DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: CB2X

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00411

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245631**
2.STATE VENDOR OR MEDICAID NO.
(L2)

3. NAME AND ADDRESS OF FACILITY
(L3) **MN VETERANS HOME - LUVERNE**
(L4) **1300 NORTH KNISS, PO BOX 539**
(L5) **LUVERNE, MN** (L6) **56156**

4. TYPE OF ACTION: **7** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/10/2018** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
06/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **85** (L18)
13.Total Certified Beds **85** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel __ 6. Scope of Services Limit
__ 3. 24 Hour RN __ 7. Medical Director
__ 4. 7-Day RN (Rural SNF) __ 8. Patient Room Size
__ 5. Life Safety Code __ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	85			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Holly Kranz, Unit Supervisor 10/18/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Sr. Health Program Rep 10/18/2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
08/31/2016
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
CMS Certification Number (CCN): 245631

November 27, 2018

Administrator
MN Veterans Home - Luverne
1300 North Kniss, Po Box 539
Luverne, MN 56156

Revised letter

Dear Administrator:

This correction date in this letter has been changed from 9/10/2018 to 9/14/2018.

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective September 14, 2018 the above facility is certified for:

85 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 85 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
CMS Certification Number (CCN): 245631

November 7, 2018

Administrator
MN Veterans Home - Luverne
1300 North Kniss, Po Box 539
Luverne, MN 56156

Revised letter

Dear Administrator:

This correction date in this letter has been changed from 9/10/2018 to 9/14/2018.

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

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Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
CMS Certification Number (CCN): 245631

October 18, 2018

Administrator
MN Veterans Home - Luverne
1300 North Kniss, Po Box 539
Luverne, MN 56156

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

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Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 27, 2018

Administrator
MN Veterans Home - Luverne
1300 North Kniss, PO Box 539
Luverne, MN 56156

Revised letter

RE: Project Number S5631002

Dear Administrator:

This correction date in this letter has been changed from 9/10/2018 to 9/14/2018.

On August 31, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for, a standard survey, completed on August 9, 2018. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On September 14, 2018, the Minnesota Department of Health, completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 9, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 14, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 9, 2018, effective September 10, 2018 and therefore remedies outlined in our letter to you dated August 31, 2018, will not be imposed.

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 if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 7, 2018

Administrator
MN Veterans Home - Luverne
1300 North Kniss, PO Box 539
Luverne, MN 56156

Revised letter

RE: Project Number S5631002

Dear Administrator:

This correction date in this letter has been changed from 9/10/2018 to 9/14/2018.

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Sincerely,

Kamala Fiske-Downing

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Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 18, 2018

Administrator
MN Veterans Home - Luverne
1300 North Kniss, PO Box 539
Luverne, MN 56156

RE: Project Number S5631002

Dear Administrator:

On August 31, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for, a standard survey, completed on August 9, 2018. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

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Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: CB2X

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00411

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245631**
2.STATE VENDOR OR MEDICAID NO.
(L2)

3. NAME AND ADDRESS OF FACILITY
(L3) **MN VETERANS HOME - LUVERNE**
(L4) **1300 NORTH KNISS, PO BOX 539**
(L5) **LUVERNE, MN** (L6) **56156**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/09/2018** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
06/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **85** (L18)
13.Total Certified Beds **85** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	85			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Angela Hatch, HFE NE II 09/10/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Sr. Health Program Rep 10/03/2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
08/31/2016
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered

August 31, 2018

MN Veterans Home - Luverne
Attn: Administrator
1300 North Kniss, PO Box 539
Luverne, MN 56156

RE: Project Number S5631002

Dear Mr. Schryvers:

On August 9, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" tag) and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Holly Kranz, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: holly.kranz@state.mn.us
Phone: (507) 344-2742
Fax: (507) 344-2723

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 18, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within ten calendar days of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by November 9, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 9, 2019 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us

Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245631	A. BUILDING _____ B. WING _____	08/09/2018

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MN VETERANS HOME - LUVERNE	1300 NORTH KNISS, PO BOX 539 LUVERNE, MN 56156

