after admission include: the report of physical examination; report of subsequent reports of appropriate general medical cond and limitations; instru patient's or resident's written orders for all n treatments, special d restriction of activity;	ed and recorded by a lays prior to or within 72 . The medical record shall the admission history and the admitting diagnosis and physical examinations; laboratory examinations; ition including disabilities ctions relative to the total program of care; nedications with stop dates, iets, and for extent or physician's orders and condition on discharge or				
	defined in Minnesota Informational Bulletin Prevention and Contr Home, Minnesota Ru	a Rule 4655.1000, and as Department of Health 09-03 Tuberculosis ol Guidelines:Boarding Care Ile 4655.4700 Subpart 1 t Tuberculosis Program is				
	Conditions of Waver:					
	Prevention's "(Guideli Transmission of Myco	ters for Disease Control and ines for Preventing the obacterium tuberculosis in , 2005," (MMWR) 2005; 54				

STATEMENT	a Department of Health OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00788	00788 B. WING			
NAME OF PR	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE			12312010
IN VETER	RANS HOME HASTINGS		ST 18TH STREET GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
3 830	Continued From page	2 4	3 830			
	infection control proce ("CDC Guidelines"). F	No. RR-17), and as subsequently amended, for ifection control procedures and requirements CDC Guidelines"). Refer to the "CDC Guidelines" for complete definitions of terms.				
	tuberculosis (TB) infe program to appropriat responsibilities includ infection control team completion (and perior risk assessment, and	e responsibility for the ction control & prevention te personnel. Administrative e establishment of an (one or more individuals), odic review) of a written TB development (and periodic B infection control plan.				
	3 months prior to adm include an assessment factors for TB, and an and a two-step TST or release assay (IGRA)	eceive baseline TB ours of admission or within hission. TB Screening must nt of the resident's risk by current TB symptoms, or a single interferon gamma of for M. tuberculosis (e.g., Gold or TB Gold In Tube,				
	tests (TSTs), results f tuberculosis, medical radiograph results mu resident's medical re recommendations for	evaluations, and chest ist be maintained in the cord. Consult current CDC the diagnosis of TB for up of residents who display				
	partment of Health					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00788	D788 B. WING		09/29/2016	
NAME OF PR	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	ZIP CODE		
MN VETER	RANS HOME HASTINGS		ST 18TH STREET GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLET DATE
3 830	Continued From page	9 5	3 830			
	by: Based on interview and facility failed to ensur- residents, (R37, R9, F physical examination admission and failed ordered by a physicial were completed by a	t is not met as evidenced nd document review, the e 5 of 5 newly admitted R12, R90, R138) received a by a physician upon to ensure medications were in and discharge orders physician upon discharge R160) whose records were				
	Findings include:					
	R37's admission histo examination, dated 10 completed by a nurse physician.	0/27/15 revealed it was				
	(MD), reported a nur complete the physica then complete a revie	m., the medical director se practitioner would I examinations. He would w of the patient record and and either write and sign or				
	reported the facility ha nurse practitioners (N residents, such as ph writing orders, as this practice. The facility a director. R9's admission histor	ysical examinations and was in an NP's scope of also had a physician medical y and physical examination, ed it was completed by a				

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED	
				A. BUILDING:			
		00788	B. WING		09	9/29/2016	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE ST 18TH STREET	, ZIP CODE			
MN VETER	RANS HOME HASTINGS		GS, MN 55033				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE	
3 830	Continued From page	e 6	3 830				
	examination, dated 8 completed by a nurse physician.						
	R90's admission histo examination, dated 8 completed by a nurse physician.	/4/15 revealed it was					
	R138's admission his examination, dated 1 completed by a nurse physician.	1/19/15 revealed it was					
	revealed discharge o medication orders da	ician. They were completed					
	medication administra						
	"I. written discharge of obtained if discharge discharge is unexpect physician will be obta and type of discharge will be counted and li						
		by doctor, or destroyed procedure Doctor's order n of medications."					
		OD FOR CORRECTION: designee could review and					

STATEMENT	a Department of Health r OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00788	B. WING		09	/29/2016
NAME OF PI	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE	, ZIP CODE		
NN VETEI	RANS HOME HASTINGS		ST 18TH STREET			
	SUMMARY ST		GS, MN 55033	PROVIDER'S PLAN O		(2/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETE DATE
3 830	Continued From page	27	3 830			
	TIME PERIOD FOR ( (21) days.	CORRECTION: Twenty-one				
3 835	MN Rule 4655.4700 S Examinations and Or		3 835			
	requirements. Each r be examined by a phy months and each boa	physical examination nursing home patient shall vsician at least every six rrding care home resident at e often if indicated by the				
	by: Based on interview an facility failed to ensure at the facility for more R92, R24, R42, R61,	t is not met as evidenced nd document review, the e 8 of 9 residents residing than 1 year, (R117, R23, R113, and R28) had annual s completed by a physician.				
	Findings include:					
	R117's annual review completed 7/25/16, re a nurse practitioner a	evealed it was completed by				
	R23's annual review a completed 4/29/16, re a nurse practitioner a	evealed it was completed by				
	R92's annual review a completed 4/6/16, rev	and physical exam, realed it was completed by a				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00788	B. WING			)/29/2016
AME OF PF	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE			12312010
	RANS HOME HASTINGS		ST 18TH STREET GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
3 835	Continued From page	2 8	3 835			
	nurse practitioner and	d not a physician.				
	(MD), reported a nur complete the physica then complete a revie	m., the medical director se practitioner would I examinations. He would w of the patient record and and either write and sign or				
	reported the facility has nurse practitioners (N residents, such as ph writing orders, as this practice. The facility a director. R24's annual review a	ysical examinations and was in an NP's scope of also had a physician medical and physical exam, evealed it was completed by				
	R42's annual review a completed 7/14/16, re a nurse practitioner a	evealed it was completed by				
	R61's annual review a completed 3/8/16, rev nurse practitioner and	vealed it was completed by a				
	R113's annual review completed 5/19/16, re a nurse practitioner a	evealed it was completed by				
	R28's annual review a completed 2/12/16, re a nurse practitioner, r	evealed it was completed by				
	SUGGESTED METH	OD FOR CORRECTION:				

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED 09/29/2016	
		00788	B. WING			
IAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
IN VETE	RANS HOME HASTINGS		ST 18TH STREET GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
3 835	Continued From page	9	3 835			
	revise procedures rela	designee could review and ated to annual history and elated to these procedures liance.				
	TIME PERIOD FOR ( (21) days.	CORRECTION: Twenty-one				
3 840	MN Rule 4655.4700 S Examinations and Ore		3 840			
	progress note shall be	of physical examinations. A e recorded in the patient's or le time of each examination.				
	by: Based on interview ar facility failed to ensure	t is not met as evidenced nd document review, the e 1 of 14 residents (R14) n the record for the most ination.				
	Findings include:					
	R14's record had no r examination within the	record of a physical e previous 12 months.				
	supervisor (HIS) confi explained R14 went to for the annual physical explained the record of examination was not clinic. Records from c	o a clinic outside the facility				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			SURVEY	
		00788			09	/29/2016	
	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE A <b>ST 18TH STREET</b>	, ZIP CODE			
IN VETEI	RANS HOME HASTINGS		GS, MN 55033				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLE <sup>-</sup> DATE	
3 840	Continued From page	: 10	3 840				
		m. R14 confirmed R14 had n in October of 2015 at a ity.					
	The administrator or or revise procedures relations	OD FOR CORRECTION: designee could review and ated to annual history and elated to these procedures liance.					
	TIME PERIOD FOR ( (21) days.	CORRECTION: Twenty-one					
3 980	MN Rule 4655.6400 S Clean linen	Subp. 2G Adequate Care;	3 980				
		or determining adequate ermining adequate and ude:					
		Bed linen shall be changed as needed. Beds shall be htened as necessary.					
	by: Based on observation	t is not met as evidenced and interview, the facility 40 residents (R43, R127 nen and bed made.					
	Findings include:						
	A tour was completed maintenance worker ( between 8:20 a.m. an concerns were observ PME-A.	PME)-A on 9/28/16 d 9:50 a.m. The following					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		00788	B. WING		09	/29/2016
AME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE, ST 18TH STREET	, ZIP CODE		
N VETEI	RANS HOME HASTINGS		GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLE <sup>-</sup> DATE
3 980	Continued From page	2 11	3 980			
	with clothes. R43 repo with cleaning his room had been in a similar R127 and R94's room	erved. The bed was piled orted no one helped him n. PME-A reported the room condition "for years." n was observed. The pillow n the bed was stained				
	of cardboard and plas boxes was an accum mattress. PME-A note	erved. The bed had large pile stic boxes. Surrounding the ulation of dust on the ed the room had been in a bout a year and a half.				
	The administrator or or resident beds are man provided on a at least administrator or desig	a weekly basis. The nee could review and revise staff could be trained related The administrator or				
	TIME PERIOD FOR ( (21) days.	CORRECTION: Twenty One				
31010	MN Rule 4655.7000 S Units; Comfortable be	Subp. 1A Patient or Resident	31010			
		ements. The following items each patient or resident:				
	good springs, and a c	bed at least 36 inches wide, lean, firm, comfortable s pad. At least one clean,				

Minnesota Departmen STATE FORM

6899

00788     B. WING     09/29/2016       NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE     1200 EAST 18TH STREET		OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE COMF	SURVEY PLETED
STREET ADDRESS, CITY, STATE, ZIP CODE       120 EAST 181 STREET       MAURE HASTINGS       INV CETERANS HOME HASTINGS       INV CETERANS HOME HASTINGS       INV CETERANS HOME HASTINGS       PROVIDERS PLAN OF CORRECTION (PART)       INV CETERANS HOME HASTINGS       PROVIDERS PLAN OF CORRECTION (PART)       ONC       ONC       ONC       ONC       ONC       ONC       ONC       ONC       ONC       ONC    <			00788			09/29/2016	
NUM VETERANS HOME HASTINGS         HASTINGS, MN 55033           (M) ID MEERX TAC         SUMMARY STEEMENT OF DEFICIENCES (EACH DEFICENT/UNIST EF RECED BY FULL REGULATIONY OF LSCIDENTIFYING INFORMATION)         ID PREPX INAC         ID PROVIDERS FLAN OF CORRECTIVE ACTION SHOULD BE CROSS-SHEPELED ON SHOULD BE CROSS-SHEPELED ON SHOULD BE CROSS-SHEPELED ON SHOULD BE DEFICIENCY)         0(0) CROSS-SHEPELED ON SHOULD BE CROSS-SHEPELED ON SHEP-CROSS SHEPELED ON SHEP-CROSS-SHEPELED ON SHEPELED ON SHEPELED ON SHEP-CROSS-SHEPELED ON SHEPELED ON SHEPELED ON SHEPELED ON SHEPELED ON SHEPELED ON SHEPELED ON SHEPELED ON	NAME OF PF	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	03	129/2010
Minimized TAG     REAL-LIBERGIENCY MOST BE PRECEDED BY FULL REDULATORY OR LSCIDENTIFYING INFORMATION)     PRETIVE TAG     CRACE-CREENCE TO THE APPROPRIATE DEFICIENCY)     Continued From page 12       31010     Continued From page 12     31010       and the patient's needs. Clean, lightweight blankets and bed linen in good condition and of the proper size shall be kept on hand for use at all times. Clean sheets and pillow cases shall be furnished at least once a week. Each bed shall have a washable bedgread. A molisture-proof mattress cover or rubber or plastic sheeting shall be provided for mattresses of all bed patients and for other beds as an eccessary. Rollaway type beds, cots, or folding beds shall not be used.       This MN Requirement is not met as evidenced by: Based on observation and interview the facility failed to ensure 4 of 140 residents, (R43, R127, R94 and R32) had a comfortable and clean bed and bed linen.       Findings include:       A tour was completed of Building 23 with a maintenance worker (PME)-A on 9/28/16 between 8:20 a.m. and 9:50 a.m. The following concerns were observed. The bed was piled with clothes, R43 room was observed. The bed was piled with clothes, R43 reported no one helped him with cleaning his room. PME-A reported the room had been in a similar condition Tor years.'       R127 and R94's room was observed. The pillow case and comforter on the bed was stained yellow.	MN VETER	RANS HOME HASTINGS					
<ul> <li>comfortable pillow with extra pillows available to meet the patient's needs. Clean, lightweight blankets and bed linen in good condition and of the proper size shall be kept on hand for use at all times. Clean sheets and pillow cases shall be trunished at least once a week. Each bed shall have a washabib bedspread. A moisture-proof mattress cover or rubber or plastic sheeting shall be provided for mattresses of all bed patients and for other beds as necessary. Rollaway type beds, cots, or folding beds shall not be used.</li> <li>This MN Requirement is not met as evidenced by: Based on observation and interview the facility failed to ensure 4 of 140 residents, (R43, R127, R94 and R32) had a comfortable and clean bed and bed linen.</li> <li>Findings include:</li> <li>A tour was completed of Building 23 with a maintenance worker (PME)-A on 9/28/16 between 8:20 a.m. and 9:50 a.m. The following concerns were observed and confirmed by PME-A.</li> <li>R43's room was observed. The bed was piled with clothes. R43 reported no one helped him with clothes and confirmed by PME-A.</li> </ul>	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE AC CROSS-REFERENCED TO	CTION SHOULD BE THE APPROPRIATE	COMPLET
accumulation of cardboard and plastic boxes.	31010	comfortable pillow with meet the patient's new blankets and bed line the proper size shall the all times. Clean shee furnished at least onch have a washable bed mattress cover or rub be provided for mattree for other beds as new cots, or folding beds as This MN Requirement by: Based on observation failed to ensure 4 of 1 R94 and R32) had a control and bed linen. Findings include: A tour was completed maintenance worker (between 8:20 a.m. and concerns were observe PME-A. R43's room was observe with clothes. R43 report with cleaning his room had been in a similar R127 and R94's room case and comforter of yellow. R32's room was observe	h extra pillows available to eds. Clean, lightweight n in good condition and of be kept on hand for use at its and pillow cases shall be e a week. Each bed shall spread. A moisture-proof ber or plastic sheeting shall esses of all bed patients and essary. Rollaway type beds, shall not be used. t is not met as evidenced n and interview the facility 40 residents, (R43, R127, comfortable and clean bed l of Building 23 with a (PME)-A on 9/28/16 id 9:50 a.m. The following ved and confirmed by erved. The bed was piled orted no one helped him n. PME-A reported the room condition "for years." n was observed. The pillow in the bed was stained	31010	DEFICIEN		

STATE FORM

STATEMENT	a Department of Health FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE COMF	SURVEY PLETED	
		00788	B. WING		09	09/29/2016	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
MN VETEI	RANS HOME HASTINGS		ST 18TH STREET GS, MN 55033				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE	
31010	been in a similar cond half. SUGGESTED METH The administrator or or resident rooms are clo provided on a at least administrator or desig related procedures. S to these procedures. designee could monit	PME-A noted the room had dition for about a year and a OD FOR CORRECTION: designee could ensure eaned and clean linen is a weekly basis. The nee could review and revise staff could be trained related The administrator or	31010				
31105	A system shall be c care home to assure distributed safely and shall be distributed ar by the physician. Any resident reactions sha	all be reported to the I an explanation made in the	31105				
	by: Based on interview an facility failed to ensure reviewed (R117, R92, R28, R90, R138) were medications with physi medications were ord discharge orders were	, R14, R37, R23, R9, R12,					

	a Department of Health FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
		00788	B. WING		09	9/29/2016
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE,	ZIP CODE		
IN VETEI	RANS HOME HASTINGS		ST 18TH STREET SS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
31105	Continued From page	e 14	31105			
	records were reviewe	d.				
	Findings include:					
	revealed medications practitioner, not a phy	, dated 9/20/16 and 8/29/16 ordered by a nurse ysician. R117's September hese medications were				
	medications ordered l a physician. R92's Se	dated 7/26/16 revealed by a nurse practitioner, not eptember 2016 MAR ations were distributed to				
	medications ordered l a physician. R14's Se	dated 7/26/16 revealed by a nurse practitioner, not eptember 2016 MAR ations were distributed to				
	medications ordered l	dated 8/24/16 revealed by a nurse practitioner, not tember 2016 MAR revealed ere distributed to R37.				
	medications ordered l a physician. R23's Se	dated 7/26/16 revealed by a nurse practitioner, not ptember 2016 MAR ations were distributed to				
	nurse practitioners (N residents, such as ph writing orders, as this	ad an onsite clinic and used				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		00788	B. WING		00	09/29/2016	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	, ZIP CODE	09	12912010	
NN VETER	RANS HOME HASTINGS		ST 18TH STREET				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	GS, MN 55033 ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AO CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE ) THE APPROPRIATE	(X5) COMPLET DATE	
31105	Continued From page	e 15	31105				
	revealed medications practitioner, not a phy 2016 MAR revealed t distributed to R9. R12's current orders, revealed medications practitioner, not a phy 2016 MAR revealed t distributed to R12. R28's current orders, revealed medications practitioner, not a phy 2016 MAR revealed t distributed to R28. R90's current orders, revealed medications practitioner, not a phy	vsician. R9's September hese medications were dated 9/28/16 and 9/15/16 ordered by a nurse vsician. R12's September hese medications were dated 9/15/16 and 9/14/16 ordered by a nurse vsician. R28's September hese medications were dated 9/23/16 and 9/15/16					
	revealed medications practitioner, not a phy	s, dated 9/27/16 and 9/15/16 ordered by a nurse ysician. R138's September hese medications were					
	revealed discharge of medication orders dat	cian. They were completed					
	R160's orders, dated revealed medications						

