Department of Veterans Affairs State Veterans Home Survey Report

This survey report and the information contained herein, resulted from the State Veterans Home (SVH) Survey as a Summary Statement of Deficiencies. (Each Deficiency Must be Preceded by Full Regulatory or applicable Life Safety Code Identifying Information.) Title 38 Code of Federal Regulations Part 51 is applied for SVHs applicable by level of care.

General Information:

Facility Name: Minnesota Veterans Home - Hastings

Location: 1200 East 18th Street East, Hastings, MN 55033

Onsite / Virtual: Onsite

Dates of Survey: 1/18/23 – 1/19/23

NH / DOM / ADHC: DOM

Survey Class: Annual

Total Available Beds: 200

Census on First Day of Survey: 110

VA Regulation Deficiency	Findings
	Initial Comments: An Annual VA Survey was conducted from January 18, 2023 through January 19, 2023 at the Minnesota Veterans Home – Hastings. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§ 51.210 (o) (1) Clinical records. (1) The facility management must maintain clinical records on each resident in accordance with accepted professional standards and practices that are— (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized. Level of Harm – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Many	Based on interviews and record review, the facility failed to maintain complete clinical records for each resident by failing to document COVID-19 testing results in each resident's medical record. This deficient practice affected all 110 residents residing at the facility. The findings include: The facility was asked for a policy governing the processes for ensuring laboratory studies were documented in the medical records of residents. No policy was produced. Review of the medical record for Resident #1 revealed an initial admission date of [DATE]. Resident #1's medical history included Schizophrenia, Type 2 Diabetes, Basal Cell Carcinoma of the Skin, Hyperlipidemia, Bipolar Disorder, and [DIAGNOSIS]. Resident #1 expired in the facility on [DATE].

	Review of a facility investigation related to Resident #1's death revealed documentation that Resident #1 tested positive for COVID-19 on [DATE]. Continued review of Resident #1's medical record revealed no documented COVID-19 test results. During an interview with Administrative Nurse A, on 1/19/23, at 1:07 p.m., they explained that the facility had a "blanket order for antigen testing" and stated, "We submit the results to the database, but we don't document them in each veteran's record." When asked whether a laboratory test would be considered a component of the medical record, Administrative Nurse A stated, "Yes."
§ 51.300 (a) (1) Notice of rights and services – notification of changes. Facility management must immediately inform the resident and consult with the primary care physician when there is (i)An accident involving the resident that results in injury and has the potential for requiring physician intervention; (ii) A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); (iii) A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (iv) A decision to transfer or discharge the resident from the facility as specified in paragraph (d) of this section. Level of Harm – Actual Harm that is not immediate jeopardy **Residents Affected** – Few	Based on interviews and record review, the facility failed to notify the medical provider of a change in condition for one (1) of three (3) residents (Resident #1) reviewed for changes in condition from a total of 11 sampled residents. The findings include: The facility was asked to produce a policy governing notifications for changes in condition. The facility provided a policy titled, "Notification of Changes," which indicated an effective date of 12/26/18. The policy's purpose read: "To ensure that the MVH [Minnesota Veterans Home] notifies the physician and/or delegated non-physician practitioner of resident condition, as appropriate." Section A of the procedure read: "The MVH will immediately inform the resident, consult with the resident's provider, and notify the resident's representative(s) (consistent with their authority for such notification) when there is: 2. A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications)." According to the Mayo Clinic, accessed on 1/19/23, (https://www.mayoclinic.org/healthy-lifestyle/fitness/expert-answers/heart-rate/faq-20057979): "a normal resting heart rate for adults ranges from 60 to 100 beats per minute. Although there's a wide range of normal, an unusually high or low heart rate may indicate an underlying problem." According to the Mayo Clinic, accessed 1/19/23, (https://www.mayoclinic.org/symptoms/hypoxemia/basics/definition/sym-20050930): "Hypoxemia is a below-normal level of oxygen in your blood, specifically in the arteries. Hypoxemia is a sign of a problem related to breathing or circulation, and may result in various symptoms, such as shortness of breath."

