



*Protecting, Maintaining and Improving the Health of Minnesotans*

Certified Mail # 7008 1830 0003 8091 4240

March 25, 2009

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

Re: Enclosed State Boarding Care Home Licensing Orders - Project Number SL00788018

Dear Mr. Cox:

The above facility survey was completed on March 12, 2009 for the purpose of assessing compliance with Minnesota Department of Health Boarding Care Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

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

Minnesota Veterans Home Hastings

March 25, 2009

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

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

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

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

Please feel free to call me with any questions.

Sincerely,



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

Enclosure(s)

cc: Original - Facility  
Licensing and Certification File

L007s09.rtf

MDH LHC 3201

**SENDER: COMPLETE THIS SECTION**

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Mr. Charles Cox, Administrator  
 Minnesota Veteran's Home Hastings  
 1200 East 18<sup>th</sup> Street  
 Hastings, MN 55033

**COMPLETE THIS SECTION ON DELIVERY**

A. Signature  Agent  
 Addressee  
*x Paul A. Scott*

B. Received by (Printed Name) C. Date of Delivery  
3-27-09

D. Is delivery address different from item 1?  Yes  
 If YES, enter delivery address below:  No

3. Service Type

Certified Mail  Express Mail  
 Registered  Return Receipt for Merchandise  
 Insured Mail  C.O.D.

4. Restricted Delivery? (Extra Fee)  Yes

7008 1830 0003 8091 4240

*Please return in 5 days*

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>00788</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/12/2009</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MN VETERANS HOME HASTINGS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1200 EAST 18TH STREET HASTINGS, MN 55033</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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3 000	<p><b>INITIAL COMMENTS</b></p> <p>*****ATTENTION*****</p> <p><b>BOARDING CARE HOME LICENSING CORRECTION ORDER</b></p> <p>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.</p> <p>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.</p> <p>You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.</p> <p><b>INITIAL COMMENTS:</b> On, March 12, 2009, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health,</p>	3 000	<p>Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Boarding Care Homes.</p>	
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Minnesota Department of Health	TITLE	(X6) DATE
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Minnesota Department of Health

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3 000	Continued From page 1  Division of Compliance Monitoring, Licensing and Certification Program; Complaints; P.O. Box 64900, St. Paul, Minnesota 55164-0900.	3 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings is the Time Period For Correction.  PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.  THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
3 945	MN Rule 4655.6400 Subp. 1 Adequate Care; Care in General  Subpart 1. Care in general. Each patient or resident shall receive nursing care or personal and custodial care and supervision based on individual needs. Patients and residents shall be encouraged to be active, to develop techniques for self-help, and to develop hobbies and interests. Nursing home patients shall be up and out of bed as much as possible unless the attending physician states in writing on the patient	3 945		

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3 945	<p>Continued From page 2</p> <p>'s medical record that the patient must remain in bed.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review the facility did not provide nursing care to 1 of 18 residents (#3) who had a change in his annual physical examination. Findings included:</p> <p>Resident #3 had a physical examination performed 2/3/09 and at that time the residents urinalysis showed 3+ blood in the urine. The RNP signed the annual physical on 2/6/09 and the MD signed the physical on 2/10/09 and both did not notice the 3+ blood. Nursing had assessed the resident prior to the physical and had performed the dip stick urinalysis which showed the 3+ blood. Nursing did not alert the RNP or the MD of the results.</p> <p>When interviewed on 3/12/09 at 3:00PM the RNP stated everyone had missed the 3+ blood in the urine.</p> <p><b>SUGGESTED METHOD FOR CORRECTION:</b> The administrator and director of nursing could develop a plan to provide each resident with nursing and medical care based on individual needs. A monitoring program could be established in order to ensure provision of care and interventions in response to resident needs.</p> <p><b>TIME PERIOD FOR CORRECTION:</b> Seven (7) days</p>	3 945	
31105	<p>MN Rule 4655.7810 Distribution of Medications</p> <p>A system shall be developed in each boarding</p>	31105	