STATEMENT	a Department of Health OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		00788	B. WING		09/29/2016	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		12312010
MN VETEI	RANS HOME HASTINGS		ST 18TH STREET SS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
31105	medication administra these medications we Facility's discharge po discharge order by ph discharge is planned unexpected, a phone be obtained. Order wi discharge. II. Dischar counted and listed, ei approved by doctor, o proper procedure D disposition of medicat	vsician. R160's January 2016 ation record (MAR) revealed ere distributed to R160. blicy revealed "I. written hysician will be obtained if in advance. If discharge is order from the physician will ill include time and type of ge medications will be ther sent with resident if or destroyed according to toctor's order will include tions." OD FOR CORRECTION: designee could review and ated to distribution of ff related to these	31105			
31130	TIME PERIOD FOR ( (21) days. MN Rule 4655.7830 S Containers; Labeled	-	31130			
	medications shall be container bearing the information stating the name of drug, strengt expiration dates of all directions for use, res name, date of origina refill, the most recent address of the license	original label with legible e prescription number, h and quantity of drug,				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			SURVEY PLETED	
			A. BUILDING.				
		00788	B. WING		09/29/2016		
IAME OF PI	ROVIDER OR SUPPLIER	STREETA	ADDRESS, CITY, STATE	, ZIP CODE			
IN VETER	RANS HOME HASTINGS		ST 18TH STREET GS, MN 55033				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
31130	Continued From page	e 17	31130				
i	the boarding care hor prescription number a if these are not on the	and name of the medication					
	by: Based on observation review, the facility fail were stored and labe residents (R32, R39, R128) reviewed for m	t is not met as evidenced n, interview and document led to ensure medication led properly for 7 of 13 R80, R90, R91, R118 and nedication storage and failed of medication bottle for 1 of iewed for medication					
	Findings include:						
	at the facility, medica R90, R91, R118 and drops and insulin, lac medication name and	l direction label, lacked n they were opened, or the					
	2:35 p.m. with the lice (LPN)-A, in the medic multiple opened, und medication bottles an medication bins. Obs following: - R32's Timolol Ma	cation room (Pharmacy), ated and unlabeled					
	(Glaucoma). Latanop	aleate solution 0.25 % rost solution 0.005% bottles were opened, used					

STATE FORM

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
			B. WING			
		00788			09	0/29/2016
	ROVIDER OR SUPPLIER	1200 EA	DDRESS, CITY, STATE ST 18TH STREET	, ZIP CODE		
MN VETEI	RANS HOME HASTINGS	HASTIN	GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
31130	Continued From page	e 18	31130			
	opened, used and wa - R90's Timolol Ma (Glaucoma) was oper - R91's Travoprost opened, used and wa - R118's Dorzolam solution 22.3-6.8 mg// Prednisolone Acetate were opened, used al addition, Dorzolamide and Brimonidine Tartr to be opened, undate stored in R118 medic room. - R128's Timolol M	aleate solution 0.5 % ned, used and was undated. t Z solution 0.004 % was us undated. nide HCL-Timolol Maleate ml (Glaucoma) and suspension 1% (cataracts)				
	LPN-A verified the me and labeled properly and stored properly. I medications needed t and insulin are norma ask registered nurse	n 9/26/16, at 3:05 p.m. edications were not stored and needed to be labeled _PN-A added that opened to be dated when opened ally dated when opened. Will (RN)-A with what to do with and the insulin pen that abeled properly.				
	p.m. RN-A verified the labeled and stored pr Further mentioned, "V eye drops and the ins from our pharmacy ar	LPN-B on 9/26/16, at 3:20 e medication needed to be operly with proper labels. We will be destroying those sulin pen, reorder new one nd date them when open. ff to date the eye drops and n."				
anosoto Der		dated 11/14/14, title EYE IISTRATION, directed staff,				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			B. WING				
	ROVIDER OR SUPPLIER	00788	B. WING 09/29/20				
			ST 18TH STREET	,211 0000			
	RANS HOME HASTINGS	HASTIN	GS, MN 55033				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE	
31130	Continued From page	9 19	31130				
	check the expiration of container the first time".	for ophthalmic use. Then late. Remember to date the e you use the medication					
	Medications dispense labeled in compliance Pharmacy name, a number of the pharma drug order patient ' s name of prescribing p labels must be legible containers that are ille	CATIONS, directed staff, "1. ed to residents must be e with MN Board of ddress, and telephone acy filling the prescription name prescription number practitioner 2. Medication e at all times. Medication egible or inadequate must					
	relabeling by the phar according to the facili destruction." Policy and procedure ADMINISTRATION O "1. Check medication insulin syringe. 3. Obto opening a bottle of ne	ty 's policy for medication					
	The administrator or o						
	TIME PERIOD FOR ( (21) days.	CORRECTION: Twenty-one					
31180	MN Rule 4655.8300 S linen	Subp. 1&3 Linen; Soiled	31180				

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00788	B. WING		09/29/2016	
AME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	, ZIP CODE	08	1/29/2010
IN VETER	RANS HOME HASTINGS		ST 18TH STREET GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
31180	Continued From page 20 Subpart 1. Application. Subparts 2 to 6 apply to boarding homes only.		31180			
	collected in a cleanab bag for removal to the or to the laundry. Han shall be cleaned or wa cleanable laundry true	en. Soiled linen shall be le hamper, container, or soiled linen collection room mpers, containers, or bags ashed regularly. Easily cks or containers for nd sorting of soiled linen				
	by: Based on interview ar failed to ensure soiled in a cleanable condition shower room. This has	t is not met as evidenced nd observation, the facility I linen containers were kept on on the 3rd floor East d the potential to impact 42 3rd floor of building 23.				
	Findings include:					
	A tour was completed maintenance worker ( between 8:20 a.m. an concerns were observ PME-A.	PME)-A on 9/28/16 d 9:50 a.m. The following				
	The 3rd floor East sho towel bin covered in r	ower was observed with a ust.				
	The administrator or o	OD FOR CORRECTION: designee could replace any red in rust or not cleanable I bin.				
	TIME PERIOD FOR (	CORRECTION: Twenty-one				

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00788	B. WING		09/29/2016	
IAME OF PF	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
	ANS HOME HASTINGS	1200 EA	ST 18TH STREET			
		HASTIN	GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
31180	Continued From page	21	31180			
	(21) days.					
31305	MN Rule 4655.8670 S Food	Subp. 1 Food Supplies;	31305			
tl	sources approved or	All food shall be from considered satisfactory by nealth, and shall be clean,				
	nonacid, or low-acid f processed in a place	randing, and safe for No hermetically sealed,				
	by: Based on observation review, the facility fail second and third floor a sanitary manner. Th	t is not met as evidenced n, interview, and document ed to maintain building 23 t kitchenette lounge units in his had the potential to esiding on 2nd and 3rd floor				
	Findings include:					
	the registered dieticia forks and a small bow the table. RD stated t on the table for dirty of daily.	it tour was completed with n (RD). Two dirty plates, two /I were observed sitting on here should be a plastic bin lishes to be picked up once				
	general maintenance following concerns we by GMW-A.	m. third floor west it tour was completed with worker (GMW-A). The ere observed and confirmed observed to have food				

STATE FORM

Minnesota Department of He STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE COM			E SURVEY PLETED
			A. BUILDING:		
	00788	B. WING		09	/29/2016
NAME OF PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, Z	ZIP CODE		
MN VETERANS HOME HASTIN	GS	ST 18TH STREET GS, MN 55033			
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
31305 Continued From pa	ige 22	31305			
splatter on the insid freezer contained to 7/8/16, and the oth freezer contained a cheese macaroni. unlabeled, undated plastic container of small carrots and of All three plastic sto on the top and side GMW-A confirmed schedule did not ha as being cleaned a it daily and clean re food items opened GMW-A stated the GMW-A observed stated staff should the refrigerator dai refrigerators were GMW-C walked int housekeeper clear the weekly Septern being checked off, forgotten to mark to proceeded to clear On 9/29/16, at 11.1 kitchenette lounge general maintenan following concerns by GMW-A. The microwave wa splatter on the insid refrigerator contain bagged undated cl partially full drink c cup of unlabeled in contained a rotting	de top, back and sides. The wo bags of fish, one dated er bag was undated. The in unlabeled store container of The refrigerator contained an l container of soup and a small meat. There were five bags of ne undated, unlabeled apple. rage bins had food drippings es. the refrigerator cleaning ave September dates checked nd indicated staff should check egularly. GMW-A confirmed and undated would be tossed. food bins should be cleaned. the cleaning schedule and clean once a week and check y. GMW-A further stated the cleaned every Wednesday. o the lounge with the ing cart. When asked about ber cleaning schedule not GMW-C stated "must have ne cleaning sheet" and				

STATEMENT	a Department of Health OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
		00788	B. WING		09/:	
NAME OF PF	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	ZIP CODE	0	9/29/2016
MN VETER	RANS HOME HASTINGS		ST 18TH STREET GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
31305	Continued From page	23	31305			
	September dates che the weeks of 9/14, 9/2 Facility resident expe revealed: "8) Food sto refrigerators must hav it will be disposed of.' Facility 2:30 to 6:30 ro policy revised 2-15-16 floor bins for dirty dish replace with a fresh b SUGGESTED METH environmental superv develop and impleme resident refrigerators cleanliness and expire food storage areas co and expired food disc or designee could edu basic food safety.	ctations policy dated 9/14, ored in the lounge ve a name and date on it or outine check list of duties 6, revealed: "4. Check third nes. Sanitize table and				
31455	General Requirement Subpart 1. General facility, including walls fixtures, equipment, a maintained in a clean condition throughout a offensive odors, dust, hazards. Accumulatio	al requirements. The entire s, floors, ceilings, registers, and furnishings shall be , sanitary, and orderly and shall be kept free from	31455			
	This MN Requiremen	t is not met as evidenced				

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00788			09/29/	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	, ZIP CODE		12012010
MN VETER	RANS HOME HASTINGS	1200 EA	ST 18TH STREET			
		HASTIN	GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
31455	Continued From page	24	31455			
	review, the facility fail environment was kep orderly condition. This all 140 residents resid	t in a clean, sanitary and s had the potential to impact ding at the facility including: 2, R79, R30, R25, R2, R50,				
	Findings include:					
	concerns were observ PME-A. PME-A notect physical, mental and	(PME)-A on 9/28/16 Id 9:50 a.m. The following				
	multicolor spots on th stairwells were traver	sed by surveyors at various ning on 9/26, 9/27, 9/28 and ved each time with an				
	with clothes. Several The floor had an accu garbage, such as spo containers. Brown sta and heater. There wa R43 reported no one	erved. The bed was piled boxes were on the floor. imulation of crumbs and ons, cups and old food tins were noted on the table s tape on the window blinds. helped him with cleaning his d the room had been in a years."				
	sills and wardrobe ha	n was observed. The window d an accumulation of dust ad a ring of black substance				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00788	B. WING		09	/29/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE	· ·	
MN VETEI	RANS HOME HASTINGS		ST 18TH STREET GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETI DATE
31455	on the inside surface. was mold. There were outside of the fridge. accumulation of dust, cobwebs, bugs and h accumulation of dirt o dried spills on the floo pillow case and comfo yellow. Holes and sta curtains. R32's room was obse accumulation of card Surrounding the boxe dust on the mattress. of dirt, spills and garb was an accumulation and nightstand. A film plate next to electrica were out. R32 reported for room order, and h from staff. Lounge 426 was obse accumulation of dust lamp and an accumul in the window tracks. worn and stained. R79's room was obse of dirt and dust on the register. Garbage was R30's room was obse was covered in rust.	MW reported he thought it e brown spills noted on the The floor was sticky with an soiled facial tissues, food, air on it. The mats had an on them. There were also or of various colors. The orter on the bed was stained ins were noted on the erved. The bed had an board and plastic boxes. es was an accumulation of There was an accumulation bage o on the floor. There of dust on the fan, wardrobe in was noted on the blank il switch. The ceiling lights ed they were out for 2 I he was solely responsible ad received no assistance erved. There was an on the window sills and lation of dust and dead bugs Six out of seven chairs were erved. There was a buildup e windows, floor and heat s on the floor.	31455			

Minnesota Department of Health STATE FORM

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00788		B. WING		N20/2046
NAME OF PR	OVIDER OR SUPPLIER		DDRESS, CITY, STATE,	, ZIP CODE	0:	9/29/2016
MN VETER	ANS HOME HASTINGS		ST 18TH STREET			
			GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T( DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
31455	Continued From page	e 26	31455			
	Near rooms 251 and 253 there were noted 3 stained chairs in the hallways.					
	The 2nd floor west lo	unge had 11 chairs, each				
	worn and stained. The floor was worn with stains. R44 noted the furniture and floor in the lounge					
	were "old" and need to be replaced." The 2nd					
	floor east lounge had 7 chairs worn with stains, some with blankets or towels on them. R125					
	noted residents put blankets and towels on the					
		chairs because they were sticky. R125				
	suggested, regarding the chairs to either "throw in garbage or get cleaner" and noted the carpet					
	was "pretty worn out" The carpet was noted to be					
	worn and stained in several areas, particularly					
	near the sink. The win perimeter of the loung	ndowsills around the ge were coated with dust.				
		2nd floor was noted to have				
		nd tears in the carpet at				
		during the survey on 9/26, The windows and window				
		ve an accumulation of dust,				
	cobwebs and dead be	ugs.				
		accumulation of dust and				
	dried spills on the floo					
	noted no staff helped	n throughout the room. R25 clean his room.				
		ad towels and paper towels				
	with brown stains on had accumulated on	the floor. Garbage and dust the floor.				
	R121's room had an	accumulation of dust buildup				
	on window sills, heat were noted in the cor	register and floor. Cobwebs ners.				
	The center elevator tr	racks had a large				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	ROVIDER OR SUPPLIER	00788	ADDRESS, CITY, STATE		09	/29/2016
		1200 EA	ST 18TH STREET	, ZIF CODE		
MN VETER	RANS HOME HASTINGS	HASTIN	GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
31455	Continued From page	e 27	31455			
	were noted on the wa	alls of the elevator.				
	The carpet was wear	ed to have 7 stained chairs. ing thin, especially near the nulated on the window sills the room.				
	R59's room had bowls of crusty noodles with sauce and multicolored specks in them. The room had an odor of body odor and rotten food. There was a thick accumulation of dirt and dust on the floor, heat register and nightstand. Dirty clothes garbage and papers were strewn throughout the room.					
	A drinking fountain ne and covered with duc	ear room 337 was cracked t tape.				
	sinks. A buildup of du on the window ledge, window screens. Dus ceiling vent in a show dispensers of the sho shower curtains did n Red, yellow and oran noted in the grout in t shower curtains. A to	ower room had stained ist and dead bugs was noted window panes, between the it was buildup on the floor, a ver stall and and on the soap ower stalls. One out of 3 ot provide full visual privacy. ge stains and buildup were he shower stalls and on the wel bin was covered in rust. had sticky floor, dirt and w panes.				
		lined with boxes of knick access to the heat register.				
	the floor near the bed been there "about a v window sills and piles	cigarette butts, and oor. A brown spill dried on I. R95 noted the spill had veek" The heat register, of paper strewn throughout ed in dust. R95 noted no				

STATEMEN	a Department of Health T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		00788	B. WING		09	/29/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
	RANS HOME HASTINGS	1200 EA	ST 18TH STREET			
	KANS HOWE HAS HINGS	HASTING	GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
31455	Continued From page	28	31455			
	staff person assisted and orderly.	with keeping his room clean				
	In lounge room 315 10 chairs were worn and stained. The carpet was worn within. Window sills around the room were covered in dust. A bed was sitting in the hallway of the lounge. PME-A noted it had been there "for weeks"					
	the residents were ex order on their own, w exception of mopping Rounds were to be co	a.m. the administrator noted spected to maintain room ithout staff help, with the the floor. Health and Safety ompleted weekly and staff a clean room project to help				
	1/2016 directed staff announce your prese the 5 qt. {quart} Buck germicidal into the res dresser. Damp dust fl bedside table. 6. Dam Proceed to foot of bed furniture, damp dust a Housekeeper proceed check all walls and cl germicidal cleaner. 9. window frame-clean a exterior portion of pat spot clean wall as nee 12. Proceed to cleani and return to room wi counter brush. Weekl	Spot check window and as needed. 10. Check ient's closet-damp dust and eded. 11. Vacuum carpet. ng cart, return all equipment th dust mop, dust pan and				
	information, refer to " Patient room weekly of	High Dusting" procedures. cleaning or at discharge 1. Ledge above patient				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00788	B. WING		00	)/29/2016
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
MN VETER	RANS HOME HASTINGS		ST 18TH STREET GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
31455	Continued From page	29	31455			
	dust. 4. Patient's TV-v except the screen wit	ack of patient door-damp wipe with germicide solution h glass cleaner. 5. Wall and ist. 6. Check corners and				
	"2. Wring out germicia corner of restroom, da Remove marks or fing partitions. 3. Proceed bottom, starting with I Spot check mirror-cle Wring out cloth in ger sink. Begin with inside sink, then to outside a and "10. Renew germ or shower stall." and ' accumulation of soap holder. 13. Wring out and spot wash the wa and ceiling vents with Clean by wiping the s solution. 4. Scrub the	ng procedure directed staff dal solution-start in one amp wipe all surfaces. gerprints from walls and to sink area. Clean top to ight fixture. Damp wipe. 4. an with glass cleaner. 5. micidal solution and clean e, move to the top of the and underneath the sink." icidal solution-clean the tub '12. Remove all and film from the soap cloth in germicidal solution ills." and "1. Clean all wall high dust tool" and "3. hower stalls with germicidal shower floor with a short and germicide solution."				
	be accessible and bo "Beds must have line stored in room-nothin day."; "Refrigerator m No cardboard boxes a Trash must be proper overflowing. Furniture	f "Heating/cooling unit must tom must not be blocked."; ns." "No open food or drink g perishable for more than 1 ust be clean and defrosted. are allowed on the floor.				
		ect procedure, undated, tify Veterans whose rooms				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
		00788	B. WING		00	0/29/2016
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,	ZIP CODE		
		1200 EA	ST 18TH STREET			
	RANS HOME HASTINGS	HASTIN	GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T( DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
31455	Continued From page	e 30	31455			
	criteria will first be acl and Safety Rounds be problematic in a more assigned team will the described below, by f barriers each Veteran room, determining the	en follow the protocol as irst attempting to identify the has in maintaining a clean e severity of clutter (if ng with the Veteran to				
	general maintenance GMW-E were taking of housekeeping carts fr janitor closet. The car heavy accumulation of units, with hair and pa as numerous empty of The janitor closet had	om the building 23 first floor ts were observed to have a of dust on the three shelf aper particles present as well vrappers and visible soil. I a heavy accumulation of hair, and a black debris				
	carts were dirty and the housekeeping carts be to clean them except hose them down. Bot of any policy to clean GMW-E reported due decision, chemical cl only on 1st floor. GMM the mop buckets were was not convenient to	verified the housekeeping ney did not clean the ecause there was no place to take them outside and h verified they did not know the carts. GMW-D and				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00788	B. WING			/29/2016
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	ZIP CODE	03	129/2010
			ST 18TH STREET			
	RANS HOME HASTINGS	HASTIN	GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
31455	Continued From page	31	31455			
	would not be unusual to use the same bucket of water and chemical all day. A policy was requested regarding keeping the janitor closet and carts clean, sanitary and orderly condition but was not received at the time of the exit conference.					
	- 11:01 a.m. with the p (PME)-B, general mai and physical plant dir	with on 9/27/16 at 9:27 a.m. blant maintenance engineer intenance worker (GMW)-A ector (PPD). The following and verified by PME-B,				
	wood chip below the or room (205) was observed rusty brown stains ap of the mirror glass. On 9/27/16 at 10:05 a findings and indicated supervisor who was a	l, they had housekeeping ssigned to do rounds				
	this concern to him. On third floor, east sid the laundry room was	eek ago and no one brought de corridor in the hallway by observed. The garbage bin and was over flow with he laundry room that				
	includes the second fi east and west sides, fi building 23. In building garbage bins with no	loor west side, third floor fourth floor in the center in g 25 on the ground floor had lids.				
	going to look at the ga	a.m. GMW-A, stated, "We arbage cart that have lids on st for the one that we have				