	Review of the medical record for Resident #1 revealed an initial admission date of [DATE]. Resident #1's medical history included Schizophrenia, Type 2 Diabetes, Basal Cell Carcinoma of the Skin, Hyperlipidemia, Bipolar Disorder, and [DIAGNOSIS]. Resident #1 expired in the facility on [DATE]. Review of Resident #1's progress notes revealed an entry, dated [DATE], at 12:43 p.m., by Licensed Nurse A which indicated Resident #1 experienced a sore throat. Cardiovascular and pulmonary findings were documented as "WNL [within normal limits]." The progress note did not include documentation of any additional assessments, interventions, or notification to the medical provider. Review of Resident #1's vital sign flow records revealed an entry for pulse, dated [DATE], at 12:44 p.m., with a result of 105. An entry for oxygen saturation, on [DATE], at 12:44 p.m., indicated a result of 91%. The entry was documented by Licensed Nurse A. There were no subsequent assessments of pulse or oxygen saturation or notifications to the medical provider documented for that shift. A progress note, dated [DATE], at 8:35 a.m., authored by Licensed Nurse B indicated Resident #1 complained of a sore throat and Resident #1 stated, "It hurts to breath." The note also read, "Resident states [Resident #1] is kind of tired." The progress note did not include documentation of notification to the medical provider. A progress note, dated [DATE], at 2:12 p.m., authored by Administrative Staff A indicated Resident #1 had been found deceased. On 1/18/23, at approximately 2:30 p.m., an interview was conducted with Administrative Nurse A who explained that they were out of the office at the time of Resident #1's death. Administrative Nurse A provided a copy of an investigation that they conducted while they worked remotely. The investigation indicated Resident #1 tested positive for COVID-19 on [DATE], and had been found unresponsive on [DATE], at approximately 12:30 p.m., by Dietary Staff A. An interview was conducted, on 1/19/23, at 12:40 p.m., with Dietary Staff A. They explained that they were passing meal trays to residents and knocked on Resident #1's door to deliver the meal tray. After receiving no response, Dietary Staff A placed the meal tray on a table just inside the resident's door and knocked again with no response. After receiving no response, Dietary Staff A opened Resident #1's door and observed them unresponsive on the floor. Dietary Staff A explained that they called the Nursing Department via cell

	phone and alerted the nurse for Resident #1 that they were unresponsive on the floor of their room. Dietary Staff A explained that this was the first time they had seen Resident #1 that day, but found it odd that a bottle of water was still sitting on the table inside Resident #1's room because the bottle of water had likely been distributed earlier in the day as part of a snack. Dietary Staff A added that this was what prompted them to enter Resident #1's room. On 1/19/23, at 1:07 p.m., a second interview was conducted with Administrative Nurse A regarding any actions the facility had taken as a result of the investigation into Resident #1's death. Administrative Nurse A explained that the facility had reviewed its procedures for ensuring Cardiopulmonary Resuscitation (CPR) equipment was immediately available, and that it had also repaired a broken radio. Administrative Nurse A added that staff education had been initiated on the care of residents with a diagnosis of COVID-19. Administrative Nurse A explained that no opportunities had been identified to address supervision levels of residents with acute illnesses, such as COVID-19, and added that no opportunities had been identified to improve processes for notifying medical providers for changes in condition. On 1/19/23, at 1:17 p.m., an interview was conducted with Licensed Nurse B via phone. Licensed Nurse B explained that they had evaluated Resident #1 on the night of [DATE], and documented those findings in the progress note dated [DATE], at 8:35 a.m. Licensed Nurse B confirmed that Resident #1 complained of pain and discomfort when breathing and complained of a sore throat along with feeling tired. When asked whether the medical provider had been notified of Resident #1's change in condition, Licensed Nurse B stated, "No." When asked whether they felt the medical provider should have been notified given Resident #1's change in condition, Licensed Nurse B stated, "Looking back at the whole thing, yes." When asked how many times they had seen Resident #1 during the shift, Licensed Nurse B stated, "I worked a double that day. I saw [Resident #1] at about 11:30 p.m., for the COVID assessment and that was the only time." When asked whether they thought to increase the frequency of supervision for Resident #1 as a result of an acute illness (COVID-19), Licensed Nurse B stated, "I completely agree with you. However, because of the staffing levels on night shift it just wouldn't be possible. There are usually only two [2] nurses and just not enough people to be everywhere at once."
§ 51.300 (g) (1) Social services. The State home must provide social work services to meet the social and	Based on observations and interviews, the facility failed to provide services for one (1) of one (1) resident (Resident #4) who had loud outbursts and did not feel they fit in at the facility