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31105	Continued From page 3  care home to assure that all medications are distributed safely and properly. All medications shall be distributed and taken exactly as ordered by the physician. Any medication errors or resident reactions shall be reported to the physician at once and an explanation made in the resident's personal care record.  This MN Requirement is not met as evidenced by: Based on interview and record review the facility did not comprehensively investigate narcotic discrepancies for 6 residents (#20,#22,#21,#19,#23,#24) and failed to administer medication as specified by the physicians order for 3 residents (#16, #18, #25) in the sample. Findings include:  Six residents had shortages of narcotics, at various times and no internal investigation was conducted.  On 7/20/08 on the evening shift during the narcotic count resident #20 was missing one Tylenol #3. Two staff signed the discrepancy form and indicated the reason for the shortage could have been that the resident was administered 2 tablets instead of one. The RN charge nurse was notified however no action to prevent further discrepancies was listed and the report was not routed to the other people as it should have been.  On 7/25/08 at 2:30 PM during the narcotic count for resident #22 there was a shortage of one tablet of Morphine SR. Only one staff member signed the report. No reason for the discrepancy was given, no one else was notified and no action was listed. The report was not routed to the other people as it should have been.	31105		

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31105	<p>Continued From page 4</p> <p>On 8/26/08 at 6:15 PM there was a discrepancy for resident #21 of four tablets of Vicodin 5/500. The reason for the shortage was listed as when the drug was delivered from the pharmacy it stated there were 60 tablets in the bottle but there was only 56 in the bottle. There were two staff signing the report and they indicated the bottle came sealed. The RN supervisor was notified however no action was taken. The RN manager was notified however the ADON and pharmacist were not.</p> <p>On 9/14/08 at 11:00PM during the narcotic count for resident #20 there was a shortage of one tablet of Zolpidem (Ambien). Two staff signed the report and the reason for the discrepancy was unknown. An LPN who was the officer of the day was notified. No actions to prevent further discrepancies were listed and the report was not routed to the other people as it should have been.</p> <p>On 10/2/08 at 10:00PM during the narcotic count for resident #19 there was a shortage of one table of oxycodone 5 mg. Two staff signed the error report and reported it to the RN on duty. The reason given for the missing drug was "unknown." The action given to prevent the error from occurring was for staff to count medications remaining when administered. On the "Narcotic Discrepancy Report" form there are 3 people listed to route the form to, RN manager, ADON, and pharmacist. The RN manager and pharmacist were not routed the report.</p> <p>On 10/8/08 at 4:25 PM there was a shortage of one tablet of Diazepam (Valium) for resident #23. Two staff members signed the form. The reason for the discrepancy was listed as drug missing from cassette. Two RN's were notified. The</p>	31105		
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31105	Continued From page 5  action taken was for the staff to check all cassette slots when logged in. The RN manager was notified but not the ADON or pharmacist.  On 11/11/08 at 10:30 PM during the narcotic count for resident #24 one tablet of Clonazepam (Klonopin) was missing. Two staff members signed the report however the reason for the discrepancy was not listed, no one else was notified and no action was taken. The form was signed by the RN manager but not the ADON or pharmacist.  The policy and procedure updated 12/08 for Controlled Drug/Narcotic Receipt, Counting, Label Changing and Discontinuation indicated for narcotic discrepancies; recheck the amount through review of the MAR (medication record) and narcotic book, recheck the previously administered doses for correct math and documentation, notify the charge nurse or RN supervisor of the narcotic discrepancy, completed the narcotic discrepancy form and the RN Administrative Supervisor should notify the Pharmacy of any discrepancies. The Pharmaceutical policy and procedure updated 12/08 indicated narcotic discrepancies are to be reported immediately and documented on the appropriate record.  When interviewed on 3/11/09 at 4:00PM the RN supervisor acknowledged there was a system problem with the dispensing of narcotic medications, the accountability and the discrepancy reporting.  During observation of medication administration, the medication nurse prepared a nebulizer treatment for Resident #18 and then gave the nebulizer to the resident to self administer. The	31105		