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STATEMENT	a Department of Health FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE COMF	SURVEY PLETED
	00788		B. WING	B. WING		/29/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
MN VETEI	RANS HOME HASTINGS	1200 EA	ST 18TH STREET			
		HASTIN	GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
31455	Continued From page		31455			
	and there was duct ta corner. On 9/27/16 at confirmed by PME-B, mentioned, this was t no one brought it to h PME-B indicated, was replace with new corn PME-B added, "My ex been reported and was floor." At 10:47 a.m. F multiple ways of repor residents and housek weekly or monthly rou On 9/28/16 at 1:30 p. the second floor by ro Overflow dirty soiled I in the hallway by soile Policy and procedure PROCEDURES - PO Directed staff, "lobbie and pull trash (as new receptacle. 5. Police f mop or vacuum as new Policy and procedure PROCEDURES FOR STATIONS reviewed Check walls and mirro needed. 4. Empty tras SUGGESTED METH The administrator or or resident rooms, and r thoroughly cleaned. A	9:47 a.m. Findings were GMW-A and PPD. PPD he first time seeing this and is attention. At 10:44 a.m. shing machine will be mercial washing machine. xpectation is, it should have a do monthly rounds on each PPD stated, there are rting such as housekeepers, eeping supervisor on unds. m. during a routine tour on bom 239 was witnessed. inen cart uncovered sitting ed linen storage. title SPECIFIC LICING, reviewed date 1/16. s and Corridors 1. Check eded), wipe out waste floor (pick up paper, spot eeded)." title SPECIFIC CLEANING NURSING date 1/16, indicated, "3. ors for spots. Clean as sh and reline container." OD FOR CORRECTION: designee could ensure all esident and staff areas are A system could be developed , order and sanitation is ents are provided needed nistrator or designee could				

STATEMENT	a Department of Health OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:		(X3) DATE COMF	SURVEY LETED
		00788	B. WING		09/	/29/2016
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
	RANS HOME HASTINGS		ST 18TH STREET SS, MN 55033			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN O	F CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLET
31455	Continued From page	33	31455			
	TIME PERIOD FOR ( (21) days.	CORRECTION: Twenty-one				
31460	MN Rule 4655.9000 S Cleaning Program	Subp. 2 Housekeeping;	31460			
	Subp. 2. Development of cleaning program. A program shall be established for routine housekeeping. Besides the daily duties, the program shall include policies and procedures for any special cleaning necessary.					
	by: Based on observation review, the facility fail program for maintaini clean, sanitary and or potential to impact all the facility including: F	t is not met as evidenced a, interview and document ed to ensure an effective ng the environment in a derly condition. This had the 140 residents residing at R43, R127, R94, R32, R79, 5, R2, R50, R121, R59, R51,				
	Findings include:					
	A tour was completed maintenance worker ( between 8:20 a.m. an concerns were observ PME-A.	(PME)-A on 9/28/16 Id 9:50 a.m. The following				
	multicolor spots on th stairwells were traver	sed by surveyors at various hing on 9/26, 9/27, 9/28 and red each time with an				

Minnesota Department of Health STATE FORM

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		00788	B. WING		00/00/0040		
AME OF PI	ROVIDER OR SUPPLIER		B. WING         09/29/2016           ET ADDRESS, CITY, STATE, ZIP CODE         09/29/2016				
IN VETER	RANS HOME HASTINGS		ST 18TH STREET				
			GS, MN 55033				
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE	(X5) COMPLET DATE	
31460	Continued From page	e 34	31460				
	with clothes. Several The floor had an accu garbage, such as spo containers. Brown sta and heater. There wa R43 reported no one room. PME-A reporte similar condition "for y R127 and R94's room sills and wardrobe ha on them. The fridge h on the inside surface. was mold. There were outside of the fridge." accumulation of dust, cobwebs, bugs and h accumulation of dirt of dried spills on the floor pillow case and comfor	erved. The bed was piled boxes were on the floor. umulation of crumbs and oons, cups and old food ains were noted on the table is tape on the window blinds. helped him with cleaning his d the room had been in a years." In was observed. The window d an accumulation of dust ad a ring of black substance MW reported he thought it e brown spills noted on the The floor was sticky with an soiled facial tissues, food, air on it. The mats had an on them. There were also or of various colors. The porter on the bed was stained ins were noted on the					
	R32's room was obse accumulation of cardl Surrounding the boxe dust on the mattress. of dirt, spills and garb was an accumulation and nightstand. A film plate next to electrica were out. R32 reported	erved. The bed had an board and plastic boxes. es was an accumulation of There was an accumulation hage o on the floor. There of dust on the fan, wardrobe h was noted on the blank I switch. The ceiling lights ed they were out for 2 I he was solely responsible ad received no assistance					
	Lounge 426 was obse accumulation of dust	erved. There was an on the window sills and					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			SURVEY PLETED	
		00788	B. WING		09	09/29/2016	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
IN VETER	RANS HOME HASTINGS		ST 18TH STREET GS, MN 55033				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLET DATE	
31460	Continued From page 35		31460				
	•	ation of dust and dead bugs Six out of seven chairs were					
		erved. There was a buildup e windows, floor and heat s on the floor.					
	R30's room was obse was covered in rust.	erved. The heat register vent					
	The 418 mop closet had an accumulation of garbage and dirt on the floor.						
	Near rooms 251 and stained chairs in the h	253 there were noted 3 nallways.					
	worn and stained. The R44 noted the furnitur were "old" and need to floor east lounge had some with blankets of noted residents put bl chairs because they we suggested, regarding in garbage or get clear was "pretty worn out" worn and stained in s near the sink. The win	the chairs to either "throw aner" and noted the carpet The carpet was noted to be everal areas, particularly					
	stains, worn areas an various times of day of 9/27, 9/28 and 9/29.	nd floor was noted to have d tears in the carpet at during the survey on 9/26, The windows and window ve an accumulation of dust, ugs.					
	R25's room had an a partment of Health	ccumulation of dust and					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00788	788 B. WING		09/29/2016	
NAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
MN VETER	ANS HOME HASTINGS		ST 18TH STREET GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
31460	Continued From page	e 36	31460			
	dried spills on the floo wrappers were strewn noted no staff helped	n throughout the room. R25				
		ad towels and paper towels the floor. Garbage and dust the floor.				
	R121's room had an accumulation of dust buildup on window sills, heat register and floor. Cobwebs were noted in the corners.					
	The center elevator the accumulation of dirt a were noted on the war	and dust buildup and spots				
	The carpet was wear	ed to have 7 stained chairs. ing thin, especially near the nulated on the window sills f the room.				
	dried sauce and mult room had an odor of There was a thick acc					
	A drinking fountain ne and covered with duc	ear room 337 was cracked st tape.				
	sinks. A buildup of du on the window ledge, window screens. Dus ceiling vent in a show dispensers of the sho	ower room had stained ist and dead bugs was noted window panes, between the st was buildup on the floor, a ver stall and and on the soap ower stalls. One out of 3				
		not provide full visual privacy. Ige stains and buildup were				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00788	B. WING		09/29/2016	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	08	0/29/2010
MN VETEI	RANS HOME HASTINGS		ST 18TH STREET			
	1		GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
31460	Continued From page	e 37	31460			
	shower curtains. A to	he shower stalls and on the wel bin was covered in rust. had sticky floor, dirt and v panes.				
	R51's room had walls lined with boxes of knick knacks and blocked access to the heat register.					
	the floor near the bed been there "about a w window sills and piles the room were covered	cigarette butts, and bor. A brown spill dried on . R95 noted the spill had week" The heat register, of paper strewn throughout ed in dust. R95 noted no with keeping his room clean				
	stained. The carpet w around the room were	0 chairs were worn and vas worn within. Window sills e covered in dust. A bed was of the lounge. PME-A noted weeks"				
	general maintenance GMW-E were taking of housekeeping carts fr janitor closet. The car heavy accumulation of units, with hair and pa as numerous empty w The janitor closet had	rom the building 23 first floor ts were observed to have a of dust on the three shelf aper particles present as well vrappers and visible soil. I a heavy accumulation of hair, and a black debris				
	carts were dirty and the housekeeping carts b	verified the housekeeping				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			B. WING				
	ROVIDER OR SUPPLIER	00788	B. WING         09/29/20           raddress, city, state, zip code         09/29/20				
			ST 18TH STREET				
	RANS HOME HASTINGS	HASTIN	GS, MN 55033				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIE!	CTION SHOULD BE	(X5) COMPLET DATE	
31460	Continued From page	9 38	31460				
	of any policy to clean GMW-E reported due decision, chemical cle only on 1st floor. GMM the mop buckets were was not convenient to from third floor just to would not be unusual water and chemical a	eaning supplies were stored W-D explained the water in e not changed because it o come down to the first floor change the dirty water, so it to use the same bucket of					
	janitor closet and cart	s clean, sanitary and orderly received at the time of the					
	The administrator or or resident rooms, and r thoroughly cleaned. A to ensure cleanliness maintained and reside	OD FOR CORRECTION: designee could ensure all esident and staff areas are a system could be developed , order and sanitation is ents are provided needed nistrator or designee could r for compliance.					
	TIME PERIOD FOR ( (21) days.	CORRECTION: Twenty-one					
31475	MN Rule 4655.9020 Supplies; Janitor's Clo		31475				
	closets and all other a	nel shall be kept in a clean,					
	This MN Requiremen	t is not met as evidenced					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		00788	B. WING		09	/29/2016
NAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
	RANS HOME HASTINGS	1200 EA	ST 18TH STREET			
	ANS HOME HAS HINGS	HASTIN	GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
31475	Continued From page	e 39	31475			
	review, the facility fail closet and housekeep sanitary and in an oro potential to affect all building 23 of the corr Findings include: During an observation general maintenance GMW-E were taking housekeeping carts fi closet. The carts were	n on 9/28/16, at 7:45 a.m., worker (GMW)-D and out three of the rom the first floor janitor e observed to have a heavy				
	hair and paper particl numerous empty wra Janitor closet had a h paper particles, hair, like streaks on the flo	on the three shelf units, with les present as well as ppers and visible soil. The neavy accumulation of dust, and a black debris grease por. 9/28/16, at 7:45 a.m.				
	GMW-D and GMW-E carts were dirty and t housekeeping carts b to clean them except hose them down. Bot of any policy to clean GMW-D explained th	e verified the housekeeping hey did not clean the because there was no place to take them outside and th verified they did not know the carts. Furthermore, at they were not allowed to				
	because administration remove all cleaning of closets on second and all the cleaners had to the mop buckets and Furthermore, GMW-E water in the mop buck	a up on the other floors on made the decision to chemicals from the janitor ad third janitor closets so that o come to first floor to empty get chemicals to clean. D explained that is why the kets were not changed				
nesota Der		onvenient to come down to rd floor just to change the				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00788	B. WING		09/29/2016	
IAME OF PI	ROVIDER OR SUPPLIER		 DDRESS, CITY, STATE	, ZIP CODE		123/2010
IN VETEI	RANS HOME HASTINGS		ST 18TH STREET GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
31475	Continued From page	9 40	31475			
		d not be unusual to use the and chemical all day.				
	janitor closet and cart	ed regarding keeping the is clean, sanitary and orderly received at the time of the				
	during a tour of build had an accumulation	8:20 a.m. and 9:50 a.m. ing 23, the 418 mop closet of garbage and dirt on the ance engineer (PME)-A				
	The director of house administrator and the nurse could ensure a current, and staff resp	infection control registered ppropriate policies were consible would receive be conducted, and the				
	TIME PERIOD FOR ( (21) days.	CORRECTION: Twenty-one				
31480	MN Rule 4655.9020 Supplies;Mops/Bucke		31480			
	buckets shall be emp	d buckets cleaning. Mop tied after each cleaning, and ashed after each use and necessary.				
	by: Based on observatior	t is not met as evidenced n, interview and document ed to empty the mop bucket				

	a Department of Health OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00788	B. WING		09/29/2016	
NAME OF PR	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
IN VETER	RANS HOME HASTINGS		ST 18TH STREET GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLET DATE
31480	Continued From page	e 41	31480			
		his had the potential to on 3rd floor of Building 23.				
	Finding include: During an observation on 9/28/16, at 7:45 a.m., general maintenance worker (GMW)-D was taking out the housekeeping cart from the first floor janitor closet. The mop bucket was full of dark black gray water. When interviewed on 9/28/16, at 7:45 a.m. GMW-D verified the dark black gray water was because the mop bucket was put away from the day before without emptying or cleaning out the soiled mop bucket and the mop head was not changed after use. GMW-D verified leaving in a hurry the day before and did not take the time to empty the dirty water bucket or change the mop head. GMW-D explained that they were not allowed to use the janitor rooms up on the other floors because administration made the decision to remove all cleaning chemicals from the janitor closets on second and third janitor closets so that all the cleaners had to come to first floor to empty the mop buckets and get chemical to clean. Furthermore, GMW-D explained that is why the water in the mop buckets aren't changed because it is not convenient to come down to the first floor from third floor just to change the dirty water, so it would not be unusual to use the same bucket of					
	empty the soiled mop was not received duri	ed a regarding how often to bucket and mop head, but ng the survey process. OD OF CORRECTION:				
	The director of house					

STATE FORM

STATEMEN	a Department of Health FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00788	B. WING		09/29/2016	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
MN VETEI	RANS HOME HASTINGS		ST 18TH STREET GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
31480	Continued From page	: 42	31480			
	current, and staff resp training. Audits could results brought to the review. TIME PERIOD FOR 0	opropriate policies were ponsible would receive be conducted, and the quality committee for CORRECTION: Twenty-one				
31495	(21) days. MN Rule 4655.9030 [	Deodorizers	31495			
	substitute for accepta they be used to mask	oing or sanitation. Ozone				
	by: Based on observation review, the facility fail odors on the third floc cover the odor with th aerosols. This had the residents residing on	t is not met as evidenced a, interview and document ed to eliminate the source of or areas and attempted to e use of deodorizers and e potential to affect all 43 the 3rd floor in building 23 R46, R77, R79, R88, R109				
	Findings include:					
	and concern forms in the foul, and at times	esident council meetings dicated complaints about strong urine, feces, and og on the third floor certain t year.				
		9/23/16, at 4:40 p.m. R53 dministration on numerous				