emotional needs of residents to attain or maintain the highest practicable mental and psychosocial well-being of each resident. Level of Harm – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	because they did not consider themself a Veteran like the other residents at the facility. The findings include: Resident #4 lived in a building that was secure, with several other residents, across the street from the main building. Interviews between 1/18/23, and 1/19/23, with the Residents #5, #6, and #7, who resided in the building with Resident #4, revealed they had concerns with them and their behavior. This was due to Resident #4 having occasions when they would stomp around, slam doors, yell, and swear at any time day or night, including after midnight, on several occasions. The residents would be kept up all night when this happened in the middle of the night. These concerns had been discussed with the leaders at the facility and they felt nothing was being done. An interview with Resident #4, on 1/19/23, at 12:15 p.m., in their room revealed they had been at the facility for a while and that they were not sure how long. They felt they had nothing in common with the other residents because they did not consider themself a Veteran and did not want to talk about their time in the military. They had a part time job, but were concerned about how much money they had because the facility took all of it. They wanted to be outside working and had not wanted to sit in their room doing stuff. They said the other residents were lazy and just sat around. They did not like to take their medications because they were not on them prior to coming to the facility. They did not like going to the [LOCATION] because there were many people up there that they did not relate to, and they wanted to talk about their time in the military. Many times, in the conversation, Resident #4 stated that they did not fit in with any of the other residents and had nothing in common with them. An interview with Consultant Staff A, on 1/19/23, at 1:15 p.m., revealed they would visit with Resident #4 whenever they were there, and did not wait for them to come to them. Consultant A had set up appointments with a behavioral therapist that was only accepting virtual appointments. Resident #4 did not like virtual appointments and would not attend them, but would walk to the office instead and no one was there. Resident #4 had not been on medications prior to admission, so they had been working with them on figuring them out. Consultant Staff A had created a document for staff to use when Resident #4 had episodes of screaming and swearing. An interview with Licensed Nurse A, on 1/19/23, at 2:15 p.m., regarding Resident #4 revealed they had not had any training regarding mental health or how to deal with a person when they were in crisis. When Resident #4 was yelling and being

	disruptive, Security was called to observe them and calm them down and make sure no one got hurt. Security had increased the number of times they would round at that building since Resident #4 was admitted. Resident #4 had an as needed (prn) medication for anxiety, but they would have to go to the nurses' station in the [LOCATION] to get it. Licensed Nurse A was not aware if they were comfortable or not coming to the [LOCATION]. An interview with Consultant Staff B, on 1/19/23, at 2:20 p.m., in their office revealed they were not at the facility fulltime, but there was Consultant Staff C on site full time. Consultant Staff B was aware of the concerns the other residents and staff had in regard to Resident #4 screaming and swearing in the middle of the night. Consultant Staff B was not doing any tracking of data to determine how often the resident had these episodes, or the resident's relationship to medications. Consultant Staff B had told Resident #4 to go to their primary care physician to get a referral to go to a behavioral therapist, and they had not done so. Consultant Staff B had not contacted other facilities to see if they would be better suited to meet Resident #4's needs. Consultant Staff B was not aware of any training that was provided to staff to help them assist Resident #4 when they were having outbursts. An interview with Consultant Staff D revealed Resident #4 was admitted to the facility after they had not paid their rent for two (2) years and were being evicted. Resident #4 painted a neighbor's car because it was rusted, and they were attempting to make it look better. Prior to their admission, they had not received any mental health care and were not on any medication. Since their admission they had been put on medication. There were times when they did not take their medication because they would not go up to get them, or they did not want to take them. All the other residents in their building had been moved away from them due to the disruptions. They had given the other residents noise cancelling headphones, white noise machines, and spoken with Resident #4 about the outbursts. They had worked with them on their finances because they felt that was a stressor for them due to not having enough money. They confirmed there was no one tracking the events to determine a cause or stressor. The sister facility had a behavioral therapist, but Consultant Staff D had not spoken with them to ask for interventions to help when Resident #4 had an episode of shouting, stomping, and swearing. The process when they were upset was to call Security to monitor them. An interview with Administrative Staff A, on 1/19/23, at 3:15 p.m., in their office regarding Resident #4 revealed Administrative Staff A had discontinued the behavioral therapist position because they felt it was more reactive versus proactive.