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E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 8/6, 8/7, 8/8 and 8/9/18 during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 8/6/18 through 8/9/18, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to	F 625		9/14/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/05/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 625	Continued From page 1 the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the resident and/or resident's representative was informed of the bed hold policy at the time of hospitalization for 1 of 1 resident (R26) reviewed for hospitalization. Findings include: R26 was admitted to the facility on 8/11/16, with diagnoses including: Alzheimer's disease, Dementia, weakness, arteriosclerotic heart disease, major depressive disorder, anxiety, and hypertension (high blood pressure (BP)). On 2/9-2/12/18, R26 was hospitalized with	F 625	F626 – Bed hold notice was sent to resident R26's brother in law for date of hospitalization. All residents who are hospitalized or take a therapeutic leave from the facility had the potential to be affected by the deficient practice. The facility bed hold policy was reviewed. Bed hold forms were added to each residents transfer packet. A transfer checklist was developed for licensed nursing staff. The licensed nursing staff	

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F 625	Continued From page 2 diagnoses of hypotension (low BP) and dehydration. However, review of both the electronic medical record (EMR) and paper record lacked documentation of R26 having received a bed hold notice within 24 hours of being transferred to the hospital on 2/9/18. R26's progress noted dated 2/9/18 at midnight, indicated R26 had been found passed out on the toilet with his extremities cyanotic (blue discoloration), drooling, and his eyes "rolled back". The progress notes indicated R26 was unresponsive to stimuli and vital signs were recorded as blood pressure (BP) 70/43 beats per minute (BPM) (Normal values are 120/80), temperature (T) 94.6 degrees Fahrenheit (F) (Normal value 98.6 degrees F), respirations 10 breaths per minute (bpm) (normal 12-18 breaths per minute (BPM), heart rate (HR) 54 BPM, (Normal is 60-100 BPM), and his oxygen saturation was at 84% on room air, (Normal is 95 -100%). Emergency response was contacted and R26 was transferred to the local hospital. Progress notes indicated on 2/12/18 at 10:05 a.m., the long term care facility had been notified R26 would be returning to the facility. During interview with the assistant director of nursing (ADON) on 8/9/18 at 11:26 a.m., the ADON described the facility's procedure for giving residents information on bed-hold notices. The ADON stated the procedure included a packet being sent with the resident at the time of transfer which would contain the policy addressing bed holds and the need for the form to be signed. The ADON stated she was unaware whether the packet had been sent with R26 at the time of transfer, but confirmed there was no record bed	F 625	were educated on the need to complete a bed hold for all residents that leave the facility for a hospitalization or take a therapeutic leave from the facility per facility policy. The Director of Nurses or designee will complete audits on residents who are hospitalized or take a therapeutic leave from the facility to ensure bed hold forms are completed. Audits will continue until as determined by the facility QAPI Committee The audit results will be reviewed during the facility QAPI Meetings and the QAPI Committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process base on the compliance noted from the audits The Director of Nurses or designee are responsible for monitoring compliance	

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F 625	Continued From page 3 hold information had been provided to the resident and/or representative. The ADON further indicated there was a note in the progress notes dated 2/9/18, that R26's son had been contacted about the resident's hospitalization, but no indication a bed hold had been obtained. The facility's Resident Financial-Bed Hold Rights policy dated 2/16/18, included: "The MVH (Minnesota Veteran's Home) ensure residents at its facilities are provided opportunity to reserve residency upon a temporary absence due to hospitalization or therapeutic leave...1. Notice before transfer. Before MVH transfers a resident to a hospital or the resident goes on therapeutic leave, MVH staff shall provide written information to the resident or resident representative that specifies: a. The duration of the State bed-hold policy, during which the resident is permitted to return and resume residence in our home; b. The reserve bed payment policy; and c. Return requirements. 2. Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, MVH staff shall provide to the resident and/or the resident representative written notice which specifies the duration of the bed-hold and bed hold process according to the rules."	F 625		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of	F 755		9/14/18

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F 755	Continued From page 4 a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to insure Latanoprost (eye drops for glaucoma) were re-ordered and administered in a timely manner for 1 of 2 sampled resident (R63) with eye medications. Findings include: Review of the electronic medical record (EMR) for R63 indicated he'd been admitted 1/4/18, with a diagnosis of glaucoma (disease causing increased eye pressure and potentially leading to blindness).	F 755	F755 – The eye drops for resident R63 were reordered, obtained, and administered to R63 as ordered by the physician. All residents who receive routine, emergency drugs, or biologicals at the facility had the potential to be affected by the deficient practice. The facility pharmaceutical procurement policy was reviewed and revised. The licensed nursing staff were educated on	