STATEMEN	a Department of Health FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
		00788	B. WING		09/29/2016	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE	•	
	RANS HOME HASTINGS		ST 18TH STREET GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETI DATE
31495	occasions the foul od building 23. During an 2:00 p.m. R11, R46, F verified the odor on th conversation this pass used deodorizers and the cleaning root of th When interviewed on administrator verified aerosols were used to the third floor of buildi administrator verified use deodorizers and	ors in areas of the third floor interview on 9/25/16, at R77, R79, R88, R109, R132, hird floor has been a topic of t year but the administration aerosols versus getting to be problem. 9/29/16, at 11:15 a.m. the the use of deodorizers and b cover the odor smell on ing 23. Furthermore, the there was not a policy to not aerosols as a substitute to valuating the housekeeping	31495			
31500	The director of house administrator and infe nurse could ensure a current, and staff resp training. Audits could results brought to the review. TIME PERIOD FOR 0 (21) days. MN Rule 4655.9040 I Any condition on the conducive to the harb insects, rodents, or of eliminated immediate control program shall	ection control registered poropriate policies were bonsible would receive be conducted, and the quality committee for CORRECTION: Twenty-one nsect and Rodent Control e site or in the facility orage or breeding of	31500			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00788	B. WING		09/29/2016	
NAME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,	ZIP CODE		
	RANS HOME HASTINGS		ST 18TH STREET GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
31500	Continued From page	9 44	31500			
	identified and stored i	n a locked space.				
	by: Based on observation failed to ensure the en- conducive to the harb This had the potential of the facility including R79, R25, R2, R50, F Findings include: A tour was completed maintenance worker of between 8:20 a.m. an concerns were observ PME-A. PME-A noted areas made the facilit harborage of insects a R43's room was observed	oring rodents and insects. I to impact all 140 residents g: R43, R127, R94, R32, R121, R59, and R95. I of Building 23 with a (PME)-A on 9/28/16 id 9:50 a.m. The following ved and confirmed by I the condition of resident y vulnerable to the and rodents.				
	garbage, such as spo containers.	Imulation of crumbs and ions, cups and old food				
	was sticky with an act facial tissues, food, co	n was observed. The floor cumulation of dust, soiled obwebs, bugs and hair on it. I spills on the floor of various				
	accumulation of cardl	erved. The bed had an board and plastic boxes. ulation of dirt, spills and				
	R79's room was obse	erved. Garbage was on the				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE COMF	SURVEY
		00788	B. WING		09/29/2016	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
MN VETEI	RANS HOME HASTINGS		ST 18TH STREET GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLE DATE
31500	Continued From page	9 45	31500			
	floor.					
	windows and window	nd floor was toured. The sills were noted to have an cobwebs and dead bugs.				
	dried spills on the floo	ccumulation of dust and or. Garbage and food n throughout the room.				
	R2 and R50's room had towels and paper towels with brown stains on the floor. Garbage and dust had accumulated on the floor.					
	R121's room had cobwebs noted in the corners.					
	sauce and multicolore room had an odor of r	s of crusty noodles with ed specks in them. The rotten food. Dirty clothes were strewn throughout the				
	of dust and dead bug ledge, window panes	athroom had sticky floor, dirt				
	been there "about a w	cigarette butts, and bor. R95 noted the spill had veek" There were piles of out the room and covered in				
	During interview on 9, noted observing mice	/27/16 at 3:35 p.m. R14 in the facility.				
	The administrator or o	OD FOR CORRECTION: designee could inspect the on which may be conducive				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00788	B. WING		09	9/29/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
	RANS HOME HASTINGS	1200 EAS	ST 18TH STREET			
		HASTING	GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AO CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE ) THE APPROPRIATE	(X5) COMPLET DATE
31500	Continued From page	e 46	31500			
	mice and vermin. A sy eliminate any concern	nee could train staff and				
31800	MN Rule 144.651 Sub of HCF Bill of Rights	od. 4 Patients & Residents	31800			
	and residents shall, at there are legal rights it their stay at the facility of treatment and mair and that these are de- written statement of the responsibilities set for case of patients admir as defined in section 25 statement shall also of person 16 years old of provided in section 25 shall list the names are individuals and organ advocacy and legal se residential programs. accommodations shall communication impair speak a language oth facility policies, inspec- local health authorities the written statement to patients, residents, chosen representative to the administrator of person, consistent with	escribe the right of a r older to request release as i3B.04, subdivision 2, and nd telephone numbers of izations that provide ervices for patients in				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		00788	 B. WING			09/29/2016	
NAME OF PI	ROVIDER OR SUPPLIER		ET ADDRESS, CITY, STATE, ZIP CODE				
MN VETER	RANS HOME HASTINGS		ST 18TH STREET				
(X4) ID		ATEMENT OF DEFICIENCIES	GS, MN 55033	PROVIDER'S PLAN (		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	O THE APPROPRIATE	COMPLET DATE	
31800	Continued From page	e 47	31800				
	This MN Requiremen by:	t is not met as evidenced					
	Based on observatior	n, interview and document					
		ed to post state survey					
		t area, or post notice of their the potential to affect all 140					
		the facility including R11,					
	R46, R53, R77, R79,	R88, R105, R109, R132					
	and R134.						
	Findings include:						
	During observation or	n 9/26/16, 9/27/16, at 12:00					
	noon and 6:00 p.m., 9	9/28/16 and 9/29/16 at 8:00					
		were no postings of the					
	•	ngs or other local health /ailable in the main entrance					
	and resident gatherin						
	During a group intervi	iew on 9/28/16, at 2:00 p.m.					
		R77, R79, R88, R105, R109,					
	•	ied they did not know where ndings were posted at the					
		ed they did not see or hear					
	, , ,	ction findings from 2015.					
	During an interview w	vith the administrator on					
	•	. verified the inspection					
		notebook in the main					
		nore, the administrator n findings were not in the					
	main entrance gather						
		ified there was not a policy					
	directing the state and postings to be available	d local health authorities ble to the residents.					
	The director of social	OD OF CORRECTION: services with the					
		nsure appropriate policies					

STATE FORM

STATEMEN	a Department of Health FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE COMP	
		00788	B. WING		09/29/2016	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
	RANS HOME HASTINGS		ST 18TH STREET			
(X4) ID	SUMMARY ST		GS, MN 55033	PROVIDER'S PLAN O	F CORRECTION	(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLETE
31800	Continued From page	48	31800			
	training. Audits could results brought to the review.	ff responsible would receive be conducted, and the quality committee for CORRECTION: Twenty-one				
	(21) days.	SORRECTION. Twenty-one				
31880	MN Rule 144.651 Sub of HCF Bill of Rights	od. 20 Patients & Residents	31880			
	shall be encouraged a their stay in a facility of to understand and exe patients, residents, ar residents may voice of changes in policies ar and others of their cho- interference, coercion including threat of dis grievance procedure of well as addresses and Office of Health Facili nursing home ombuds Americans Act, sectio posted in a conspicuo	ad citizens. Patients and rievances and recommend ad services to facility staff bice, free from restraint, , discrimination, or reprisal, charge. Notice of the of the facility or program, as d telephone numbers for the ty Complaints and the area sman pursuant to the Older n 307(a)(12) shall be sus place.				
	residential program as 253C.01, every non-a facility employing mor provides outpatient m have a written interna at a minimum, sets fo followed; specifies tim limits for facility respo or resident to have th	cute care facility, and every e than two people that ental health services shall I grievance procedure that, rth the process to be le limits, including time nse; provides for the patient				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		00788	B. WING		09/29/2016	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	1 00	
MN VETEI	RANS HOME HASTINGS		ST 18TH STREET			
			GS, MN 55033	PROVIDER'S PLAN		0(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
31880	Continued From page	e 49	31880			
	an impartial decision not otherwise resolve residential programs a 253C.01 which are ho treatment programs, a centers with section 1 health maintenance of 62D.11 is deemed to					
	by: Based on interview at facility failed to ensur- made to resolve resid resident (R11, R46, R R109, R132, R134) re grievance to facility st	t is not met as evidenced nd document review, the e that prompt efforts are lent grievances for 10 of 10 253, R77, R79, R88, R105, eviewed who expressed a taff. This had the potential to nts residing at the facility.				
	Findings include:					
	R79, R88, R105, R10 9/28/16, at 2:00 p.m. expressed and an appression that admir perception that admir what they had to cont felt this was due to th the administration. For	nistration was not listening to ribute and these residents e lack of follow through by				
	in certain areas of but but that management associate with the cle According to the resid	ilding 23 on the third floor, had ignored the pleas to aning of the facility.				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			SURVEY PLETED	
		00788	B. WING			/29/2016	
AME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE			
IN VETEI	RANS HOME HASTINGS		GS, MN 55033				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
31880	Continued From page	e 50	31880				
	back to 11/25/15.						
		his interview on 9/28/16, at nts also expressed concerns sues:					
	residents due to the p being brought in and outside source who re Residents had contin to be installed to vide interviewed on 9/28/1 guard for the facility v concerns of drugs po property. Security can the 11/25/15 resident	een expressed by the berception that drugs were sold at the facility by an ented the adjacent property. uously pleaded for a camera to the accounts. When 6, at 5:00 p.m. the security vas not aware of the resident ssibly being sold on the meras were addressed at council meeting but no talled to watch the rental					
	about since 11/25/15 received new furnitur The other resident lou furniture but that had furniture in building 2 stained, uncleanable tour of the facility on and 9:50 a.m. The res	e in the television room. unges were to receive new not happened. Lounge 3 was observed to be and in disrepair during a 9/28/16, between 8:20 a.m. sidents expressed istration did not obtain better					
	pool table 11/25/15, their building they did table. Instead, accord have duct tape pool p of the pool table beca	25 were promised a new but because it did not fit into I not receive the new pool ding to the residents they bockets into the four corners ause management had not ution for their pool table.					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED	
		00788	B. WING			09/29/2016	
AME OF PF	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	ZIP CODE	09	//29/2016	
IN VETER	RANS HOME HASTINGS		ST 18TH STREET				
(X4) ID	SUMMARY ST		GS, MN 55033	PROVIDER'S PLAN C	)F CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE ) THE APPROPRIATE	COMPLET	
31880	Continued From page	9 51	31880				
	p.m. verified the four were duct taped to ca	pockets of the pool table tch the pool balls.					
	to be able to chose the person responsible for choice of what bingo select. In the resident unacceptable but the	concern because they used eir bingo card, but now, the r bingo did not allow them a cards they would like to s view, this was y did not feel anyone in ening to what they had to					
	November 2015 throu reviewed and verified	resident council minutes, igh September 2016, were these issues had been idents in writing but there					
	9/29/16, at 11:15 veri been brought up, and The administrator rep	ith the administrator on fied these concerns had was aware of the concerns. orted there had not been a erns, but ongoing work on opening.					
	The social service dir could ensure appropr and staff responsible Audits could be condu	OD OF CORRECTION: ector with the administrator iate policies were current, would receive training. ucted, and the results committee for review.					
	TIME PERIOD FOR ( (21) days.	CORRECTION: Twenty-one					
31935	MN Rule 144.652 Sul Patient/Res.Violation	od. 1 Bill of Right Notice to	31935				
	Subdivision 1. Di	stribution; posting. Except					

STATE FORM

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00788	B. WING		09	)/29/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE, 2	ZIP CODE	• • •	
MN VETE	RANS HOME HASTINGS		ST 18TH STREET GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE ) THE APPROPRIATE	(X5) COMPLET DATE
31935	as provided below, se posted conspicuously facilities licensed und 144.50 to 144.58, or 1 shall be furnished the patient or resident's upon admittance to th providing services to 144.651, subdivisions portions of other subdivisions portions of other subdivisions portions of other subdivisions portions of other subdivisions patients, from copies patients with appropri- have additional rights statement shall include telephone number of Practice and/or the na- the person within the about the medical car The notice shall include describing how to file of Health Facility Comp- pursuant to section 14 violation of section 14 statute or rule. This m Address and phone m Health Facility Complet This MN Requirement by: Based on observation interview, the facility f current version of the conspicuous place in potential to affect all r facility including 14 of	ection 144.651 shall be in a public place in all er the provisions of sections 144A.02. Copies of the law patient or resident and the guardian or conservator e facility. Facilities patients may delete section 24 to 29, and those livisions that apply only to a posted or distributed to ate notation that residents under law. The policy ie the address and the Board of Medical ame and phone number of facility to whom inquiries e received may be directed. de a brief statement a complaint with the Office nplaints established 14A.52 concerning a 4.651 or any other state notice shall include the umber of the Office of aints. t is not met as evidenced b, document review and ailed to post the most Bill of Rights in a the facility. This had the esidents residing in the 14 residents reviewed (R9, R28, R37, R42, R61, R90,	31935	DEFICIEI		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		00788	B. WING		00	/29/2016	
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE				
MN VETEI	RANS HOME HASTINGS		ST 18TH STREET GS, MN 55033				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
31935	for building 24 by the with numbers that rea Building 23, posted or second, third and four numbers " 08/09". E second floor on the w each floor. with letters In addition, review of provided to R9, R12, R42, R61, R90, R92, revealed they were gi of rights, dated July 1 was an out of date bil rights had been devel On 9/27/16 at 9:05 a. the bill of rights poste most current version a quality director registe most current version. administrator indicate every floor but not the the MDH website toda copies and will order Policy and procedure RESIDENT BILL OF I [Minnesota Veterans and abide by the Res	Rights, posted on the wall administrator's office area ids No 217-250/10-05. In each floor that includes th floor had with letters and Building 25 on first and all at the left corridor area of a and numbers " 08/09 ". The most current bill of rights R14, R23, R24, R28, R37, R113, R117 and R138 ven the wrong version of bill , 2007 and 12-2015. This I of rights, as a revised bill of oped in December 4, 2015. The administrator verified d in the building are not the and stated he will call the ered nurse (RN)-B for the At 11:17 a.m. the d, "We have posted on e 12/4/15 version. I went on ay and get the 2015 version posters today." revised date 1/16, title RIGHTS, read, "The MVH Home]-Hastings will honor ident Bill of Rights. Each epresentative will receive a	31935				
	lobby." SUGGESTED METH administrator or desig appropriate policies w	y is posted in the front OD OF CORRECTION: The nee could ensure /ere current, and staff ceive training. Audits could					

	a Department of Health OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		00788	B. WING		09/29/2016	
IAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
IN VETER	RANS HOME HASTINGS		ST 18TH STREET GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETE DATE
31935	Continued From page	2 54	31935		,	
		e results brought to the				
	TIME PERIOD FOR ( (21) days.	CORRECTION: Twenty one				
34580	MN Rule 4660.6900 S New	Subp. 1 Floors, Existing and	34580			
		Il requirements. All floors in as for patients and residents and residents ad/or cleanable.				
	by: Based on interview an common areas throug to be soiled and not in	t is not met as evidenced nd observation, the floors in ghout the facility were noted n a cleanable condition. This npact all 140 residents.				
	Findings include:					
	A tour was completed maintenance worker ( between 8:20 a.m. an concerns were observ PME-A.	(PME)-A on 9/28/16 od 9:50 a.m. The following				
	noted the floor in the to be replaced." The c	unge was observed. R44 lounge was "old" and need carpet was noted to be worn l areas, particularly near the				
	stains, worn areas an	nd floor was noted to have d tears in the carpet at during the survey on 9/26,				

TATEMENT	a Department of Health OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:	DNSTRUCTION		E SURVEY PLETED	
		00788	B. WING		09/29/2016		
IAME OF PF	ROVIDER OR SUPPLIER	I	T ADDRESS, CITY, STATE, ZIP CODE				
IN VETER	RANS HOME HASTINGS		ST 18TH STREET GS, MN 55033				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIE!	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE	
34580	Continued From page	9 55	34580				
	In Lounge 351 the ca soiled, especially nea	rpet was wearing thin and r the sink.					
	In lounge room 315 th worn thin.	ne carpet was soiled and					
	The administrator or of facility for areas of un flooring and take step replace any flooring w	OD OF CORRECTION: designee could inspect the icleanable or unclean as to clean, repair and/or with concerns. A system to maintain flooring in good					
	TIME PERIOD FOR ( (21) days.	CORRECTION: Twenty-one					
	partment of Health						



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7015 0640 0003 5695 6382 October 18, 2016

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

Re: Enclosed State Boarding Care Home Licensing Orders - Project Number SL00788025

Dear . Burnside:

The above facility survey was completed on September 29, 2016 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, Health Regulation 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.

MN Veterans Home Hastings October 18, 2016 Page 2

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 MN, 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,

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure(s) cc: Licensing and Certification File

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00788	B. WING		09/29/2016	
AME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATI	E, ZIP CODE		
	RANS HOME HASTINGS		ST 18TH STREET GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE COMPLE	
3 000	INITIAL COMMENTS		3 000	DEFICIENCY)		
	*****ATTENTION					
	BOARDING CARE					
	144A.10, this correcting pursuant to a survey. found that the deficient herein are not correct not corrected shall be	innesota Statute, section on order has been issued If, upon reinspection, it is ney or deficiencies cited ed, a fine for each violation assessed in accordance es promulgated by rule of ment of Health.				
	corrected requires correquirements of the runumber and MN Rule When a rule contains comply with any of the lack of compliance. L re-inspection with any result in the assessme	ther a violation has been mpliance with all ule provided at the tag number indicated below. several items, failure to e items will be considered ack of compliance upon v item of multi-part rule will ent of a fine even if the item ng the initial inspection was				
	that may result from r orders provided that a	earing on any assessments non-compliance with these a written request is made to n 15 days of receipt of a for non-compliance.				
	above Licensed Boar following licensing or	9/28/16 and 9/29/16, artment's staff visited the d and Care provider and the ders were issued. When eted, please sign and date,		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal softwa Tag numbers have been assigned to Minnesota state statutes/rules for Nur Homes.		

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
00788		B. WING		09/29/2016	
	ROVIDER OR SUPPLIER	1200 EA	DDRESS, CITY, ST. ST 18TH STREE GS, MN 55033		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLE
	Health Regulation Div Certification Program Minnesota Departme the State Licensing C federal software. Tag assigned to Minneso Boarding Care Home The assigned tag nur column entitled "ID F statute/rule number a the state statute/rule in the "Summary Stat column and replaces the correction order. the findings which ar statute after the state as evidenced by." F findings is the Time F PLEASE DISREGAR FOURTH COLUMN V "PROVIDER'S PLAN APPLIES TO FEDER THIS WILL APPEAR THERE IS NO REQU PLAN OF CORRECT MINNESOTA STATE MN Rule 4655.1300 S Charge; Admin's abso	<ul> <li>atota Department of Health, vision, Licensing and ;</li> <li>atot of Health is documenting correction Orders using numbers have been ta state statutes/rules for s.</li> <li>and the statutes/rules for s.</li> <li>and the corresponding text of out of compliance is listed rement of Deficiencies" the "To Comply" portion of This column also includes e in violation of the state ment, "This Rule is not met ollowing the surveyors period For Correction.</li> <li>D THE HEADING OF THE VHICH STATES, OF CORRECTION." THIS Precision of the state statutes of the state state state state state.</li> <li>D THE HEADING OF THE VHICH STATES, OF CORRECTION." THIS Precision of the state state state.</li> <li>D THE HEADING OF THE VHICH STATES, OF CORRECTION." THIS Precision of the state state.</li> <li>D THE HEADING OF THE VHICH STATES, OF CORRECTION." THIS Precision of the state state.</li> <li>D THE HEADING OF THE VHICH STATES, OF CORRECTION." THIS Precision of the state state.</li> <li>D THE HEADING OF THE VHICH STATES, OF CORRECTION." THIS Precision of the state state.</li> <li>D THE HEADING OF THE VHICH STATES, OF CORRECTION." THIS Precision of the state state.</li> <li>D THE HEADING OF THE VHICH STATES.</li> <li>D THE HEADING STATUTES/RULES.</li> <li>D THE State State</li></ul>	3 000	The assigned tag number appears in far left column entitled " ID Prefix Tag The state statute/rule out of complian listed in the "Summary Statement of Deficiencies" column and replaces th Comply" portion of the correction orde This column also includes the finding which are in violation of the state stat after the statement, "This Rule is not as evidence by." Following the survey findings are the Suggested Method o Correction and Time period for Correct PLEASE DISREGARD THE HEADIN THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. TH WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION VIOLATIONS OF MINNESOTA STAT STATUTES/RULES.	g." ce is e "To er. s ute met yors f ction. G OF IIS
		ator's absence; dministrator or person in e the premises without giving			

STATE FORM

6899

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If continuation sheet 2 of 58