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31105	<p>Continued From page 6</p> <p>medication nurse also drew up insulin and gave the syringe with insulin to Residents #16 and #25 to self administer. The physician orders on Resident #16, #18 and #25 stated that "the nurse to administer meds and treatments unless otherwise specified"</p> <p>Resident #16 was admitted to the facility on 10/29/07 with medical conditions that included but not limited to: Chronic Obstructive Pulmonary Disease (COPD), Diabetes-Type II, Right Hip Fracture, Depression, Hypertension, Chronic Pancreatitis, Gastritis, Esophageal Varices by history, Anemia, Alcohol Liver Disease-Cirrhosis and Thrombocytopenia. The physician order of 1/22/09 specified that the resident was to receive Insulin Glargine 68 units subcutaneous (SubQ) at bedtime and not to mix with other insulins. The physician order also indicated that the resident was to receive Novolog Aspart Insulin, SubQ prior to meals, with 28 units every morning, 20 units at noon and evening and four times per day per sliding insulin scale. On 3-10-09 at 11:45 AM, the resident came to the Medication Dispensing Room and informed the Medication Nurse that his Blood Glucose was 231.</p> <p>Resident #18 was admitted to the facility on 6/20/95 with medical conditions that included but not limited to: Alcoholism, Organic Personality Syndrome, and Chronic Obstructive Pulmonary Disease (COPD). On 3-10-09 at 11:50 AM, the resident came to the Medication Dispensing Room and requested his scheduled Nebulizer treatment. The medication nurse took the resident and a vial of Albuterol 0.083% Solution to a room close to the area where medications were dispensed, put the Albuterol 0.083% into the nebulizer cup, turned the nebulizer on, gave resident #18 the nebulizer equipment (tubing</p>	31105		

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31105	<p>Continued From page 7</p> <p>attached to nebulizer and mouthpiece), which he put into his mouth and left the room. The nurse indicated that the resident always does this himself. A Resident Contract for Self-Administered Medication was completed with the resident on 9/13/03 and stated that "It is the policy of the Minnesota Veterans Home-Hastings that medications will be dispensed by Nursing, however, there may be some medications (i.e. ointments, creams, or inhalers) that you may self administer and keep at bedside". An Assessment for Self-Medication was completed by Registered Nurse Certified Nurse Practitioner (RN, CNP) on 5/7/08 and stated that "I feel this resident needs to have medications dispensed by the nursing staff. A Self-Administered Medication/Treatment Assessment was completed by a LPN on 8/1/08 and concluded that the resident was not competent to SAM (Self Administer Medication).</p> <p>Resident #25 was admitted to the facility on 4/28/05 with medical conditions that included but not limited to: Alcohol Cirrhosis Liver, Hepatic Coma, Portal Hypertension, Chronic Pancreatitis, Ascites, Depression, Diabetes Type II, Hepatic Encephalopathy and Common Bile and Pancreatic Duct Strictures. On 3/10/09 at 11:45 AM, the resident came to the Medication Dispensing Room and informed the medication nurse that his blood glucose was 166. The medication nurse then drew up 4 units of Novolog Aspart Insulin and gave the filled syringe to the resident, who went into a different room and self administered the insulin. The Medication Nurse stated that they allow the residents to take their insulin to a different room for privacy. A Resident Contract for Self-Administered Medication was completed with the resident on 4/28/05 and stated that "It is the policy of the Minnesota</p>	31105	

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31105	<p>Continued From page 8</p> <p>Veterans Home-Hastings that medications will be dispensed by Nursing, however, there may be some medications (i.e. ointments, creams, or inhalers) that you may self administer and keep at bedside". An Assessment for Self-Medication was completed by RN, CNP on 3/31/08 and stated that "I feel this resident needs to have medications dispensed by the nursing staff. A Self-Administered Medication/Treatment Assessment completed on 9/29/08 by LPN, concluded that the resident was not competent to self administer medication.</p> <p><b>SUGGESTED METHOD OF CORRECTION:</b> A system should be developed in each boarding care home to assure that all medications are distributed safely and properly and that all narcotics are accounted for. Any medication errors or narcotic discrepancies shall be thoroughly investigated and reported to the proper people at once and an explanation made as to why there was a discrepancy. The administrator and director of nursing could develop a plan to provide each resident with nursing and medical care based on individual needs. A monitoring program could be established in order to ensure provision of care and interventions in response to resident needs.</p> <p><b>TIME PERIOD FOR CORRECTION:</b> Twenty-one (21) Days</p>	31105		
31155	<p>MN Rule 4655.7850 Subp. 1 Disposition of Medications;Discharge/transfer</p> <p>Subpart 1. Discharged or transferred residents. If authorized by the attending physician or the physician in charge, medications belonging to residents shall be given to them when discharged or transferred. This shall be recorded on the resident's personal care record.</p>	31155		

