MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:
St. John Lutheran Home
201 South County Road 5
Springfield, MN 56087
Brown County

Report#: H5407008

Date: May 6, 2016

Date of Visit: June 22 and 23, 2015
Time of Visit: 12:00 p.m. - 5:30 p.m.
8:00 a.m. - 4:30 p.m.

By: William Nelson, RN, Special Investigator

Type of Facility: ☒ Nursing Home ☐ HHA ☐ Home Care Provider
☐ SLF ☐ ICF/IID
☐ Hospital ☐ Other: _____

☐ Facility Self Report ☒ Complaint

Allegation(s): **It is alleged** that a resident was neglected when the facility staff failed to monitor for medication side effects and did not assess a change in condition when the resident had five suicide attempts after starting a medication that has suicidal ideations as a known side effect. In addition, the facility failed to notify the family of these incidents.

An unannounced visit was made at this facility and an investigation was conducted under:

☐ Federal Regulations for Hospital Conditions of Participation (42 CFR, Part 482)
☑ Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
☐ Federal Regulations for ICF/IID (42 CFR Part 483, subpart I)
☐ Federal Regulations for HHA (Home Health Agencies) (42 CFR, Part 484)
☐ Federal Regulations for CAH (Critical Access Hospital) (42 CFR, Part 485)
☐ Federal Regulations for EMTALA (42 CFR Part 489)

☐ State Licensing Rules for Boarding Care Homes (MN Rules Chapter 4655)
☑ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
☐ State Licensing Rules for Supervised Living Facilities (MN Rules Chapter 4665)
☐ State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483)
☐ State Statutes for Maltreatment of Minors (MN Statutes, section 626.556)
☑ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
☑ State Statutes Chapters 144 and 144A

Conclusion:

Minnesota Vulnerable Adults Act (MN 626.557)

Under the Minnesota Vulnerable Adults Act (MN. 626.557):

☐ Abuse ☑ Neglect ☐ Financial Exploitation was:

◉ Substantiated ○ Not Substantiated ○ Inconclusive based on the following information:

Based on a preponderance of evidence neglect did occur when the facility staff failed to assess, monitor, and provide for a resident who had a decline in mental health and made multiple suicide statements and attempts for 35 days. The facility did not notify the physician of the resident's change in condition for 35 days, at which time the resident required hospitalization for 22 days.

The resident was a long term resident of the facility. The resident's diagnosis included dementia. The facility documentation did not include any evidence of a history of suicide attempts. The resident wandered the secured care unit multiple times throughout the day. The resident required assistance with all activities of daily living (ADL) due to the resident's advanced dementia.

The resident's physician prescribed the resident an anti-psychotic medication called Seroquel after the resident had increased episodes of aggression associated with delusional/paranoid thoughts. Shortly after starting Seroquel, the resident started wishing s/he were dead. Staff heard the resident say things like, "if I had a gun I would shoot myself." Within 2 days of starting the Seroquel, while in the day room folding laundry, the resident tied the sleeves of his/her shirt around his/her neck. The resident asked the staff present to pull the garment tighter, and the resident said that s/he wanted to die. Later that day, staff found the resident in the resident's bedroom with a chair pad cord wrapped around the resident's neck. The staff removed the cord from the resident's neck. The resident became upset, yelling at staff, and pacing the unit for two hours. The staff removed the chair pad and cord from the resident's room. Staff did not assess the resident for safety, implement interventions to increase the resident's supervision or notify the physician or family. Staff indicated the resident expressed the desire to die frequently.

Three weeks later the staff found the resident in front of the medication room with a compression stocking tied "very tightly" around the resident's neck. The resident yelled, "Let me out of here" after the staff removed the compression stocking. The resident continued to yell at staff and pace in the unit, eventually calming down. Staff did not implement interventions to increase the resident's supervision, or notify the physician or family. The resident continued to tell staff s/he wanted to die. The resident would talk of going to the river and

drowning, getting a gun and shooting self and stating s/he would be better off dead. The resident made statements including, but not limited to; "I wish I had a gun" and I wish I were dead". The facility allowed the resident to continue to have access to items used to attempt suicide, to express suicidal wishes, and to experience feeling as though she would be better off dead.