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00788	B. WING		09	0/29/2016
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE <b>ST 18TH STREET</b>	, ZIP CODE		
MN VETER	RANS HOME HASTINGS		GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
3 360	Continued From page	e 2	3 360			
	information as to where this person can be reached and without delegating authority to a person who is at least 21 years of age, physically able, competent, and capable of acting in an emergency. At no time shall a home be left without competent supervision. The person left in charge shall have the authority and competency to act in an emergency.					
	by: Based on observatior review, the facility fail person in charge in th This had the potentia currently residing at th	t is not met as evidenced n, interview and document led to designate in writing the ne administrators absence. I to affect all 140 residents he facility.				
	Findings include:					
	on 9/26/16, at 2:00 p. Nursing (DON) termin had not been replace indicated conversatio designate the two nur position of the DON a	ns were in place to rse seniors to be the shared and that one of them would the administrator but there n to indicate those				
	registered nurse (RN) considered the senior	r nurse verified there was no icate RN-A was to be in				
	the days of the surve	cility entrance throughout y, 9/26/16, 9/27/16, 9/28/16 reveal a posting of who was				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00788		B. WING		09/29/2016	
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
MN VETEI	RANS HOME HASTINGS		ST 18TH STREET GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
3 360	Continued From page	23	3 360			
	in charge in the admir	nistrators absence.				
	administrator verified writing as to who was administrators absend to designate who was SUGGESTED METH The two registered nu administrator could en were current, and sta training. Audits could	ce, and there was no policy				
	TIME PERIOD FOR ( (21) days.	CORRECTION: Twenty-one				
3 620	Contents of record Subpart 1. Conten record shall be initiate resident within 72 hou contain identifying infe previous address, soo marital status, age, da previous occupation, name, address, and to nearest relative, and to an emergency or dea arrangements, if avail pastor; and the name resident's attending p	date and hour of admission; elephone number of the the person to be notified in th; information as to funeral lable; church affiliation and of the patient's or	3 620			

STATEMENT	a Department of Health OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		00788	B. WING		09	/29/2016
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
MN VETER	RANS HOME HASTINGS		ST 18TH STREET GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
3 620	Continued From page	2 4	3 620			
	facility failed to ensure	nd document review, the e a complete and accurate 5 of 5 residents (R37, R14,				
	Findings include:					
	R23 and R92 reveale one of the following c	records for R37, R14, R117, d each was missing at least omponents: previous revious occupation, church				
	On 9/29/16 between 9 health information sup accuracy of admission					
	health information sup could review and revies admission record and	OD OF CORRECTION: The pervisor (HIS) or designee se systems for completion of I train staff in completion of S or designee could monitor				
	TIME PERIOD FOR ( (21) days.	CORRECTION: Twenty-one				
3 830	MN Rule 4655.4700 S Examinations and Or		3 830			
	Each patient or reside medical history and c examination performe physician within five c hours after admission					

Minnesota Department of Health STATE FORM

6899

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If continuation sheet 5 of 58

STATEMENT	a Department of Health OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
	00788		B. WING		09	/29/2016
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
MN VETEI	RANS HOME HASTINGS		ST 18TH STREET GS, MN 55033			
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3 830	Continued From page	9 5	3 830			
	report of subsequent reports of appropriate general medical cond and limitations; instru- patient's or resident's written orders for all n treatments, special d restriction of activity; progress notes; and of transfer, or cause of of Pursuant to Minnesota Informational Bulletin Prevention and Contr Home, Minnesota Ru	total program of care; nedications with stop dates, iets, and for extent or physician's orders and condition on discharge or death. a Rule 4655.1000, and as Department of Health				
	Prevention's "(Guideli Transmission of Myco Health-Care Settings, (No. RR-17), and as s infection control proce ("CDC Guidelines"). F Guidelines" for compl	ete definitions of terms.				
	tuberculosis (TB) infe program to appropriat responsibilities includ infection control team completion (and perior risk assessment, and	e responsibility for the ction control & prevention te personnel. Administrative e establishment of an (one or more individuals), odic review) of a written TB development (and periodic B infection control plan.				

OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
	00788	B. WING		09	0/29/2016
ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE, Z	ZIP CODE	·	
ANS HOME HASTINGS					
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Continued From page	9 6	3 830			
screening within 72 h 3 months prior to adm include an assessme factors for TB, and ar and a two-step TST of release assay (IGRA) QuantiFERON ® TB of T-SPOT ®.TB). - All reports and copie tests (TSTs), results ff tuberculosis, medical radiograph results mu resident's medical re recommendations for recommended follow- signs or symptoms of	ours of admission or within hission. TB Screening must nt of the resident's risk by current TB symptoms, or a single interferon gamma of or M. tuberculosis (e.g., Gold or TB Gold In Tube, es of resident tuberculin skin rom IGRAs for M. evaluations, and chest ust be maintained in the cord. Consult current CDC the diagnosis of TB for -up of residents who display active TB disease.				
by: Based on interview and facility failed to ensure residents, (R37, R9, F physical examination admission and failed ordered by a physicial were completed by a	nd document review, the e 5 of 5 newly admitted R12, R90, R138) received a by a physician upon to ensure medications were in and discharge orders physician upon discharge				
	ROVIDER OR SUPPLIER RANS HOME HASTINGS SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From page - All residents must rescreening within 72 h 3 months prior to adminclude an assessme factors for TB, and ar and a two-step TST or release assay (IGRA) QuantiFERON ® TB T-SPOT ®.TB). - All reports and copie tests (TSTs), results ff tuberculosis, medical radiograph results muresident's medical re recommended follow- signs or symptoms of This MN Requirement by: Based on interview at facility failed to ensur- residents, (R37, R9, F physical examination admission and failed ordered by a physicial were completed by a	F CORRECTION       IDENTIFICATION NUMBER:         STREET A         STREET A         SUMMARY STATEMENT OF DEFICIENCIES         CONTINUMER FOR DEFICIENCIES         CONTINUMER TO STATEMENT OF DEFICIENCIES         CONTINUE FROM DEFICIENCIES         CONTINUE FROM DEFICIENCIES         CONTINUE TO CONTINUE TO BASING TO THE SUMPTONS, and a two-step TST or a single interferon gamma release assay (IGRA) for M. tuberculosis (e.g., QUANTIFERON ® TEB GOID ON THE GOID I	F CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING:         00788       B. WING         ROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, J.         SUMMARY STATEMENT OF DEFICIENCIES       1200 EAST 18TH STREET HASTINGS, MN 55033         SUMMARY STATEMENT OF DEFICIENCIES       ID         REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG         Continued From page 6       3 830         - All residents must receive baseline TB screening within 72 hours of admission or within 3 months prior to admission. TB Screening must include an assessment of the resident's risk factors for TB, and any current TB symptoms, and a two-step TST or a single interferon gamma release assay (IGRA) for M. tuberculosis (e.g., QuantiFERON ® TB Gold or TB Gold In Tube, T-SPOT ®.TB).         - All reports and copies of resident tuberculin skin tests (TSTs), results from IGRAs for M. tuberculosis, medical evaluations, and chest radiograph results must be maintained in the resident's medical record. Consult current CDC recommended follow-up of residents who display signs or symptoms of active TB disease.         This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 5 of 5 newly admitted residents, (R37, R9, R12, R90, R138) received a physical examination by a physician upon admission and failed to ensure medications were ordered by a physician upon admission and failed to ensure medications were ordered by a physician upon discharge	F CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING:         IDENTIFICATION NUMBER:       A. BUILDING:         IDENTIFICATION NUMBER:         AND CORSUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE         CONDER STREET THASTINGS, MIN 55033         SUMMARY STATEMENT OF DEFICIENCIES         (REAH DEFICIENCIES         (REAH DEFICIENCIES DEFICIENCIES         (REAH DEFICIENCIES DEFICIENCIES INCOMPTORY OR LSC IDENTIFYING INFORMATION)         PROVIDER'S PLAN         (REAH DEFICIENCIES INCOMPTORY OR LSC IDENTIFYING INFORMATION)         Continued From page 6         - All residents must receive baseline TB         screening must         Include an assessment of the resident's risk         factors for TB, and any current TB symptoms, and a two-step TST or a single intefereng gamma release assay (IGRA) for M. tuberculosis (e.g., QuantIFERON ® TB Gold or TB Gold in Tube, T-SPOT ®.TB).         - All reports and copies of resident tuberculin skin tests (TST), results from IGRAs for M. tuberculosis, medical evaluations, and chest radiograph results must be maintained in the resident's medical record. Consult current CDC recommended follow-up of residents who display signs or symptoms of active TB disease.         This MN Requirement is not met as evidenced by:	F CORRECTION       IDENTIFICATION NUMBER:       A BUILDING:

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
00		00788	5.000			120/2016
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,		09	/29/2016
MN VETEI	RANS HOME HASTINGS		ST 18TH STREET GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
3 830	Continued From page	97	3 830			
	Findings include:					
	R37's admission histo examination, dated 10 completed by a nurse physician.	0/27/15 revealed it was				
	(MD), reported a nurs complete the physical then complete a revie	m., the medical director se practitioner would examinations. He would w of the patient record and nd either write and sign or				
	nurse practitioners (N residents, such as ph writing orders, as this practice. The facility a director. R9's admission histor	ad an onsite clinic and used P) to provide care to ysical examinations and was in an NP's scope of ilso had a physician medical y and physical examination, ed it was completed by a				
	R12's admission histo examination, dated 8/ completed by a nurse physician.	4/16 revealed it was				
	R90's admission histo examination, dated 8/ completed by a nurse physician.	4/15 revealed it was				
	R138's admission his examination, dated 1 <sup>°</sup> completed by a nurse physician.	1/19/15 revealed it was				

STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED	
		00788	B. WING		09	/29/2016
AME OF PF	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	E, ZIP CODE	·	
IN VETER	RANS HOME HASTINGS		ST 18TH STREET GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
3 830	Continued From page	28	3 830			
	revealed discharge o medication orders da completed by a physi by a nurse practitioner R160's orders, dated revealed medications practitioner, not a phy medication administra these medications we Facility's discharge pr "I. written discharge o obtained if discharge discharge is unexpect physician will be obta and type of discharge will be counted and lit resident if approved b	cian. They were completed er. 1/1/2016-1/31/2016 ordered by a nurse ysician. R160's January 2016 ation record (MAR) revealed ere distributed to R160. 0licy dated 5/13/88, revealed order by physician will be is planned in advance. If ted, a phone order from the ined. Order will include time e. II. Discharge medications sted, either sent with by doctor, or destroyed rocedure Doctor's order				
	The administrator or revise procedures rel	•				
	TIME PERIOD FOR ( (21) days.	CORRECTION: Twenty-one				
3 835	MN Rule 4655.4700 S Examinations and Or		3 835			
	-	physical examination nursing home patient shall				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
	00788					
			B. WING		09	9/29/2016
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE ST 18TH STREET	, ZIP CODE		
MN VETEI	RANS HOME HASTINGS		GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
3 835	Continued From page	9	3 835			
	months and each boa	ysician at least every six arding care home resident at e often if indicated by the				
	by: Based on interview an facility failed to ensure at the facility for more R92, R24, R42, R61,	t is not met as evidenced nd document review, the e 8 of 9 residents residing e than 1 year, (R117, R23, R113, and R28) had annual s completed by a physician.				
	Findings include:					
	R117's annual review completed 7/25/16, re a nurse practitioner a	evealed it was completed by				
	R23's annual review a completed 4/29/16, re a nurse practitioner a	evealed it was completed by				
	R92's annual review a completed 4/6/16, rev nurse practitioner and	vealed it was completed by a				
	(MD), reported a nurs complete the physical then complete a revie	m., the medical director se practitioner would I examinations. He would w of the patient record and and either write and sign or				
	nurse practitioners (N residents, such as ph	ad an onsite clinic and used				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		00788	B. WING		09	/29/2016
ME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE	1	
	RANS HOME HASTINGS		ST 18TH STREET			
			GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLE DATE
3 835	Continued From page	: 10	3 835			
	director. R24's annual review a	evealed it was completed by				
	R42's annual review and physical exam, completed 7/14/16, revealed it was completed by a nurse practitioner and not a physician.					
	R61's annual review a completed 3/8/16, rev nurse practitioner and	ealed it was completed by a				
	R113's annual review completed 5/19/16, re a nurse practitioner a	evealed it was completed by				
	R28's annual review a completed 2/12/16, re a nurse practitioner, r	evealed it was completed by				
	The administrator or or revise procedures relations	OD FOR CORRECTION: designee could review and ated to annual history and elated to these procedures liance.				
	TIME PERIOD FOR ( (21) days.	CORRECTION: Twenty-one				
3 840	MN Rule 4655.4700 S Examinations and Or		3 840			
	Subp. 3. Records	of physical examinations. A				

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED	
	ROVIDER OR SUPPLIER	00788	B. WINGADDRESS, CITY, STATE, ZIP CODE			0/29/2016	
	RANS HOME HASTINGS		ST 18TH STREET				
		HASTIN	GS, MN 55033				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLE DATE	
3 840	Continued From page	e 11	3 840				
		e recorded in the patient's or the time of each examination.					
	by: Based on interview an facility failed to ensur	t is not met as evidenced nd document review, the e 1 of 14 residents (R14) n the record for the most ination.					
	Findings include:						
	R14's record had no record of a physical examination within the previous 12 months.						
	supervisor (HIS) conf explained R14 went to for the annual physical explained the record examination was not clinic. Records from c	o a clinic outside the facility					
		m. R14 confirmed R14 had n in October of 2015 at a ity.					
	The administrator or or revise procedures relation	OD FOR CORRECTION: designee could review and ated to annual history and elated to these procedures liance.					
	TIME PERIOD FOR ( (21) days.	CORRECTION: Twenty-one					

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE COMP	SURVEY LETED
		00788	B. WING		09/29/2016	
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE		
IN VETEI	RANS HOME HASTINGS		ST 18TH STREET GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
3 980	Continued From page	9 12	3 980			
3 980	MN Rule 4655.6400 S Clean linen	Subp. 2G Adequate Care;	3 980			
		or determining adequate ermining adequate and ude:				
		Bed linen shall be changed as needed. Beds shall be htened as necessary.				
	by: Based on observation	t is not met as evidenced and interview, the facility 40 residents (R43, R127 nen and bed made.				
	Findings include:					
	A tour was completed maintenance worker ( between 8:20 a.m. an concerns were observ PME-A.	(PME)-A on 9/28/16 id 9:50 a.m. The following				
	with clothes. R43 repo	erved. The bed was piled orted no one helped him n. PME-A reported the room condition "for years."				
	R127 and R94's room case and comforter or yellow.	n was observed. The pillow n the bed was stained				
	of cardboard and plas boxes was an accum	rved. The bed had large pile stic boxes. Surrounding the ulation of dust on the ed the room had been in a				

	a Department of Health OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00788	B. WING		09	9/29/2016
AME OF PF	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	, ZIP CODE		
	RANS HOME HASTINGS		ST 18TH STREET SS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE ) THE APPROPRIATE	(X5) COMPLET DATE
3 980	Continued From page similar condition for a	e 13 bout a year and a half.	3 980			
	The administrator or or resident beds are man provided on a at least administrator or design	a weekly basis. The nee could review and revise taff could be trained related The administrator or				
	TIME PERIOD FOR ( (21) days.	CORRECTION: Twenty One				
31010	Units; Comfortable be Subpart 1. Require	Subp. 1A Patient or Resident ed ements. The following items each patient or resident:	31010			
	good springs, and a c mattress and mattress comfortable pillow wit meet the patient's new blankets and bed line the proper size shall t all times. Clean shee furnished at least onc have a washable bed mattress cover or rub be provided for mattress	bed at least 36 inches wide, lean, firm, comfortable s pad. At least one clean, h extra pillows available to eds. Clean, lightweight n in good condition and of be kept on hand for use at ts and pillow cases shall be e a week. Each bed shall spread. A moisture-proof ber or plastic sheeting shall esses of all bed patients and essary. Rollaway type beds, shall not be used.				
	This MN Requiremen	t is not met as evidenced				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:		(X3) DATE COMP	SURVEY LETED
		00788	B. WING		09/29/2016	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
IN VETE	RANS HOME HASTINGS		ST 18TH STREET GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
31010	by: Based on observation failed to ensure 4 of 1 R94 and R32) had a of and bed linen. Findings include: A tour was completed maintenance worker ( between 8:20 a.m. an concerns were observe PME-A. R43's room was observe with clothes. R43 report with cleaning his room had been in a similar R127 and R94's room case and comforter of yellow. R32's room was obse accumulation of cardt Surrounding the boxe dust on the mattress. been in a similar conc half. SUGGESTED METHO The administrator or of resident rooms are cle provided on a at least administrator or desig	of Building 23 with a PME)-A on 9/28/16 d 9:50 a.m. The following ved and confirmed by rved. The bed was piled orted no one helped him n. PME-A reported the room condition "for years." was observed. The pillow in the bed was stained rved. The bed had an board and plastic boxes. s was an accumulation of PME-A noted the room had lition for about a year and a OD FOR CORRECTION: lesignee could ensure eaned and clean linen is a weekly basis. The nee could review and revise taff could be trained related The administrator or	31010			

STATEMENT	a Department of Health OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			SURVEY PLETED
		00788	B. WING		09/29/2016	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
IN VETEI	RANS HOME HASTINGS		ST 18TH STREET			
			GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
31010	Continued From page	: 15	31010			
	TIME PERIOD FOR ( (21) days.	CORRECTION: Twenty-one				
31105	MN Rule 4655.7810 [	Distribution of Medications	31105			
	A system shall be developed in each be care home to assure that all medications a distributed safely and properly. All medical shall be distributed and taken exactly as o by the physician. Any medication errors of resident reactions shall be reported to the physician at once and an explanation made resident's personal care record.	that all medications are properly. All medications ad taken exactly as ordered medication errors or all be reported to the I an explanation made in the				
	by: Based on interview ar facility failed to ensure reviewed (R117, R92, R28, R90, R138) were medications with phys medications were ord discharge orders were	R14, R37, R23, R9, R12, e only distributed sician orders and ensure ered by a physician and e completed by a physician of 5 residents (R160) whose				
	Findings include:					
	revealed medications practitioner, not a phy	, dated 9/20/16 and 8/29/16 ordered by a nurse ysician. R117's September hese medications were				
	medications ordered I a physician. R92's Se	dated 7/26/16 revealed by a nurse practitioner, not ptember 2016 MAR ations were distributed to				