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F 755	Continued From page 5 During interview on 8/6/18 at 2:08 p.m., R63 stated he was supposed to be receiving eye drops for his glaucoma for at least 4 or 5 days. R63 stated staff had told him they were not able to obtain the eye drops. Review of the EMR indicated a physician's order dated 1/4/18, indicating Latanoprost 1 drop to both eyes was to be administered at bedtime for glaucoma. Review of R63's medication administration record (MAR) indicated no Latanoprost eye drops had been administered from 8/1 through 8/6/18. A note in the MAR indicated the medication was not available during those dates. The assistant director of nursing (ADON) was interviewed on 8/9/18 at 10:05 a.m.. The ADON confirmed R63's Latanoprost eye drops had not been administered as ordered from 8/1 through 8/6/18. The ADON stated she was uncertain why the medication had not been re-ordered and stated if there had been a problem with obtaining the ordered medication from [R63's pharmacy], it should have been ordered locally. The ADON clarified the facility was able to obtain medications from a local pharmacy when needed so residents did not miss ordered doses. Registered nurse (RN)-B verified during interview 8/9/18 at 10:18 a.m., R63 had not received his Latanoprost from 8/1 through 8/6/18. RN-B stated the facility had likely run out of the Latanoprost on 7/31/18 but stated she was unaware why R63's medication had not been reordered. RN-B stated the medication should have been ordered prior to the last dose being administered on 7/31/18.	F 755	the timely ordering and reordering of routine, emergency drugs, and biologicals per the facility policy. The Director of Nurses or designee will complete audits on the timely ordering and reordering of routine, emergency drugs, and biologicals for all residents at the facility. Audits will continue until as determined by the facility QAPI Committee The audit results will be reviewed during the facility QAPI Meetings and the QAPI Committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process base on the compliance noted from the audits The Director of Nurses or designee are responsible for monitoring compliance	

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F 755	Continued From page 6 The facility's undated Pharmaceutical Procurement policy indicated licensed nurses on each wing were to be responsible for ordering and obtaining pharmaceutical supplies required for resident care. The policy indicated if a medication had not been received, it was the responsibility of the licensed nurse to call and obtain the medication prior to the next scheduled dose.	F 755		
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure physician's laboratory (lab) orders were followed in a timely manner for 1 of 1 resident (R58) who received Coumadin, an anti-coagulant (blood-thinning medication) with a personal history of rectal bleeding. Findings include:	F 773	F773 – Lab services were drawn and run on 8/8/18 for Resident R58. Medical Director reviewed lab results on 8/9/18. All residents who have physician laboratory orders at the facility had the potential to be affected by the deficient practice.	9/14/18

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F 773	Continued From page 7 Review of R58's medical record indicated he was admitted on 7/2/18 with diagnoses of atherosclerotic heart disease (hardening of the arteries), atrial fibrillation (A-Fib, an abnormal heart rhythm that may lead to blood clots), and long term use of anti-coagulants. R58's 7/8/18 admission Minimum Data Set (MDS) assessment indicated a Brief Interview for Mental Status (BIMS) score of 14, indicating R58 was cognitively intact. During observation and interview on 8/6/18 at 2:57 p.m., R58 was observed resting on his bed. At that time, R58 stated he liked to nap frequently. R58's skin was pale and he was thin in appearance. His hands had several small purple bruise-like areas and R58 stated he bruised easily. R58 also stated he often stayed in his room due to problems with his bowel movements (BM) being loose and the need to use the toilet frequently. R58 stated he had a problem with rectal bleeding and blood in his BM. R58 stated he'd been told by staff to let them know when he had a BM so staff could check it for blood, stating at times his BMs had bright red blood in them, and at other times were very dark brown or black colored. R58 stated he regularly received a blood thinner and had used the medication a long time due to his abnormal heart rate. Review R58's current care plan revealed he received Coumadin regularly and needed to be observed for increased bruising, bleeding, and signs and symptoms of digestive tract (GI) bleed, that included dark tarry stools or visible signs of blood in her stools. An admission history and physical (H&P) dated	F 773	The facility diagnostic services policy was reviewed and revised. The licensed nursing staff were educated on the diagnostic services policy and the documentation of lab draws. The Director of Nurses or designee will complete audits on the results of laboratory and the proper documentation being in place. Audits will continue until as determined by the facility QAPI Committee The audit results will be reviewed during the facility QAPI Meetings and the QAPI Committee will provide direction or change when necessary and will dictate the continuation or completion of this monitoring process base on the compliance noted from the audits The Director of Nurses or designee are responsible for monitoring compliance	