The facility did not notify the resident's physician for 35 days after the first attempt. After the physician received notification, the resident was admitted to the hospital for evaluation and treatment. The resident received individualized and group therapy, medication evaluations and changes. The resident did not return to the facility when discharged from the hospital.

Interview with the physician indicated that prior to this incident the facility notified him/her of changes in the residents' condition timely and there had not been a problem with communication. The physician felt that had the facility notified him/her at the time of the first suicidal gesture the resident could have been treated at the facility by adjusting the medications and monitoring the resident closely.

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☐ individual(s) and/or ☒ facility is responsible for the

☐ Abuse ☒ Neglect ☐ Financial Exploitation. This determination was based on the following:

The facility did not have a policy in place to manage residents expressing thoughts of suicide or suicide attempts. All the staff on the unit were aware the resident was experiencing this change in condition for an extended period of time however the resident's plan of care was not changed and the resident's family and physician were not notified.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

Compliance:

Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B) – Compliance Not Met
The requirements under the Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B), were not met.

Deficiencies are issued on form 2567: ☒ Yes ☐ No If no, specify: _____

(The 2567 will be available on the MDH website.)

State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) – Compliance Not Met
The requirements under State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) were not met.

State licensing orders were issued: ☒ Yes ☐ No If no, specify: _____
(State licensing orders will be available on the MDH website.)

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Met
The facility was found to be in compliance with State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557). No state licensing orders were issued.

Facility Corrective Action:

The facility took the following corrective action(s):
An unannounced revisit was completed to evaluate the violations issued as a result of the investigation. Observations, document review, and interviews confirmed the facility developed and implemented a policy/procedure on how to address suicidal statements and attempts. The facility provided education to all staff on the change of condition policy and procedure. Social Services developed a process to follow-up on change of condition to confirm notifications were done.

Definitions:

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated
"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect
"Neglect" means:

(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) which is not the result of an accident or therapeutic conduct.

(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult

which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

☒ Medical Records	☒ Care Guide
☒ Medication Administration Records	☐ Treatment Sheets
☒ Facility Incident Reports	☐ Physician Progress Notes
☐ ADL (Activities of Daily Living) Flow Sheets	☐ Laboratory and X-ray Reports
☒ Physician Orders	☒ Social Service Notes
☒ Nurses Notes	☐ Meal Intake Records
☐ Activities Reports	☐ Weight Records
☐ Therapy and/or Ancillary Services Records	☒ Assessments
☐ Skin Assessments	☒ Care Plan Records
☐ Service Plan	☐ Other, specify: _____

Other pertinent medical records:

☒ Hospital Records ☐ Ambulance/Paramedics ☐ Medical Examiner Records ☐ Death Certificate

☐ Police Report ☐ Other, specify: _____

Additional facility records:

☒ Resident/Family Council Minutes ☐ Personnel Records/Background Check, etc.

☒ Staff Time Sheets, Schedules, etc. ☐ Facility In-service Records

☐ Facility Internal Investigation Reports ☒ Facility Policies and Procedures

☐ Call Light Audits ☐ Other, specify: _____

Number of additional resident(s) reviewed: 2

Were residents selected based on the allegation(s)? ◉ Yes ○ No ○ N/A Specify: _____

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

○ Yes ◉ No ○ N/A Specify: Transferred to another SNF

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s): ◉ Yes ○ No ○ N/A Specify: _____

If unable to contact complainant, attempts were made on:
Date/time: _____ Date/time: _____ Date/time: _____

Interview with family: ◉ Yes ○ No ○ N/A Specify: _____

Did you interview the resident(s) identified in allegation: ○ Yes ◉ No ○ N/A Specify: discharged

Did you interview additional residents: ◉ Yes ○ No

Total number of resident interviews: 3

Interview with staff: ◉ Yes ○ No ○ N/A Specify: _____

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: 6

Physician interviewed: ◉ Yes ○ No

Nurse Practitioner interviewed: ○ Yes ◉ No

Physician Assistant interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ○ Yes ○ No ◉ N/A Specify: _____

Attempts to contact: Date/time: _____ Date/time: _____ Date/time: _____

If unable to contact was subpoena issued: ○ Yes , date subpoena was issued _____ ○ No