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	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE COMF	SURVEY PLETED
		00788	B. WING		09	/29/2016
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
IN VETER	RANS HOME HASTINGS		ST 18TH STREET GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE	(X5) COMPLET DATE
31105	Continued From page	9 16	31105			
	medications ordered a physician. R14's Se	dated 7/26/16 revealed by a nurse practitioner, not ptember 2016 MAR ations were distributed to				
	medications ordered	dated 8/24/16 revealed by a nurse practitioner, not tember 2016 MAR revealed ere distributed to R37.				
	medications ordered a physician. R23's Se	dated 7/26/16 revealed by a nurse practitioner, not ptember 2016 MAR ations were distributed to				
	nurse practitioners (N residents, such as ph writing orders, as this	ad an onsite clinic and used				
	revealed medications practitioner, not a phy	lated 9/15/16 and 8/23/16 ordered by a nurse vsician. R9's September hese medications were				
	revealed medications practitioner, not a phy	dated 9/28/16 and 9/15/16 ordered by a nurse vsician. R12's September hese medications were				
	R28's current orders,	dated 9/15/16 and 9/14/16				

OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
	00788	B. WING		09/29/2016	
ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	ZIP CODE	,	
RANS HOME HASTINGS					
SUMMARY ST					(X5)
•		PREFIX TAG	CROSS-REFERENCED TO	) THE APPROPRIATE	COMPLETI
Continued From page	e 17	31105			
practitioner, not a phy	sician. R28's September				
R90's current orders, dated 9/23/16 and 9/15/16 revealed medications ordered by a nurse practitioner, not a physician. R90's September 2016 MAR revealed these medications were distributed to R90.					
revealed medications practitioner, not a phy	ordered by a nurse /sician. R138's September				
revealed discharge of medication orders dat completed by a physi	rders, including individual ted 1/4/16, were not cian. They were completed				
revealed medications practitioner, not a phy medication administra	ordered by a nurse vsician. R160's January 2016 ation record (MAR) revealed				
discharge order by ph discharge is planned unexpected, a phone be obtained. Order wi discharge. II. Dischar counted and listed, ei approved by doctor, c	nysician will be obtained if in advance. If discharge is order from the physician will ill include time and type of ge medications will be ther sent with resident if or destroyed according to				
	ROVIDER OR SUPPLIER RANS HOME HASTINGS SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From page revealed medications practitioner, not a phy 2016 MAR revealed t distributed to R28. R90's current orders, revealed medications practitioner, not a phy 2016 MAR revealed t distributed to R90. R138's current orders revealed medications practitioner, not a phy 2016 MAR revealed t distributed to R90. R138's current orders revealed medications practitioner, not a phy 2016 MAR revealed t distributed to R90. R138's current orders revealed medications practitioner, not a phy 2016 MAR revealed t distributed to R138. Review of R160's dis revealed discharge o medication orders da completed by a physi by a nurse practitioner R160's orders, dated revealed medications practitioner, not a phy medication administra these medications we Facility's discharge pr discharge order by ph discharge is planned unexpected, a phone be obtained. Order w discharge. II. Dischar counted and listed, ei approved by doctor, o	IDENTIFICATION NUMBER:         00788         ROVIDER OR SUPPLIER       STREET A         RANS HOME HASTINGS       1200 EA         HASTIN       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 17       revealed medications ordered by a nurse practitioner, not a physician. R28's September 2016 MAR revealed these medications were distributed to R28.         R90's current orders, dated 9/23/16 and 9/15/16         revealed medications ordered by a nurse practitioner, not a physician. R90's September 2016 MAR revealed these medications were distributed to R90.         R138's current orders, dated 9/27/16 and 9/15/16 revealed medications ordered by a nurse practitioner, not a physician. R138's September 2016 MAR revealed these medications were distributed to R90.         R138's current orders, dated 9/27/16 and 9/15/16 revealed medications ordered by a nurse practitioner, not a physician. R138's September 2016 MAR revealed these medications were distributed to R138.         Review of R160's discharge orders dated 1/4/16, revealed discharge orders, including individual medication orders dated 1/4/16, were not completed by a physician. They were completed by a nurse practitioner.         R160's orders, dated 1/1/2016-1/31/2016 revealed medications ordered by a nurse practitioner, not a physician. R160's January 2016 medication administration record (MAR) revealed these medications were distributed to R160.         Facility's discharge policy revealed "I. written discharge order by physician will be obtained if discharge is planned in advance. If dischar	PF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING:         00788       B. WING         ROVIDER OR SUPPLIER         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 17       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       D PREFIX TAG         Continued From page 17       revealed medications ordered by a nurse practitioner, not a physician. R28's September 2016 MAR revealed these medications were distributed to R28.       31105         R90's current orders, dated 9/23/16 and 9/15/16 revealed medications ordered by a nurse practitioner, not a physician. R90's September 2016 MAR revealed these medications were distributed to R90.       3138         R138's current orders, dated 9/27/16 and 9/15/16 revealed medications ordered by a nurse practitioner, not a physician. R138's September 2016 MAR revealed these medications were distributed to R138.       N         Review of R160's discharge orders dated 1/4/16, revealed discharge orders, including individual medication orders dated 1/4/16, were not completed by a physician. They were completed by a nurse practitioner.       N         R160's orders, dated 1/1/2016-1/31/2016 revealed medications ordered by a nurse practitioner, not a physician. R160's January 2016 medication administration record (MAR) revealed these medications were distributed to R160.       Facility's discharge policy revealed "L written discharge is planned in advance. If discharge is unexpected, a phone order from the physician will be	OPE CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING:         00788         BUING         BUING         CONTRER         STREET ADDRESS, CITY, STATE, ZIP CODE         CONTRER         SUMMARY STATEMENT OF DEFICIENCIES         (ID         (EACH CORRECTIVE AT ISTN STREET         (EACH CORRECTIVE AT ISTN STREET         REQULATORY OR LSC IDENTIFYING INFORMATION)         PREVIDER'S TATEMENT OF DEFICIENCIES         (ID         PROVIDER'S PLANCE         CONTINUE FROM TO FEICIENCIES         (ID         PROVIDER'S PLANCE         CONTINUE FROM TO FEICIENCIES         ID         CONTINUE FROM TO FEICIENCIES         ID	OPERFICIENCIES PEORRECTION     (M1) PROVIDERSUPPRIERCULA IDENTIFICATION NUMBER     OCI MULTIPLE CONSTRUCTION A BULDING     (D2) DATA A BULDING <t< td=""></t<>

STATEMEN	a Department of Health T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE COMF	SURVEY PLETED
		00788	B. WING		09	/29/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
MN VETEI	RANS HOME HASTINGS		ST 18TH STREET SS, MN 55033			
(X4) ID			ID	PROVIDER'S PLAN O		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLETI
31105	Continued From page	9 18	31105			
		ff related to these				
	TIME PERIOD FOR ( (21) days.	CORRECTION: Twenty-one				
31130	MN Rule 4655.7830 Subp. 1 Medication Containers; Labeled containers		31130			
	medications shall be licontainer bearing the information stating the name of drug, strengt expiration dates of all directions for use, res name, date of original refill, the most recent address of the license the medications. It sh the boarding care hor	original label with legible e prescription number, h and quantity of drug, time-dated drugs, ident's name, physician's l issue or in the case of a date thereof, and name and ed pharmacy which issued hall be the responsibility of me to secure the and name of the medication				
	by: Based on observation review, the facility fail were stored and label residents (R32, R39, R128) reviewed for m	t is not met as evidenced a, interview and document ed to ensure medication led properly for 7 of 13 R80, R90, R91, R118 and edication storage and failed of medication bottle for 1 of newed for medication				

	a Department of Health OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00788	B. WING		09/29/2016	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
	RANS HOME HASTINGS	1200 EA	ST 18TH STREET			
		HASTIN	GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
31130	Continued From page	e 19	31130			
	administration					
	Findings include:					
	at the facility, medical R90, R91, R118 and drops and insulin, lac medication name and	l direction label, lacked n they were opened, or the				
	2:35 p.m. with the lice (LPN)-A, in the medic multiple opened, unda medication bottles an medication bins. Obse following:	ation room (Pharmacy), ated and unlabeled d pen were stored in ervations included the				
	hypertension) eye dro and was undated.	aleate solution 0.5% (Ocular op bottle was opened, used aleate solution 0.25 %				
	(Glaucoma). Latanop (Glaucoma) eye drop and were undated.	rost solution 0.005% bottles were opened, used				
	opened, used and wa - R90's Timolol Ma (Glaucoma) was oper - R91's Travoprost	aleate solution 0.5 % ned, used and was undated. : Z solution 0.004 % was				
	solution 22.3-6.8 mg/	ide HCL-Timolol Maleate ml (Glaucoma) and suspension 1% (cataracts)				
	addition, Dorzolamide and Brimonidine Tartr to be opened, undate	ate solution were observed d, unlabeled, used and was ation bin in the pharmacy				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00788	B. WING		09/29/2016	
NAME OF PF	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE,	ZIP CODE		
MN VETER	RANS HOME HASTINGS		ST 18TH STREET			
			GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE ) THE APPROPRIATE	(X5) COMPLET DATE
31130	Continued From page	20	31130			
		laleate solution 0.5 % was opened, used and was				
	LPN-A verified the me and labeled properly a and stored properly. L medications needed t and insulin are norma ask registered nurse	n 9/26/16, at 3:05 p.m. edications were not stored and needed to be labeled PN-A added that opened to be dated when opened ally dated when opened. Will (RN)-A with what to do with and the insulin pen that abeled properly.				
	p.m. RN-A verified the labeled and stored pro- Further mentioned, "V eye drops and the ins from our pharmacy ar	LPN-B on 9/26/16, at 3:20 e medication needed to be operly with proper labels. We will be destroying those sulin pen, reorder new one nd date them when open. ff to date the eye drops and n."				
	MEDICATION ADMIN "Preparation of equip medication is labeled check the expiration of	dated 11/14/14, title EYE IISTRATION, directed staff, ment make sure the for ophthalmic use. Then date. Remember to date the e you use the medication				
	Policy and procedure LABELING OF MEDIC Medications dispense labeled in compliance Pharmacy name, a number of the pharma drug order patient ' s	CATIONS, directed staff, "1. ed to residents must be				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00788	B. WING		09/29/2016	
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE	1 00	
MN VETER	RANS HOME HASTINGS		AST 18TH STREET IGS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
31130	Continued From page	e 21	31130			
	be returned to the dis relabeling by the pha according to the facili destruction." Policy and procedure ADMINISTRATION C "1. Check medication insulin syringe. 3. Ob opening a bottle of ne Discard Days A " SUGGESTED METH The administrator or of revise procedures rel and labeling, train sta procedures and moni	ty 's policy for medication dated 4/09, title OF INSULIN, directed staff, order. 2. Obtain appropriate tain insulin ordered. 4. When ew insulin, affix label, 'To After opening.' 'Date open OD FOR CORRECTION: designee could review and ated to medication storage iff related to these				
31180		Subp. 1&3 Linen; Soiled	31180			
	to boarding homes or Subp. 3. Soiled lin collected in a cleanab bag for removal to the or to the laundry. Ha shall be cleaned or w cleanable laundry true	en. Soiled linen shall be ble hamper, container, or e soiled linen collection room mpers, containers, or bags ashed regularly. Easily				

STATEMEN	a Department of Health FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00788	B. WING		09/29/2016	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
	RANS HOME HASTINGS		ST 18TH STREET GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
31180	Continued From page	22	31180			
	by: Based on interview an failed to ensure soiled in a cleanable condition shower room. This has of 43 residents on the Findings include: A tour was completed maintenance worker (	(PME)-A on 9/28/16 Id 9:50 a.m. The following				
31305	towel bin covered in r SUGGESTED METH The administrator or of towel bins found cover with a cleanable tower TIME PERIOD FOR 0 (21) days. MN Rule 4655.8670 S Food Subpart 1. Food. Sources approved or of the commissioner of h wholesome, free from adulteration and misb human consumption. nonacid, or low-acid f	OD FOR CORRECTION: designee could replace any ered in rust or not cleanable I bin. CORRECTION: Twenty-one Subp. 1 Food Supplies; All food shall be from considered satisfactory by nealth, and shall be clean, a spoilage, free from randing, and safe for No hermetically sealed,	31305			

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
		00788	B. WING		09/29/2016	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	, ZIP CODE	09	/29/2010
			ST 18TH STREET			
	RANS HOME HASTINGS	HASTING	GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
31305	Continued From page	23	31305			
	food-processing estal	plishment shall be used.				
	by: Based on observatior review, the facility fail second and third floor a sanitary manner. Th impact 85 residents re-	t is not met as evidenced n, interview, and document ed to maintain building 23 r kitchenette lounge units in his had the potential to esiding on 2nd and 3rd floor				
	of building 23. Findings include: On 9/27/16, at 2:20 p.m. third floor west					
	kitchenette lounge un the registered dieticia forks and a small bow the table. RD stated t on the table for dirty of daily. On 9/27/16, at 2:30 p	it tour was completed with n (RD). Two dirty plates, two /I were observed sitting on here should be a plastic bin lishes to be picked up once				
	-	worker (GMW-A). The ere observed and confirmed				
	freezer contained two 7/8/16, and the other freezer contained an	bbserved to have food top, back and sides. The bags of fish, one dated bag was undated. The unlabeled store container of e refrigerator contained an				
	unlabeled, undated co plastic container of m small carrots and one	ontainer of soup and a small eat. There were five bags of undated, unlabeled apple. ge bins had food drippings				
	GMW-A confirmed the schedule did not have as being cleaned and	e refrigerator cleaning September dates checked indicated staff should check ularly. GMW-A confirmed				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00788	B. WING		00	/29/2016
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STATE,	, ZIP CODE		123/2010
	RANS HOME HASTINGS	1200 EA	ST 18TH STREET			
		HASTING	GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AU CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
31305	Continued From page	24	31305			
	GMW-A stated the foo GMW-A observed the stated staff should cle the refrigerator daily. refrigerators were clean GMW-C walked into the housekeeper cleaning the weekly September being checked off, GM forgotten to mark the proceeded to clean the On 9/29/16, at 11:15 at kitchenette lounge un general maintenance following concerns we by GMW-A. The microwave was co splatter on the inside refrigerator contained bagged undated chee partially full drink cup cup of unlabeled ice of contained a rotting ap plastic bag and tissue refrigerator cleaning s September dates chee the weeks of 9/14, 9/2 Facility resident exper revealed: "8) Food sto refrigerators must hav it will be disposed of." Facility 2:30 to 6:30 re policy revised 2-15-16	g cart. When asked about r cleaning schedule not MW-C stated "must have cleaning sheet" and he refrigerator. a.m. the second floor west it tour was completed with worker (GMW-A). The ere observed and confirmed observed to have food back and sides. The a bag of undated chicken, eseburger, and undated . The freezer contained a cream. The drawers ople, dirty plastic mug, dirty es. GMW-A confirmed the schedule did not have cked as being cleaned for 21, and 9/28. ctations policy dated 9/14, ored in the lounge ve a name and date on it or outine check list of duties 6, revealed: "4. Check third				
		nes. Sanitize table and				
		OD OF CORRECTION: The risor or designee could				

	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			SURVEY
			A. BUILDING:			
		00788	B. WING		09/29/2016	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
MN VETEI	RANS HOME HASTINGS		ST 18TH STREET GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
31305	Continued From page	e 25	31305			
	resident refrigerators cleanliness and expir food storage areas co and expired food disc or designee could ed basic food safety.	ent a system to monitor and food storage area for red food. Refrigerators and build be regularly cleaned carded. The dietary manager ucate residents and staff on CORRECTION: Ten (10)				
31455	MN Rule 4655.9000 General Requiremen	Subp. 1 Housekeeping; ts	31455			
	facility, including wall fixtures, equipment, a maintained in a clear condition throughout offensive odors, dust hazards. Accumulati	al requirements. The entire s, floors, ceilings, registers, and furnishings shall be n, sanitary, and orderly and shall be kept free from , rubbish, and safety on of combustible material ed areas is prohibited.				
	by: Based on observation review, the facility fai environment was kep orderly condition. Thi all 140 residents resid	ot in a clean, sanitary and s had the potential to impact ding at the facility including: 2, R79, R30, R25, R2, R50,				
	Findings include:					
	maintenance worker	d of building 23 with a (PME)-A on 9/28/16 nd 9:50 a.m. The following				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00788	00788 B. WING		-	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	03	/29/2016
MN VETER	RANS HOME HASTINGS		ST 18TH STREET			
(X4) ID	SUMMARY ST		GS, MN 55033	PROVIDER'S PLAN C		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	COMPLET DATE
31455	Continued From page	26	31455			
	physical, mental and	ved and confirmed by I many of the residents had emotional challenges that an the room without staff				
	The handrails of floors 2, 3 and 4 had numerous multicolor spots on them. The floors and stairwells were traversed by surveyors at various times of day and evening on 9/26, 9/27, 9/28 and 9/29 and were observed each time with an accumulation of dust, dried spills and dirt.					
	with clothes. Several The floor had an accu garbage, such as spo containers. Brown sta and heater. There wa R43 reported no one	erved. The bed was piled boxes were on the floor. imulation of crumbs and ons, cups and old food ins were noted on the table s tape on the window blinds. helped him with cleaning his d the room had been in a years."				
	sills and wardrobe ha on them. The fridge h on the inside surface. was mold. There were outside of the fridge. accumulation of dust, cobwebs, bugs and h accumulation of dirt o dried spills on the floor	a was observed. The window d an accumulation of dust ad a ring of black substance MW reported he thought it e brown spills noted on the The floor was sticky with an soiled facial tissues, food, air on it. The mats had an n them. There were also or of various colors. The orter on the bed was stained ins were noted on the				
	accumulation of cards	erved. The bed had an board and plastic boxes. Is was an accumulation of				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00788	788 B. WING		09/29/2016	
NAME OF PF	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	1 00	
	RANS HOME HASTINGS	1200 EA	ST 18TH STREET			
		HASTIN	GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AU CROSS-REFERENCED TC DEFICIE!	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
31455	Continued From page	e 27	31455			
	of dirt, spills and garb was an accumulation and nightstand. A film plate next to electrica were out. R32 reported for room order, and h from staff. Lounge 426 was obse accumulation of dust lamp and an accumul in the window tracks. worn and stained. R79's room was obse of dirt and dust on the register. Garbage was	I he was solely responsible ad received no assistance erved. There was an on the window sills and lation of dust and dead bugs Six out of seven chairs were erved. There was a buildup e windows, floor and heat				
	The 418 mop closet h garbage and dirt on the	nad an accumulation of ne floor.				
	Near rooms 251 and stained chairs in the h	253 there were noted 3 nallways.				
	worn and stained. The R44 noted the furnitur were "old" and need to floor east lounge had some with blankets of noted residents put bl chairs because they we suggested, regarding	unge had 11 chairs, each e floor was worn with stains. re and floor in the lounge to be replaced." The 2nd 7 chairs worn with stains, r towels on them. R125 lankets and towels on the were sticky. R125 the chairs to either "throw aner" and noted the carpet				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		SURVEY	
		00788	B. WING			09/29/2016	
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, <b>.ST 18TH STREET</b>	ZIP CODE			
MN VETEI	RANS HOME HASTINGS		GS, MN 55033				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE	
31455	Continued From page	e 28	31455				
	worn and stained in several areas, particularly near the sink. The windowsills around the perimeter of the lounge were coated with dust.						
	stains, worn areas ar various times of day 9/27, 9/28 and 9/29.	and floor was noted to have nd tears in the carpet at during the survey on 9/26, The windows and window ave an accumulation of dust, ugs.					
	dried spills on the floo	accumulation of dust and or. Garbage and food n throughout the room. R25 clean his room.					
		ad towels and paper towels the floor. Garbage and dust the floor.					
		accumulation of dust buildup register and floor. Cobwebs ners.					
	The center elevator to accumulation of dirt a were noted on the wa	and dust buildup and spots					
	The carpet was wear	ed to have 7 stained chairs. ing thin, especially near the nulated on the window sills f the room.					
	sauce and multicolor room had an odor of There was a thick ac						

