



**DEPARTMENT OF VETERANS AFFAIRS  
NEBRASKA-WESTERN IOWA HEALTH CARE SYSTEM**

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Lincoln NE 68510-2493

Grand Island  
2201 N Broadwell Avenue  
Grand Island NE 68803-2196

In Reply Refer To: 636

October 6, 2010

Jerry Eisenhauer, Administrator  
Norfolk Veterans Home  
600 East Benjamin Avenue  
Norfolk, Nebraska 68702

Dear Mr. Eisenhauer:

The Nebraska-Western Iowa Health Care System survey team conducted the annual survey of the Norfolk State Veterans Home and Domiciliary in Norfolk, Nebraska on March 9-11, 2010. At that time the Domiciliary was found to be in full compliance. However, during the survey, deficiencies were cited in the nursing home and a letter was sent to you on April 5, 2010 listing those deficiencies. On April 13, 2010 you responded with the facilities corrective action plan.

On September 23, 2010 Nebraska Western Iowa Health Care System requested a detailed report demonstrating that the plan of correction has been implemented for all deficient standards. You responded with these documents on September 30, 2010.

The survey team reviewed the evidence of implementation of the corrective action plan, and has determined that your facility is in compliance with all VA standards. I have granted Norfolk Veterans Home and Domiciliary full certification for 2010.

Thank you for your continued service to our nation's Veterans.

Sincerely,

for Al Washko  
Director

Peter P. Henry, FACHE  
Director VISN 23  
Extended Care & Rehab Service Line

DEPARTMENT OF VETERANS AFFAIRS  
 NEBRASKA-WESTERN IOWA HEALTH CARE SYSTEM  
 ANNUAL SURVEY  
 NORFOLK VETERANS HOME

|  | <b>RESIDENT ASSESSMENT</b>  |                           |
|--|-----------------------------|---------------------------|
| <b>Inspector determines that the nursing home failed to:</b>   | <b>Inspection Date</b>      | <b>Date of Correction</b> |
| Assure Care Plans were developed and reviewed timely and prepared by an interdisciplinary team.                  | 3/11/2010                   | 10/6/2010                 |
|  | <b>PHYSICAL ENVIRONMENT</b> |                           |
| <b>Inspector determines that the nursing home failed to:</b>   | <b>Inspection Date</b>      | <b>Date of Correction</b> |
| Assure that a back-up phone dialer was wired into fire panel to give a trouble signal when not working properly. | 3/11/2010                   | 10/6/2010                 |
|  | <b>PHYSICAL ENVIRONMENT</b> |                           |
| <b>Inspector determines that the nursing home failed to:</b>   | <b>Inspection Date</b>      | <b>Date of Correction</b> |
| Assure emergency generator annunciation panel produced audible alarm when in use.                                | 3/11/2010                   | 10/6/2010                 |
|  | <b>ADMINISTRATION</b>       |                           |
| <b>Inspector determines that the nursing home failed to:</b>   | <b>Inspection Date</b>      | <b>Date of Correction</b> |
| Assure Medication Administration Records were consistently filled out.   | 3/11/2010                   | 10/6/2010                 |
| Assure scheduled audits are completed in a timely fashion.   | 3/11/2010                   | 10/6/2010                 |
|  | <b>QUALITY OF CARE</b>      |                           |
| <b>Inspector determines that the nursing home failed to:</b>   | <b>Inspection Date</b>      | <b>Date of Correction</b> |
| Assure interventions were in place to prevent falls.   | 3/11/2010                   | 10/6/2010                 |
|  |                             |                           |
|  |                             |                           |
|  |                             |                           |