	They had hired a Skills Development Specialist to replace the position. Administrative Staff A had been involved in meetings regarding Resident #4 and the issues the other residents experienced. They had allowed the team to discuss options and manage their care, but recently had been more involved in the meeting discussions. The Skills Development Specialist had not seen this resident or been consulted regarding this resident.
§ 51.350 Life safety from fire. (c) Life safety from fire. The facility must meet the applicable requirements of the National Fire Protection Association's NFPA 101, Life Safety Code, as incorporated by reference in § 51.200. Level of Harm – No Actual Harm, with potential for more than minimal harm **Residents Affected -** Many	**Smoke Barriers and Sprinklers** 1. Based on observations and interview, the facility failed to install the required placard for K-type fire extinguisher. The deficient practice one (1) of 11 smoke compartments in [LOCATION], staff, and no residents. The facility had the capacity for 200 beds with a census of 110 on the day of survey. The findings include: Observation during the building inspection tour, on 1/18/23, at 11:56 a.m., in [LOCATION] revealed there was no instructional placard conspicuously placed near the extinguisher that stated that the fire protection system shall be actuated prior to using the fire extinguisher, as required by section 5.5.5.3 of NFPA 10, Standard for Portable Fire Extinguishers. An interview, on 1/18/22, at 11:58 a.m., with Maintenance Staff A revealed the facility was not aware of the missing placard. The census of 110 was verified by Administrative Staff A on 1/18/23. The findings were acknowledged by Administrative Staff A and Maintenance Staff A during the exit interview on 1/19/23. **Actual NFPA Standard: NFPA 101 (2012), Life Safety Code** **33.3.1.2.2*** Impractical. Large facilities classified as impractical evacuation capability shall meet the requirements of Section 33.3 for impractical evacuation capability, or the requirements for limited care facilities in Chapter 19, unless the authority having jurisdiction has determined equivalent safety is provided in accordance with Section 1.4. **Actual NFPA Standard: NFPA 101, Life Safety Code (2012)** 4.6.12 Maintenance, Inspection, and Testing. 4.6.12.1 Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, fire-resistive construction, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, fire-resistive construction, or other feature shall thereafter be continuously

	maintained. Maintenance shall be provided in accordance with applicable NFPA requirements or requirements developed as part of a performance-based design, or as directed by the authority having jurisdiction. 4.6.12.2 No existing life safety feature shall be removed or reduced where such feature is a requirement for new construction. 4.6.12.3* Existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed. **Actual NFPA Standard: NFPA 10, Standard for Portable Fire Extinguishers (2010)** 5.5.5* Class K Cooking Media Fires. Fire extinguishers provided for the protection of cooking appliances that use combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. 5.5.5.1 Class K fire extinguishers manufactured after January 1, 2002, shall not be equipped with extended wand–type discharge devices. 5.5.5.2 Fire extinguishers installed specifically for the protection of cooking appliances that use combustible cooking media (animal or vegetable oils and fats) without a Class K rating shall be removed from service. 5.5.5.3* A placard shall be conspicuously placed near the extinguisher that states that the fire protection system shall be actuated prior to using the fire extinguisher. **Building Services (Elevators, Escalators, Laundry Chutes, etc.)** 2. Based on observation and interview, the facility failed to properly install gas equipment and appliances. The deficient practice one (1) of 11 smoke compartments in [LOCATION], staff, and no residents. The facility had the capacity for 200 beds with a census of 110 on the day of survey. The findings include: Observation during the building inspection tour, on 1/18/23, at 11:58 a.m., revealed the gas equipment, flat-top grille located on the cooking line with casters in [LOCATION] were not provided with a restraint system to limit the movement of the appliance to prevent strain on the connections, as required by sections 9.6.1.2 and 10.12.6 of NFPA 54, National Fuel Gas Code.