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31155	Continued From page 9  This MN Requirement is not met as evidenced by: Based on record review and interview the facility failed to document the disposition of medication upon discharge for 1 of 5 discharged residents (#26) records reviewed. The findings include:  The facility did not adequately document the disposition of resident #26's medication upon his discharge from the facility.  On 3/12/09 a record review for resident # 26 who was admitted to the facility on 1/31/08 with diagnoses including history of Prostate Cancer and ETOH was conducted. Review of the physician orders revealed an order on 9/16/08 which stated "OK to discharge to independent living with medications". Review of the current medication orders dated 8/28/08 revealed the following medications "Flunisolide Nasal Spray (AEROBID)- inhale two sprays into nostril (s) at bedtime. Bedside", Vardenafil (VIAGRA) 20 mg.- take one tablet by mouth 1 hour prior to sexual activity. Max 4 doses/month" and "Analgesic Balm- apply to back twice daily as needed- Bedside". Review of the "Discharge Summary" signed by the Registered Nurse on 9/19/08 stated that the resident discharged to independent living and further indicated "no medications or treatments". Review of the "Drug Disposition" form revealed no documentation that the above medication were destroyed by the facility.  On 3/13/09 at 9:50 AM the Director of Nursing was interviewed via telephone and confirmed that resident #26 had current orders for the above medications upon his discharge from the facility and further acknowledged that the disposition of	31155		

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31155	Continued From page 10  the medications was not documented in the record.  <b>SUGGESTED METHOD FOR CORRECTION:</b> The administrator and director of nursing could develop a plan to send medications belonging to residents, and authorized by the attending physician or the physician in charge, with residents when the residents are discharged or transferred, and record this information on the residents' personal care records. <b>TIME PERIOD FOR CORRECTION:</b> Fourteen (14) days	31155		
31810	<b>MN Rule 144.651 Subd. 6 Patients &amp; Residents of HCF Bill of Rights</b>  Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources.  This MN Requirement is not met as evidenced by: Based on interview and record review the facility did not assess 2 of 2 residents (#14,#4) who wished to self administer medications for the right to self administer medications. Findings included: Resident #14 and resident #4 had requested self administration of medications assessment, which was not done. During interview, 3/10/09 at 9:45 AM resident #14 stated, "I would like some control over my medications. Why can't we be treated individually	31810		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>00788</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/12/2009</b>	
NAME OF PROVIDER OR SUPPLIER  <b>MN VETERANS HOME HASTINGS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1200 EAST 18TH STREET HASTINGS, MN 55033</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
31810	<p>Continued From page 11</p> <p>and looked at individually?" He went on to say the other night he had to come down stairs for 2 Tylenol for a headache and waited 45 minutes just to get the 2 Tylenol. "We use to have a system where we could keep the medications locked in our room but there was a problem with a few people and so we all had the privilege removed. We're so frustrated because we have no control over anything. We'd like a choice. We're not children. We'd like to get back some of our self respect."</p> <p>The facility assessment for self administration was a form signed by the physician which stated, "I feel this resident needs to have medications dispensed by the nursing staff." The physician signed this form 9/26/08. No other assessment as to the residents abilities or cognition was available.</p> <p>During interview with resident #4 on 3/10/09 at 1:05 PM, the resident expressed a desire to self administer his medications. He stated he had expressed his desire to the staff however nothing had been done. He indicated staff had not tested him to see if he was capable to self administer meds. He indicated that he has been gone from the facility for 8 days at a time and staff send his medications. The resident stated, "I take my medications then so what is so different here?"</p> <p>The facility assessment for self administration was signed by the physician on 8/11/08 which stated, "I feel this resident needs to have medications dispensed by the nursing staff." No other assessment as to the residents abilities or cognition was available.</p> <p>The policy updated 12/08 indicated that medications will be dispensed by the nursing staff to address and assure the safe administration.</p> <p>The procedure went on to say that only residents 30 days from discharge would be allowed to self-administer, however if the resident did not</p>	31810		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>00788</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/12/2009</b>
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31810	Continued From page 12  discharge within the 30 days they would be returned to nursing distributing the medications. If residents were in the facility when the policy and procedure was initiated and they were self-administering they would be allowed to continue to self-administer. The policy was initiated 10/94. When interviewed on 3/10/09 at 11:30 AM the RN stated everyone is given their medications by nursing. The only ones who can self administer are those residents within a month of discharge or those residents that have "been grandfathered" in. That is the policy and procedure. <b>SUGGESTED METHOD OF CORRECTION;</b>  The Director of Nursing or Designee could review and revise the policies allowing for each resident to be assessed periodically for the ability to self administer their own medications. Periodic audits could be performed to ensure the policy was being followed.  <b>TIME PERIOD FOR CORRECTION;Thirty (30) Days</b>	31810		