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			SURVEY PLETED
		00788	B. WING		09	/29/2016
AME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE, ST 18TH STREET	, ZIP CODE		
IN VETEI	RANS HOME HASTINGS		GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE ) THE APPROPRIATE	(X5) COMPLE DATE
31455	Continued From page	29	31455			
	A drinking fountain near room 337 was cracked and covered with duct tape.					
	sinks. A buildup of du on the window ledge, window screens. Dus ceiling vent in a show dispensers of the show shower curtains did n Red, yellow and oran noted in the grout in t shower curtains. A to A 3rd floor bathroom bugs between window R51's room had walls knacks and blocked a R95's room had dirt, newspapers on the floor the floor near the bed been there "about a w window sills and piles	lined with boxes of knick access to the heat register.				
	staff person assisted and orderly.	0 chairs were worn and				
	stained. The carpet w around the room were	vas worn within. Window sills e covered in dust. A bed was of the lounge. PME-A noted				
	the residents were ex order on their own, w	a.m. the administrator noted spected to maintain room ithout staff help, with the the floor. Health and Safety				

. STATE FORM

STATEMEN	a Department of Healti of Deficiencies of Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		00788	B. WING			09/29/2016	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
MN VETEI	RANS HOME HASTINGS		ST 18TH STREET GS, MN 55033				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLET DATE	
31455	Continued From page	e 30	31455				
	should be working on residents.	a clean room project to help					
	1/2016 directed staff announce your prese the 5 qt. {quart} Buck germicidal into the re- dresser. Damp dust fi bedside table. 6. Dam Proceed to foot of be- furniture, damp dust a Housekeeper proceed check all walls and cl germicidal cleaner. 9. window frame-clean a exterior portion of pat spot clean wall as new 12. Proceed to cleani and return to room wi counter brush. Weekh Discharge-For equipr information, refer to " Patient room weekly of specifically includes: door-damp dust. 2. To door-damp dust. 3. B dust. 4. Patient's TV except the screen wit ceiling vents-damp du baseboards."	. Spot check window and as needed. 10. Check tient's closet-damp dust and eded. 11. Vacuum carpet. ing cart, return all equipment ith dust mop, dust pan and ly Cleaning or at ment and other procedural High Dusting" procedures. cleaning or at discharge 1. Ledge above patient op of patient room ack of patient door-damp wipe with germicide solution th glass cleaner. 5. Wall and ust. 6. Check corners and ing procedure directed staff dal solution-start in one amp wipe all surfaces. gerprints from walls and					

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		00788		B. WING		09/29/2016	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,		08	1/29/2010	
IN VETE	RANS HOME HASTINGS		ST 18TH STREET GS, MN 55033				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE	
31455	sink, then to outside a and "10. Renew germ or shower stall." and ' accumulation of soap holder. 13. Wring out and spot wash the wa and ceiling vents with Clean by wiping the s solution. 4. Scrub the handled scrub brush a The Health and Safet undated, directed staff be accessible and bot "Beds must have line stored in room-nothing day."; "Refrigerator m No cardboard boxes a Trash must be proper overflowing. Furniture sticky, dirty). No odor or body odor." The Clean Room Proj directed staff "To iden a health and safety ris criteria will first be act and Safety Rounds be problematic in a more assigned team will the described below, by fi barriers each Veteran room, determining the	e, move to the top of the and underneath the sink." icidal solution-clean the tub '12. Remove all and film from the soap cloth in germicidal solution ills." and "1. Clean all wall high dust tool" and "3. hower stalls with germicidal shower floor with a short and germicide solution." y Rounds Checklist, ff "Heating/cooling unit must thom must not be blocked."; ns." "No open food or drink g perishable for more than 1 ust be clean and defrosted. are allowed on the floor. ly contained-not must be clean (not dusty, of spoiled food, urine, feces fect procedure, undated, tify Veterans whose rooms sk. Rooms meeting these chowledged during Health efore being identified as e specific area. The en follow the protocol as irst attempting to identify the has in maintaining a clean e severity of clutter (if ng with the Veteran to	31455				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00788	B. WING		09/29/2016	
AME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	, ZIP CODE		12512010
IN VETEI	RANS HOME HASTINGS		ST 18TH STREET			
			GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
31455	Continued From page	32	31455			
	general maintenance GMW-E were taking of housekeeping carts fr janitor closet. The car heavy accumulation of units, with hair and pa- as numerous empty w The janitor closet had dust, paper particles, grease like streaks or When interviewed on GMW-D and GMW-E carts were dirty and th housekeeping carts b to clean them except hose them down. Bot of any policy to clean GMW-E reported due decision, chemical cl only on 1st floor. GMW the mop buckets were was not convenient to from third floor just to would not be unusual water and chemical a A policy was requested janitor closet and cart	om the building 23 first floor ts were observed to have a of dust on the three shelf aper particles present as well vrappers and visible soil. a heavy accumulation of hair, and a black debris in the floor. 9/28/16, at 7:45 a.m. verified the housekeeping ney did not clean the ecause there was no place to take them outside and in verified they did not know the carts. GMW-D and to an administrative eaning supplies were stored W-D explained the water in e not changed because it o come down to the first floor change the dirty water, so it to use the same bucket of				
	- 11:01 a.m. with the p (PME)-B, general ma	with on 9/27/16 at 9:27 a.m. plant maintenance engineer intenance worker (GMW)-A ector (PPD). The following				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00788			09	/29/2016
IAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
IN VETER	RANS HOME HASTINGS		ST 18TH STREET GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
31455	Continued From page	e 33	31455			
	issues were observed GMW AND PPD.	d and verified by PME-B,				
	wood chip below the room (205) was obse rusty brown stains ap of the mirror glass. On 9/27/16 at 10:05 a findings and indicated supervisor who was a weekly quit about 3 w this concern to him. On third floor, east sid the laundry room was was uncovered/no lid trash. In addition, all includes the second f east and west sides, building 23. In buildin garbage bins with no On 9/27/16 at 10:49 a going to look at the g	loor west side, third floor fourth floor in the center in g 25 on the ground floor had				
	observed. The washin and there was duct ta corner. On 9/27/16 at confirmed by PME-B, mentioned, this was t	de in the laundry room was ng machine top was loss ape on the right upper : 9:47 a.m. Findings were GMW-A and PPD. PPD he first time seeing this and is attention. At 10:44 a.m.				
	PME-B indicated, was replace with new com PME-B added, "My e been reported and was floor." At 10:47 a.m. F	shing machine will be mercial washing machine. xpectation is, it should have e do monthly rounds on each PPD stated, there are rting such as housekeepers, seeping supervisor on				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED	
	ROVIDER OR SUPPLIER	00788	B. WING 09/29/2				
			ST 18TH STREET	,211 000E			
	RANS HOME HASTINGS	HASTIN	GS, MN 55033				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE	
31455	Continued From page	e 34	31455				
	the second floor by ro Overflow dirty soiled I in the hallway by soile Policy and procedure PROCEDURES - PO Directed staff, "lobbie and pull trash (as nee receptacle. 5. Police f mop or vacuum as nee Policy and procedure PROCEDURES FOR STATIONS reviewed Check walls and mirro needed. 4. Empty tras SUGGESTED METH The administrator or o resident rooms, and r thoroughly cleaned. A	title SPECIFIC LICING, reviewed date 1/16. s and Corridors 1. Check eded), wipe out waste floor (pick up paper, spot eeded)."					
	train staff and monitor TIME PERIOD FOR ( (21) days.	CORRECTION: Twenty-one					
31460	Cleaning Program Subp. 2. Developm program shall be esta housekeeping. Besid	les the daily duties, the policies and procedures for	31460				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
			B. WING			
	ROVIDER OR SUPPLIER	00788	DDRESS, CITY, STATE		09/29/2016	
			ST 18TH STREET	, 211 000E		
IN VETEI	RANS HOME HASTINGS		GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE ) THE APPROPRIATE	(X5) COMPLET DATE
31460	Continued From page	2 35	31460			
	by: Based on observation review, the facility fail program for maintaini clean, sanitary and or potential to impact all the facility including: F	t is not met as evidenced n, interview and document ed to ensure an effective ng the environment in a rderly condition. This had the 140 residents residing at R43, R127, R94, R32, R79, 5, R2, R50, R121, R59, R51,				
	Findings include:					
	A tour was completed maintenance worker ( between 8:20 a.m. an concerns were observ PME-A.	(PME)-A on 9/28/16 Id 9:50 a.m. The following				
	multicolor spots on th stairwells were traver	sed by surveyors at various ning on 9/26, 9/27, 9/28 and ⁄ed each time with an				
	with clothes. Several The floor had an accu garbage, such as spo containers. Brown sta and heater. There wa R43 reported no one	erved. The bed was piled boxes were on the floor. imulation of crumbs and ons, cups and old food tins were noted on the table s tape on the window blinds. helped him with cleaning his d the room had been in a years."				
	sills and wardrobe ha	n was observed. The window d an accumulation of dust ad a ring of black substance				

STATEMEN	a Department of Health T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
		00788	B. WING	B. WING		0/29/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	, ZIP CODE	•	
MN VETE	RANS HOME HASTINGS		ST 18TH STREET GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
31460	<ul> <li>was mold. There were outside of the fridge. Taccumulation of dust, cobwebs, bugs and haccumulation of dirt of dried spills on the floor pillow case and comfayellow. Holes and stacurtains.</li> <li>R32's room was obset accumulation of cards Surrounding the boxed dust on the mattress. of dirt, spills and garb was an accumulation and nightstand. A film plate next to electrica were out. R32 reported for room order, and h from staff.</li> <li>Lounge 426 was obset accumulation of dust lamp and an accumulation in the window tracks. worn and stained.</li> <li>R79's room was obset of dirt and dust on the register. Garbage was R30's room was obset was covered in rust.</li> </ul>	MW reported he thought it e brown spills noted on the The floor was sticky with an soiled facial tissues, food, air on it. The mats had an n them. There were also or of various colors. The orter on the bed was stained ins were noted on the erved. The bed had an obard and plastic boxes. Is was an accumulation of There was an accumulation age o on the floor. There of dust on the fan, wardrobe in was noted on the blank I switch. The ceiling lights ed they were out for 2 he was solely responsible ad received no assistance erved. There was an on the window sills and ation of dust and dead bugs Six out of seven chairs were erved. There was a buildup e windows, floor and heat s on the floor.	31460			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00788	B. WING			
NAME OF PR	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	09	/29/2016
NN VETER	RANS HOME HASTINGS		ST 18TH STREET			
		HASTING	GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
31460	Continued From page	9 37	31460			
	Near rooms 251 and stained chairs in the h	253 there were noted 3 nallways.				
	The 2nd floor west lo	unge had 11 chairs, each				
		e floor was worn with stains.				
		re and floor in the lounge o be replaced." The 2nd				
	floor east lounge had	7 chairs worn with stains,				
		r towels on them. R125 lankets and towels on the				
	chairs because they v					
		the chairs to either "throw				
	in garbage or get cleaner" and noted the carpet was "pretty worn out" The carpet was noted to be					
		everal areas, particularly				
	near the sink. The wir					
	perimeter of the loung	ge were coated with dust.				
		nd floor was noted to have				
		d tears in the carpet at				
		during the survey on 9/26, The windows and window				
		ve an accumulation of dust,				
	cobwebs and dead bu					
	R25's room had an a	ccumulation of dust and				
	dried spills on the floo					
	wrappers were strewn noted no staff helped	n throughout the room. R25 clean his room.				
		ad towels and paper towels				
		the floor. Garbage and dust				
	had accumulated on t	ne floor.				
		accumulation of dust buildup				
	on window sills, heat were noted in the corr	register and floor. Cobwebs ners.				
	The center elevator tr					
	accumulation of dirt a	nd dust buildup and spots				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			SURVEY PLETED
			A. BUILDING:			
		00788	B. WING		09	/29/2016
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
	RANS HOME HASTINGS		ST 18TH STREET GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
31460	Continued From page	e 38	31460			
	were noted on the walls of the elevator.					
	The carpet was wear	ed to have 7 stained chairs. ing thin, especially near the nulated on the window sills the room.				
	R59's room had bowls of crusty noodles with dried sauce and multicolored specks in them. The room had an odor of body odor and rotten food. There was a thick accumulation of dirt and dust on the floor, heat register and nightstand. Dirty clothes garbage and papers were strewn throughout the room.					
	A drinking fountain ne and covered with duc	ear room 337 was cracked t tape.				
	sinks. A buildup of du on the window ledge, window screens. Dus ceiling vent in a show dispensers of the sho shower curtains did n Red, yellow and oran noted in the grout in t shower curtains. A to	ower room had stained ist and dead bugs was noted window panes, between the it was buildup on the floor, a ver stall and and on the soap ower stalls. One out of 3 ot provide full visual privacy. ge stains and buildup were he shower stalls and on the wel bin was covered in rust. had sticky floor, dirt and w panes.				
		lined with boxes of knick access to the heat register.				
	the floor near the bed been there "about a w window sills and piles	cigarette butts, and oor. A brown spill dried on I. R95 noted the spill had veek" The heat register, s of paper strewn throughout ed in dust. R95 noted no				

TATEMENT	a Department of Health OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00788	 В. WING				
IAME OF PI	ROVIDER OR SUPPLIER		B. WING 09/29/20 T ADDRESS, CITY, STATE, ZIP CODE				
	RANS HOME HASTINGS	1200 EA	ST 18TH STREET				
		HASTING	GS, MN 55033				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
31460	Continued From page	e 39	31460				
	staff person assisted with keeping his room clean and orderly.						
	stained. The carpet w around the room were	0 chairs were worn and vas worn within. Window sills e covered in dust. A bed was of the lounge. PME-A noted weeks"					
	general maintenance GMW-E were taking of housekeeping carts fi janitor closet. The car heavy accumulation of units, with hair and pa as numerous empty of The janitor closet had	rom the building 23 first floor ts were observed to have a of dust on the three shelf aper particles present as well vrappers and visible soil. I a heavy accumulation of hair, and a black debris					
	GMW-D and GMW-E carts were dirty and the housekeeping carts be to clean them except hose them down. Bot of any policy to clean GMW-E reported due decision, chemical clean only on 1st floor. GMM the mop buckets were was not convenient to from third floor just to	vecause there was no place to take them outside and h verified they did not know the carts. GMW-D and to an administrative eaning supplies were stored W-D explained the water in the not changed because it to come down to the first floor change the dirty water, so it to use the same bucket of					
	janitor closet and carl	ed regarding keeping the is clean, sanitary and orderly received at the time of the					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			B. WING			
		00788			09	/29/2016
	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE A <b>ST 18TH STREET</b>	, ZIP CODE		
IN VETEI	RANS HOME HASTINGS		GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AU CROSS-REFERENCED TC DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
31460	Continued From page	2 40	31460			
	exit conference.					
	The administrator or or resident rooms, and r thoroughly cleaned. A to ensure cleanliness maintained and reside	OD FOR CORRECTION: designee could ensure all esident and staff areas are a system could be developed , order and sanitation is ents are provided needed nistrator or designee could r for compliance.				
	TIME PERIOD FOR ( (21) days.	CORRECTION: Twenty-one				
31475	MN Rule 4655.9020 S Supplies; Janitor's Clo		31475			
	closets and all other a	nel shall be kept in a clean,				
	by: Based on observation review, the facility fail closet and housekeep	lerly condition. This had the 100 residents living in				
	Findings include:					
	-					

	a Department of Health T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE COM	ISTRUCTION	(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED
		00788	B. WING		09/29/20	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE, Z	IP CODE		
MN VETE	RANS HOME HASTINGS		ST 18TH STREET GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	VE ACTION SHOULD BE	
31475	Continued From page	e 41	31475			
	accumulation of dust hair and paper particl numerous empty wraj Janitor closet had a h paper particles, hair, s like streaks on the flo When interviewed on GMW-D and GMW-E carts were dirty and th housekeeping carts b to clean them except hose them down. Bot of any policy to clean GMW-D explained that use the janitor rooms because administration remove all cleaning c closets on second an all the cleaners had to the mop buckets and Furthermore, GMW-E water in the mop buck because it was not co the first floor from thin dirty water, so it would same bucket of water A policy was requested janitor closet and cart condition but was not exit conference. On 9/28/16 between a during a tour of build had an accumulation	ppers and visible soil. The leavy accumulation of dust, and a black debris grease or. 9/28/16, at 7:45 a.m. verified the housekeeping				