	An interview with Maintenance Staff A, on 1/18/23, at 11:58 a.m., revealed the facility was not aware that gas equipment with casters in [LOCATION] required a restraint system to limit the movement of the appliance to prevent strain on the connections. The census of 110 was verified by Administrative Staff A on 1/18/23. The findings were acknowledged by Administrative Staff A and Maintenance Staff A during the exit interview on 1/19/23. **Actual NFPA Standard: NFPA 101 (2012), Life Safety Code 33.3.1.2.2*** Impractical. Large facilities classified as impractical evacuation capability shall meet the requirements of Section 33.3 for impractical evacuation capability, or the requirements for limited care facilities in Chapter 19, unless the authority having jurisdiction has determined equivalent safety is provided in accordance with Section 1.4. **Actual NFPA Standard: NFPA 101 (2012), Life Safety Code** 19.5.1 Utilities. 19.5.1.1 Utilities shall comply with the provisions of Section 9.1. 9.1 Utilities. 9.1.1 Gas. Equipment using gas and related gas piping shall be in accordance with NFPA 54, National Fuel Gas Code, or NFPA 58, Liquefied Petroleum Gas Code, unless such installations are approved existing installations, which shall be permitted to be continued in service. **Actual NFPA Standard: NFPA 54 (2012), National Fuel Gas Code** 9.6.1.1 Commercial Cooking Appliances. Commercial cooking appliances that are moved for cleaning and sanitation purposes shall be connected in accordance with the connector manufacturer's installation instructions using a listed appliance connector complying with ANSI Z21.69/CSA 6.16, Connectors for Movable Gas Appliances. The commercial cooking appliance connector installation shall be configured in accordance with the manufacturer's installation instructions. 9.6.1.2 Restraint. Movement of appliances with casters shall be limited by a restraining device installed in accordance with the connector and appliance manufacturer's installation instructions. 10.12.6 Use with Casters. Floor-mounted appliances with casters shall be listed for such construction and shall be installed in accordance with the manufacturer's installation instructions for limiting the movement of the appliance to prevent strain on the connection. **<u>Electrical Systems</u>** 3. Based on observation and interview, the facility failed to ensure that a remote, emergency stop switch was

	installed for each emergency generator. The deficient practice affected 23 of 23 smoke compartments, staff, and 110 residents. The facility had the capacity for 200 beds with a census of 110 on the day of survey. The findings include: Observation during the building inspection tour, on 1/18/23, at 10:05 a.m., revealed the facility's emergency generator was not provided with a remote, manual stop station for each generator located elsewhere on the premises, as required by sections 5.6.5.6 and 5.6.5.6.1 of NFPA 110, Standard for Emergency and Standby Power Systems. Additional observation, on 1/18/23, at 10:05 a.m., revealed there was only one remote, manual stop button for the two generators installed at the facility. An interview, on 1/18/23, at 10:05 a.m., revealed the facility was not aware that all installations should have a remote, manual stop station. The census of 110 was verified by Administrative Staff A on 1/18/23. The findings were acknowledged by Administrative Staff A and Maintenance Staff A during the exit interview on 1/19/23. **Actual NFPA Standard: NFPA 101, Life Safety Code (2012)** **33.3.1.2.2*** Impractical. Large facilities classified as impractical evacuation capability shall meet the requirements of Section 33.3 for impractical evacuation capability, or the requirements for limited care facilities in Chapter 19, unless the authority having jurisdiction has determined equivalent safety is provided in accordance with Section 1.4. **19.5 Building Services.** **19.5.1 Utilities.** **19.5.1.1** Utilities shall comply with the provisions of Section 9.1. **9.1.3 Emergency Generators and Standby Power Systems.** Where required for compliance with this Code, emergency generators and standby power systems shall comply with 9.1.3.1 and 9.1.3.2. **9.1.3.1** Emergency generators and standby power systems shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. **Actual NFPA Standard: NFPA 110, Standard for Emergency and Standby Power Systems (2010)** **5.6.5.6*** All installations shall have a remote manual stop station of a type to prevent inadvertent or unintentional operation located outside the room housing the prime mover, where so installed, or elsewhere on the premises where the prime mover is located outside the building.