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as preformed 7/3/18 at 3:10 p.m., by medical doctor (MD)-A indicated R58's had a right inguinal (groin) hernia repair approximately 2 weeks prior. The H&P indicated following the procedure, nursing staff had noticed bloody smears in R58's BM. The H&P further indicated R58 may have had dis-impaction (manual removal of stool from the rectum) which caused the rectal bleeding. During rectal examination, no blood was found. MD-A's assessment and plan included to continue to administer Coumadin to R58 related to the diagnosis of A-Fib. The Coumadin order was identified as 2.5 milligrams (mg) daily. The H&P also indicated MD-A had noticed R58 had no documented INRs (international normalized ratio, a measurement of clotting time of blood) and had ordered the laboratory (lab) to be performed. MD-A had also ordered a complete blood count (CBC) and a basic metabolic panel (BMP) to be conducted.

A 7/3/18 progress note, indicated registered nurse (RN)-B had received a telephone call from MD-A indicating the INR laboratory value was 4.85 (therapeutic range is 2.5-3.5), and that MD-A would be faxing an order for Vitamin K (vitamin that thickens blood) to be administered to R58 immediately. MD-A ordered the Coumadin to be held until 7/4/18, and to have a repeat lab draw for R58's INR conducted on 7/5/18. No results were received for the CBC or BMP.

INR lab tests were ordered and results were noted for R58 including:
(1) 7/5/18 with the INR measuring 1.68.
(2) 7/12/18 with the INR measuring 1.65.
(3) 7/19/18 with the INR measuring 1.56.
(4) 7/26/18 with the INR measuring 2.08.

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MD-A ordered Coumadin to be administered beginning 7/21/18, 2.5 mg by mouth (PO), one time daily on Mondays and Thursdays, and Coumadin 5 mg PO to be administered one time daily on Sundays, Tuesdays, Wednesdays, Fridays and Saturdays. MD-A also ordered R58's INR level to be drawn and re-checked again in one month. (Due 8/21/18). There was still no indication results were received by staff from the hospital lab regarding the CBC and BMP ordered on 7/3/18.

Review of the 8/2/18 MD-A visit note indicated R58's PT/INR were within therapeutic range. MD-A noted the rectal bleeding was presumed to be hemorrhoid bleeding.

RN-C was interviewed on 8/7/18, at 3:00 p.m. and indicated R58 had intermittent episodes of bright red blood in his BM, but some of his BM's had a dark, coffee ground appearance. RN-C stated R58 was being monitored by staff for blood in his BM and documentation was to be noted in the nursing progress notes every shift. RN-C also referenced a progress note dated 8/2/18, at 13:26 (1:26 p.m.) in which R58's family member was updated on the rectal bleeding and the family had indicated being unaware of R58 having had a problem with hemorrhoids.

Record review and interview on 8/7/18 at 3:06 p.m., with RN-C indicated she had noted R58 had been having some bright red rectal bleeding dated 8/7/18. The amount of blood observed in his BM was larger than a quarter in size, but smaller than silver dollar. RN-C indicated there was a nursing order dated 8/2/18, that included to monitor R58's rectal bleeding. There was no documentation to show MD-A had been updated

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with regard to R58's rectal bleeding at that time. RN-C agreed staff should have monitored R58 for increased bleeding and updated MD-A to the increased blood in R58's BM.