STATEMEN	a Department of Health FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION		SURVEY PLETED
		00788	B. WING		09	/29/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	·	
MN VETE	RANS HOME HASTINGS		ST 18TH STREET			
	1		GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
31475	Continued From page	2 42	31475			
	The director of house administrator and the nurse could ensure a current, and staff resp	infection control registered ppropriate policies were consible would receive I be conducted, and the				
	TIME PERIOD FOR ( (21) days.	CORRECTION: Twenty-one				
31480	MN Rule 4655.9020 Supplies;Mops/Bucke		31480			
	buckets shall be emp	d buckets cleaning. Mop tied after each cleaning, and ashed after each use and necessary.				
	by: Based on observatior review, the facility fail after each cleaning. T	t is not met as evidenced n, interview and document ed to empty the mop bucket This had the potential to on 3rd floor of Building 23.				
	Finding include:					
	general maintenance taking out the housek	n on 9/28/16, at 7:45 a.m., worker (GMW)-D was eeping cart from the first e mop bucket was full of				
		9/28/16, at 7:45 a.m. lark black gray water was ket was put away from the				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED	
		00788	B. WING		09	/29/2016
AME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
	RANS HOME HASTINGS	1200 EA	ST 18TH STREET			
		HASTIN	GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
31480	Continued From page	e 43	31480			
	soiled mop bucket an changed after use. G hurry the day before a empty the dirty water head. GMW-D explai allowed to use the jar floors because admin to remove all cleaning closets on second an all the cleaners had to the mop buckets and Furthermore, GMW-E water in the mop buck it is not convenient to from third floor just to would not be unusual water and chemical a	nptying or cleaning out the d the mop head was not MW-D verified leaving in a and did not take the time to bucket or change the mop ned that they were not nitor rooms up on the other istration made the decision g chemicals from the janitor d third janitor closets so that o come to first floor to empty get chemical to clean. D explained that is why the kets aren't changed because come down to the first floor change the dirty water, so it t to use the same bucket of II day.				
	SUGGESTED METH The director of house administrator and infe nurse could ensure a current, and staff resp training. Audits could	OD OF CORRECTION: keeping with the ection control registered ppropriate policies were consible would receive be conducted, and the quality committee for				
	TIME PERIOD FOR ( (21) days.	CORRECTION: Twenty-one				
31495	MN Rule 4655.9030 I	Deodorizers	31495			
	Deodorizers or aer substitute for accepta	osols shall not be used as a				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:		(X3) DATE COMF	SURVEY
		00788	B. WING		09	/29/2016
AME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,	ZIP CODE		
	RANS HOME HASTINGS		ST 18TH STREET GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
31495	Continued From page	e 44	31495			
	they be used to mask odors resulting from ineffective housekeeping or sanitation. Ozone generators are not permitted.					
	by: Based on observation review, the facility fai odors on the third floo cover the odor with the aerosols. This had the residents residing on	n, interview and document led to eliminate the source of or areas and attempted to ne use of deodorizers and e potential to affect all 43 the 3rd floor in building 23 R46, R77, R79, R88, R109				
	Findings include:					
	and concern forms in the foul, and at times	resident council meetings dicated complaints about strong urine, feces, and ng on the third floor certain st year.				
	verified reporting to a occasions the foul of building 23. During a 2:00 p.m. R11, R46, verified the odor on th conversation this pas	9/23/16, at 4:40 p.m. R53 administration on numerous lors in areas of the third floor n interview on 9/25/16, at R77, R79, R88, R109, R132, hird floor has been a topic of at year but the administration d aerosols versus getting to the problem.				
	administrator verified aerosols were used t the third floor of build administrator verified	9/29/16, at 11:15 a.m. the the use of deodorizers and o cover the odor smell on ling 23. Furthermore, the there was not a policy to not aerosols as a substitute to				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00788	B. WING		09	09/29/2016	
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE			
	RANS HOME HASTINGS	1200 EA	ST 18TH STREET				
		HASTIN	GS, MN 55033				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE	
31495	Continued From page	e 45	31495				
	mask odors versus e and sanitation of thirc	valuating the housekeeping I floor areas.					
	The director of house administrator and infe nurse could ensure a current, and staff resp training. Audits could	OD OF CORRECTION: keeping with the ection control registered ppropriate policies were ponsible would receive be conducted, and the quality committee for					
	TIME PERIOD FOR ( (21) days.	CORRECTION: Twenty-one					
31500	Any condition on the conducive to the hard insects, rodents, or or eliminated immediate control program shall personnel and all che poisonous nature use identified and stored This MN Requirement by:	ther vermin shall be ly. A continuous pest be maintained by qualified emical substances of a ed for pest control shall be in a locked space. t is not met as evidenced	31500				
	failed to ensure the e conducive to the hart This had the potentia	ooring rodents and insects. I to impact all 140 residents g: R43, R127, R94, R32,					

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	00788	B. WING			/29/2016	
AME OF PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE			
N VETERANS HOME HASTINGS		ST 18TH STREET GS, MN 55033				
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETI DATE	
<ul> <li>concerns were obsern PME-A. PME-A noted areas made the facilit harborage of insects</li> <li>R43's room was obser with clothes. Several The floor had an accu garbage, such as spo containers.</li> <li>R127 and R94's room was sticky with an ac facial tissues, food, co There were also dried colors.</li> <li>R32's room was obser accumulation of cardin There was an accum garbage on the floor.</li> <li>R79's room was obser floor.</li> <li>The dining room on 2 windows and window accumulation of dust,</li> </ul>	I of Building 23 with a (PME)-A on 9/28/16 ad 9:50 a.m. The following wed and confirmed by I the condition of resident ty vulnerable to the and rodents. erved. The bed was piled boxes were on the floor. unulation of crumbs and bons, cups and old food In was observed. The floor cumulation of dust, soiled obwebs, bugs and hair on it. I spills on the floor of various erved. The bed had an board and plastic boxes. ulation of dirt, spills and erved. Garbage was on the Ind floor was toured. The sills were noted to have an cobwebs and dead bugs. ercumulation of dust and	31500				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
		00788	B. WING	B. WING		/29/2016
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
MN VETEI	RANS HOME HASTINGS		ST 18TH STREET GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLET DATE
31500	Continued From page	e 47	31500			
	R121's room had cob	webs noted in the corners.				
	sauce and multicolore room had an odor of r	s of crusty noodles with ed specks in them. The rotten food. Dirty clothes were strewn throughout the				
	of dust and dead bugs ledge, window panes,	athroom had sticky floor, dirt				
	been there "about a w	cigarette butts, and bor. R95 noted the spill had veek" There were piles of out the room and covered in				
	During interview on 9/ noted observing mice	/27/16 at 3:35 p.m. R14 in the facility.				
	The administrator or of facility for any condition to harborage or breed mice and vermin. A sy eliminate any concern	nee could train staff and				
31800	MN Rule 144.651 Sub of HCF Bill of Rights	od. 4 Patients & Residents	31800			
	and residents shall, a there are legal rights t	on about rights. Patients t admission, be told that for their protection during y or throughout their course				

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE COMP	SURVEY PLETED
		00788	B. WING		09	/29/2016
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		25/2010
MN VETER	RANS HOME HASTINGS		ST 18TH STREET SS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
31800	Continued From page		31800			
	and that these are de written statement of the responsibilities set for case of patients admit as defined in section statement shall also of person 16 years old of provided in section 25 shall list the names and individuals and organ advocacy and legal as residential programs. accommodations sha communication impai speak a language oth facility policies, inspe- local health authorities the written statement to patients, residents, chosen representative to the administrator of person, consistent with Practices Act, and ser vulnerable adults. This MN Requirement by: Based on observation review, the facility fail	describe the right of a or older to request release as 53B.04, subdivision 2, and nd telephone numbers of izations that provide services for patients in Reasonable II be made for those with rments and those who her than English. Current ction findings of state and s, and further explanation of of rights shall be available their guardians or their es upon reasonable request r other designated staff th chapter 13, the Data ction 626.557, relating to t is not met as evidenced h, interview and document ed to post state survey				
	availability. This had the residents who lived in	t area, or post notice of their the potential to affect all 140 the facility including R11, R88, R105, R109, R132				
inesota Der	noon and 6:00 p.m., 9	n 9/26/16, 9/27/16, at 12:00 9/28/16 and 9/29/16 at 8:00 were no postings of the				

STATE FORM

	a Department of Health FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
		00788	B. WING		09	)/29/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE,	ZIP CODE	·	
MN VETE	RANS HOME HASTINGS		ST 18TH STREET SS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
31800	state inspection findir authorities findings av and resident gatherin During a group intervi- with R11, R46, R53, F R132, and R134 verif the state inspection fi facility. They all agree about the state inspect During an interview w 9/29/13, at 11:15 a.m results should be in a entrance and furthern verified the inspection main entrance gather The administrator ver directing the state and postings to be availab SUGGESTED METH The director of social administrator could en- were current, and sta- training. Audits could results brought to the review. TIME PERIOD FOR 0	ags or other local health vailable in the main entrance g area of the facility. iew on 9/28/16, at 2:00 p.m. R77, R79, R88, R105, R109, ied they did not know where ndings were posted at the ed they did not see or hear ction findings from 2015. with the administrator on . verified the inspection notebook in the main nore, the administrator n findings were not in the ing area. ified there was not a policy d local health authorities ole to the residents. OD OF CORRECTION: services with the nsure appropriate policies ff responsible would receive l be conducted, and the	31800			
31880	(21) days. MN Rule 144.651 Sul of HCF Bill of Rights	od. 20 Patients & Residents	31880			
	shall be encouraged a	nces. Patients and residents and assisted, throughout or their course of treatment,				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00788	B. WING		09	0/29/2016
AME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	, ZIP CODE		
IN VETEI	RANS HOME HASTINGS		ST 18TH STREET GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A) CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
31880	Continued From page	e 50	31880			
	residents may voice g changes in policies a and others of their ch interference, coercior including threat of dis grievance procedure well as addresses an Office of Health Facili nursing home ombud Americans Act, sectio posted in a conspicuo Every acute care in residential program a 253C.01, every non-a facility employing mo provides outpatient m have a written interna at a minimum, sets for followed; specifies tim limits for facility respon or resident to have th advocate; requires a grievances; and provy an impartial decision not otherwise resolver residential programs 253C.01 which are ho treatment programs, centers with section f health maintenance of 62D.11 is deemed to	nd citizens. Patients and grievances and recommend nd services to facility staff oice, free from restraint, n, discrimination, or reprisal, iccharge. Notice of the of the facility or program, as d telephone numbers for the ity Complaints and the area sman pursuant to the Older on 307(a)(12) shall be ous place. Inpatient facility, every s defined in section acute care facility, and every re than two people that nental health services shall al grievance procedure that, orth the process to be ne limits, including time onse; provides for the patient ne assistance of an written response to written ides for a timely decision by maker if the grievance is id. Compliance by hospitals,				
	This MN Requiremen	t is not met as evidenced				

STATE FORM

STATEMENT	a Department of Health OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00788	B. WING		09	)/29/2016
NAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
	RANS HOME HASTINGS	1200 EA	ST 18TH STREET			
		HASTIN	GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
31880	Continued From page	9 51	31880			
	facility failed to ensure made to resolve resid resident (R11, R46, R R109, R132, R134) re grievance to facility st impact all 140 resider Findings include: During an interview w R79, R88, R105, R10 9/28/16, at 2:00 p.m. expressed and an appresidents to become in perception that admin what they had to cont felt this was due to the the administration. For residents expressed to in certain areas of buil but that management associate with the cle According to the resider concerns were expressed back to 11/25/15. Furthermore, during to 2:00 p.m., the resider about the following isso	histration was not listening to ribute and these residents e lack of follow through by or example: Several the severe concern of odors ilding 23 on the third floor, had ignored the pleas to aning of the facility. dents present, these ssed at resident council his interview on 9/28/16, at the also expressed concerns sues:				
	outside source who re Residents had continu to be installed to vide interviewed on 9/28/1	sold at the facility by an ented the adjacent property. uously pleaded for a camera o the accounts. When 6, at 5:00 p.m. the security vas not aware of the resident				
		ssibly being sold on the				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00788	B. WING		09/29/2016	
IAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	, ZIP CODE	03	12312010
IN VETEI	RANS HOME HASTINGS		ST 18TH STREET			
	1	HASTING	GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE ) THE APPROPRIATE	(X5) COMPLET DATE
31880	Continued From page	9 52	31880			
	the 11/25/15 resident	neras were addressed at council meeting but no talled to watch the rental				
	about since 11/25/15 received new furniture The other resident lou furniture but that had furniture in building 23 stained, uncleanable tour of the facility on 9 and 9:50 a.m. The res	e in the television room. unges were to receive new not happened. Lounge 3 was observed to be and in disrepair during a b/28/16, between 8:20 a.m. sidents expressed istration did not obtain better				
	pool table 11/25/15, b their building they did table. Instead, accord have duct tape pool p of the pool table beca provided a better solu Observation of the pool	25 were promised a new but because it did not fit into not receive the new pool ling to the residents they bockets into the four corners ituse management had not attion for their pool table. bol table on 9/28/16, at 1:00 pockets of the pool table ttch the pool balls.				
	to be able to chose the person responsible for choice of what bingo select. In the resident unacceptable but the	concern because they used eir bingo card, but now, the or bingo did not allow them a cards they would like to as view, this was y did not feel anyone in ening to what they had to				
	November 2015 throu	resident council minutes, Igh September 2016, were these issues had been				

STATEMENT	a Department of Health OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION		E SURVEY PLETED
		00788	B. WING		09	/29/2016
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
MN VETEI	RANS HOME HASTINGS		ST 18TH STREET GS, MN 55033			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O	FCORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLETE
31880	Continued From page	9 53	31880			
	brought up by the res was not a resolution.	idents in writing but there				
	9/29/16, at 11:15 veri been brought up, and The administrator rep	ith the administrator on fied these concerns had was aware of the concerns. orted there had not been a erns, but ongoing work on opening.				
	The social service dir could ensure appropr and staff responsible Audits could be condu	OD OF CORRECTION: ector with the administrator iate policies were current, would receive training. ucted, and the results committee for review.				
	TIME PERIOD FOR ( (21) days.	CORRECTION: Twenty-one				
31935	MN Rule 144.652 Sul Patient/Res.Violation	od. 1 Bill of Right Notice to	31935			
	as provided below, see posted conspicuously facilities licensed und 144.50 to 144.58, or 7 shall be furnished the patient or resident ' s upon admittance to th providing services to 144.651, subdivisions portions of other subc residents, from copies patients with appropri	patients may delete section 24 to 29, and those livisions that apply only to s posted or distributed to ate notation that residents under law. The policy le the address and				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
		00788	B. WING		09/29/2016	
AME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,		03	12912010
MN VETER	RANS HOME HASTINGS		ST 18TH STREET GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLET DATE
	the person within the about the medical can The notice shall inclu describing how to file of Health Facility Con pursuant to section 14	a complaint with the Office nplaints established				
	address and phone n Health Facility Compl This MN Requiremen by: Based on observation interview, the facility f current version of the conspicuous place in potential to affect all n facility including 14 of	t is not met as evidenced n, document review and failed to post the most Bill of Rights in a the facility. This had the residents residing in the f 14 residents reviewed (R9, R28, R37, R42, R61, R90,				
	for building 24 by the with numbers that rea Building 23, posted o second, third and fou numbers " 08/09". E second floor on the w	Rights, posted on the wall administrator's office area ads No 217-250/10-05. In each floor that includes rth floor had with letters and Building 25 on first and rall at the left corridor area of a and numbers " 08/09 ".				
	provided to R9, R12, R42, R61, R90, R92, revealed they were gi of rights, dated July 1	the most current bill of rights R14, R23, R24, R28, R37, R113, R117 and R138 ven the wrong version of bill , 2007 and 12-2015. This I of rights, as a revised bill of				

Minnesota Departr STATE FORM

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		00788	B. WING		00/00/004/	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,		08	/29/2016
IN VETEI	RANS HOME HASTINGS		ST 18TH STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	GS, MN 55033	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
31935	Continued From page	9 55 oped in December 4, 2015.	31935			
	the bill of rights poste most current version a quality director registe most current version. administrator indicate every floor but not the the MDH website toda copies and will order Policy and procedure RESIDENT BILL OF I [Minnesota Veterans and abide by the Res resident and/or their r copy of the Resident	d, "We have posted on e 12/4/15 version. I went on ay and get the 2015 version posters today." revised date 1/16, title RIGHTS, read, "The MVH Home]-Hastings will honor ident Bill of Rights. Each epresentative will receive a				
	administrator or desig appropriate policies w responsible would rec be conducted, and the quality committee for	vere current, and staff ceive training. Audits could e results brought to the				
34580	New Subpart 1. Genera	Subp. 1 Floors, Existing and Il requirements. All floors in as for patients and residents	34580			

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONS A. BUILDING:			E SURVEY PLETED
	00788	B. WING		- 09/29/2016	
AME OF PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE, ZI	P CODE		
N VETERANS HOME HASTING	iS	AST 18TH STREET			
SUMMARY		IGS, MN 55033	PROVIDER'S PLAN OF		(XE)
PREFIX (EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
34580 Continued From pa	ge 56	34580			
This MN Requirement by:Based on interview common areas thro to be soiled and nor had the potential toFindings include:A tour was completed maintenance worked between 8:20 a.m. concerns were obser PME-A.The 2nd floor west noted the floor in the to be replaced." The and stained in sever sink.The dining room on stains, worn areas at various times of day 9/27, 9/28 and 9/29In Lounge 351 the of soiled, especially not In lounge room 315 worn thin.SUGGESTED MET The administrator of facility for areas of the flooring and take st	ent is not met as evidenced and observation, the floors in ughout the facility were noted t in a cleanable condition. This impact all 140 residents. ed of Building 23 with a er (PME)-A on 9/28/16 and 9:50 a.m. The following erved and confirmed by lounge was observed. R44 he lounge was "old" and need e carpet was noted to be worn ral areas, particularly near the 2nd floor was noted to have and tears in the carpet at y during the survey on 9/26, carpet was wearing thin and				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
		00788	B. WING		09	/29/2016
AME OF PR	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
IN VETER	RANS HOME HASTINGS		ST 18TH STREET			
			GS, MN 55033			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
34580	Continued From page	57	34580			
	TIME PERIOD FOR C (21) days.	CORRECTION: Twenty-one				