	5.6.5.6.1 The remote manual stop station shall be labeled. 4. Based on observation and interview, the facility failed to provide essential electric system alarm annunciators for the onsite generators. The deficient practice affected 23 of 23 smoke compartments, staff, and 110 residents. The facility had a capacity for 200 beds with a census of 110 on the day of the survey. The findings include: Observation during the building inspection tour, on 1/18/23, at 10:51 a.m., revealed that remote annunciator panels that were storage battery powered located outside of the [LOCATION] and in a location readily observed by staff could not be located for either the 400 KW or the 600 KW generators, as required by sections 6.4.1.1.17 and 6.4.1.1.17.5 of NFPA 99, Health Care Facilities code. An interview with Maintenance Staff A, on 1/18/23, at 10:51 a.m., revealed that there were no remote annunciator panels for the two (2) generators. Further observation revealed a panel which appeared to be a remote annunciator, however, it could not be verified due to the inoperability of the system. The census of 110 was verified by Administrative Staff A on 1/18/23. The findings were acknowledged by Administrative Staff A and Maintenance Staff A during the exit interview on 1/19/23. **Actual NFPA Standard NFPA 101 Life Safety Code, 2012 Edition** **33.3.1.2.2*** Impractical. Large facilities classified as impractical evacuation capability shall meet the requirements of Section 33.3 for impractical evacuation capability, or the requirements for limited care facilities in Chapter 19, unless the authority having jurisdiction has determined equivalent safety is provided in accordance with Section 1.4. 19.5.1.1 Utilities shall comply with the provisions of Section 9.1. **NFPA 101,** 9.1 Utilities. 9.1.2 Electrical Systems. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless such installations are approved existing installations, which shall be permitted to be continued in service. **Actual NFPA Standard NFPA 70 National Electrical Code 2011 Edition** III. Essential Electrical System 517.25 Scope. The essential electrical system for these facilities shall comprise a system capable of supplying a limited

	amount of lighting and power service, which is considered essential for life safety and orderly cessation of procedures during the time normal electrical service is interrupted for any reason. This includes clinics, medical and dental offices, outpatient facilities, nursing homes, limited care facilities, hospitals, and other health care facilities serving patients. Informational Note: For information on the need for an essential electrical system, see NFPA 99, Standard for Health Care Facilities. **Actual NFPA Standard NFPA 99, Health Care Facilities Code (2012)** **6.4.1.1.17 Alarm Annunciator.** A remote annunciator that is storage battery powered shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see 700.12 of NFPA 70, National Electrical Code). The annunciator shall be hard-wired to indicate alarm conditions of the emergency or auxiliary power source as follows: **(1)** Individual visual signals shall indicate the following: **(a)** When the emergency or auxiliary power source is operating to supply power to load **(b)** When the battery charger is malfunctioning **(2)** Individual visual signals plus a common audible signal to warn of an engine−generator alarm condition shall indicate the following: **(a)** Low lubricating oil pressure **(b)** Low water temperature (below that required in 6.4.1.1.11) **(c)** Excessive water temperature **(d)** Low fuel when the main fuel storage tank contains less than a 4-hour operating supply **(e)** Over crank (failed to start) **(f)** Overspeed **6.4.1.1.17.5** A centralized computer system (e.g., building automation system) shall not be permitted to be substituted for the alarm annunciator in 6.4.1.1.17 but shall be permitted to be used to supplement the alarm annunciator.