During interview with the assistant director of nursing (ADON) on 8/8/18 at 10:13 a.m., the ADON stated she had investigated the missing laboratory values for the CBC and BMP ordered for 7/3/18. The ADON stated she had personally obtained the blood work from R58 for the lab on 7/3/18 as ordered. However, the receiving hospital lab had not processed the order as indicated. The ADON agreed follow up by the nursing staff had not occurred to identify the missing lab work for R58's CBC and BMP. The ADON then re-ordered the CBC and BMP on 8/8/18 and MD-A was notified of the error in obtaining the results for the prescribed lab work. The ADON stated it was the facility's expectation nursing staff would follow up on lab orders to ensure completion in a timely manner.

Registered nurse (RN)-B was interviewed on 8/9/18 at 9:14 a.m. and stated R58's CBC and BMP lab results drawn on 8/8/18 included the following results: a low hemoglobin (HGB) of 8.1 (normal for males-14-18) but was not symptomatic. RN-B stated MD-B had received faxed notification of R58's low HGB on 8/8/18 at 2:20 p.m. and had responded that same day with an order to "hold Coumadin for now". RN-B stated staff routinely faxed abnormal lab values to the providers. RN-B also stated R58 had complained of being tired and had been observed sleeping at intervals since his admission, so there were no signs of his condition worsening. RN-B stated she should have followed-up on the ordered lab results, and stated the facility's

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process was to obtain a lab sample and give the ADON a copy to ensure lab results were obtained in a timely manner. A copy of the lab order was written on her calendar as a reminder to ensure it had been completed. All nursing staff had access to the calendar so the nursing staff would be aware of when, and what labs, were to be completed.

During a follow up interview with the ADON on 8/9/18 at 9:48 a.m., the ADON verified the MD had been faxed and the facility had received orders to hold the Coumadin. The ADON stated R58's HGB of 8.1 would be considered a significant lab result as previously documented HGB results indicated R58's HGB was 10.1 in January, 2018 and 10.8 in May, 2018.

During interview with MD-B on 8/9/18 at 1:46 p.m., MD-B stated he was unaware the ordered lab tests from 7/3/18 had not been completed until 8/9/18 when the facility had telephoned him prior to his arrival at the facility. MD-B indicated a HGB level of 8.1 would be considered serious, but not critical. MD-B indicated R58's HGB had likely declined. MD-B's professional opinion for R58's low HGB was due to chronic blood loss. MD-B stated he had suggested a colonoscopy (scope inserted into the bowel from the rectum) to R58, but R58 had declined. MD-B offered to contact R58's family and discuss options for treatment, but R58 had declined that as well. MD-B indicated in lieu of testing, he would start R58 on omeprazole (medication to decrease gastric irritation), add an iron replacement supplement, and recheck the CBC in a couple of weeks. MD-B further stated he was not aware of R58 having a history of bleeding. MD-B then stated his expectation was for staff were to collect

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245631	A. BUILDING _____ B. WING _____	08/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME - LUVERNE	1300 NORTH KNISS, PO BOX 539 LUVERNE, MN 56156

(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) COMPLETION DATE
F 773	Continued From page 12 labs as ordered, review the results, and notify him of any variances to the order or results. MD-B stated he would have immediately stopped R58's Coumadin administration if he'd known the HGB had dropped below 10, and would have expected to have been notified within 72 hours if the physician's order was not been completed. Review of the facility's current Transcription of Physician's Orders policy, indicated lab orders were processed at the local hospital. Staff were to complete a lab slip transcribing physician orders. If request is for an INR, staff were to include the resident's Coumadin dosage. Staff were to send that lab request to medial records for completion, including the resident's diagnosis and identifying information.	F 773		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245631	A. BUILDING **01 - MAIN BLDG** B. WING _____	**08/09/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME - LUVERNE	**1300 NORTH KNISS. PO BOX 539 LUVERNE, MN 56156**

(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) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, the Minnesota Veterans Home, Luverne was found to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The Minnesota Veterans Home consists of two (2) building additions to the original nursing home, and were constructed as follows: The 2009 addition is one-story, has no basement, is fully fire sprinkler protected and is of Type V(000) construction; The 2011 addition is one-story, has no basement, is fully fire sprinkler protected and is of Type V(000) construction. The Facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. All resident rooms have automatic, hard-wired smoke detectors connected to the fire alarm system. The facility has a capacity of 85 beds and had a census of 80 at time of the survey.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.