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

**INFORMATIONAL MEMORANDUM**

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

**DATE OF SURVEY:** March 9, 2009 through March 12, 2009

**BEDS LICENSED:**

HOSP: \_\_\_\_\_ NH: \_\_\_\_\_ BCH: 200 SLFA: \_\_\_\_\_ SLFB: \_\_\_\_\_

**CENSUS:**

HOSP: \_\_\_\_\_ NH: \_\_\_\_\_ BCH: 176 SLF: \_\_\_\_\_

**BEDS CERTIFIED:**

SNF/18: \_\_\_\_\_ SNF 18/19: \_\_\_\_\_ NFI: \_\_\_\_\_ NFII: \_\_\_\_\_ ICF/MR: \_\_\_\_\_ OTHER: \_\_\_\_\_

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

Kim Lechner, Admin. Assist.	Elaine Schmitz, LPN
Dotty Chamberlain, RN	Nancy Delmore, HR
Jennifer Salzman, RHIT	Mandy Forbes, LPN
Sharon Smith, RD, LD	Kelly Kaiser, HST
Diane Eide, RN Supervisor	
Mary Glaeser, RNP	
Connie Ball, RN, Clinical Admin.	

**SUBJECT:** Biennial Licensing Survey

**ITEMS NOTED AND DISCUSSED:**

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

The exit conference was tape recorded.

**RECEIVED**

MAR 09 2009

COMPLIANCE MONITORING DIVISION  
LICENSE AND CERTIFICATION

SL00788018

Minnesota Department of Health  
Licensing and Certification Program

FACILITY MN VETERANS HOME HASTINGS DATE 3-12-09

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

Surveyors Names and Titles

NAME Please Print	TITLE
Robyn Woolley, RN	Nurs. Eval- II
Karen Beshear, RN	"
Marilyn Kackko, RN	"
Elizabeth Nelson, RN	"

Exit Conference Attendees

SIGNATURE	TITLE
<i>Uche Davidson</i>	Chnrcal Adm. Asst.
<i>Kim Lechner</i>	Admin. Asst.
<i>Charles Cox</i>	ADMINISTRATOR
<i>W. Ken [Signature]</i>	Attending Physician
<i>Pat Cozz</i>	Cr. Asst. / Mental Health Div.
<i>Sharon [Signature]</i>	Div. Food + Nutrition Services
<i>Verde [Signature]</i>	Physical Plant Director
<i>George [Signature]</i>	Recreation Therapy
<i>[Signature]</i>	BUSINESS MANAGER
<i>Jennifer Sattaman</i>	RHIT
<i>Bette Chamberlain</i>	RN - Senior
<i>MAN GLASSER</i>	GNP
<i>Lonnie Bae</i>	RN
<i>Alane [Signature]</i>	RN.