Were contacts made with any of the following:

☐ Emergency personnel ☐ Police Officers ☐ Medical Examiner ☒ Other: Specify Consult pharmacist

Observations were conducted related to:

☐ Wound Care	☐ Medication Pass	☐ Meals
☐ Personal Care	☒ Dignity/Privacy Issues	☐ Restorative Care
☒ Nursing Services	☒ Safety Issues	☒ Facility Tour
☐ Infection Control	☒ Cleanliness	☐ Injury
☐ Use of Equipment	☐ Transfers	☐ Incontinence
☐ Call Light	☐ Other: _____	

Was any involved equipment inspected: ○ Yes ○ No ◉ N/A Specify: _____

Was equipment being operated in safe manner: ○ Yes ○ No ◉ N/A Specify: _____

Were photographs taken: ○ Yes ◉ No Specify: _____

xc: Health Regulation Division - Licensing & Certification
Minnesota Board of Nursing
Minnesota Board of Examiners for Nursing Home Administrators
Springfield City Police Department
Brown County Attorney
Springfield City Attorney

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	245407	A. BUILDING _____ B. WING _____	C 07/20/2015

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ST JOHN LUTHERAN HOME	201 SOUTH COUNTY ROAD 5 SPRINGFIELD, MN 56087

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F 000	INITIAL COMMENTS An abbreviated standard survey was conducted to investigate case #H5407008. As a result, the following deficiencies are issued. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; 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); 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 a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157		

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.

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F 157	Continued From page 1 The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to inform the resident's family member and physician when the resident began making suicidal statements and gestures for one of three resident's (R1) reviewed. Findings include: Review of R1's record of admission revealed that R1 was admitted to the facility on 10/6/2014. R1's diagnosis included left hip fracture with surgical repair, osteoporosis, adult failure to thrive and dementia. Review of R1's plan of care dated April, 2015 revealed that R1 expressed delusional thoughts and had short and long term memory loss. R1 exhibited inappropriate behavior such as undressing in public areas, hitting, kicking pinching and yelling sarcastic comments. Review of progress note dated 4/10/2015 at 10:00 a.m. by Social Worker- K (SW)-K. Completed Brief Interview for Mental Status(BIMS) and Patient Health Questionnaire (PHQ). R1 scored 3/15 on BIMS. Reported trouble sleeping and feeling bad about self. R1's mood/temperament changes when upset, unable to redirect. Review of progress note dated 4/13/2015 at 9:00 a.m. by Registered Nurse- F (RN)-F. Fax sent to	F 157		

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F 157	Continued From page 2 Medical Doctor - D (MD)-D requesting a urinalysis/urine culture (UA/UC) due to increased agitation and refusing of medications. (4/16/2015 UA/UC neg.) Review of progress note dated 4/22/2015 at 10:00 a.m. by RN-A. Reviewed mood, behavior and delusional thoughts with MD-D. Due to delusional thoughts causing her to have anger and behaviors MD-D ordered Seroquel, 12.5 mg. at bedtime. Family called and RN reviewed Seroquel, the risks and side effects. The family member agreed to allow Seroquel to be administered to R1. Review of progress note dated 4/24/2015 at 5:30 p.m. by LPN - H. The resident was very upset this afternoon, refused to eat supper. R1 opened front of blouse and tied the sleeves around her waist and neck. The resident tied blouse in a knot and started to pull it tight. nursing assistant tried to undo the knot and R1 loudly stated, "why don't you help me, pull it tighter". Writer explained to her that she should not do this and R1 replied," What, commit suicide, why not get a good knot on there and pull it tight". Writer and nursing assistant were able to remove blouse. R1 continued to yell. Review of progress note dated 4/24/2015 at 6:00 p.m. by RN-I. R1 took chair pad alarm cord off chair and wrapped cord around neck. Staff intervened and removed the cord and applied Tabs to shirt instead of pad. Review of progress note dated 4/27/2015 at 10:30 a.m. by RN-F. Improvement in behaviors since start of Seroquel, bath today, was calm without any resistance.	F 157		

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F 157	Continued From page 3 Review of progress note dated 5/21/2015 at 8:00 p.m. by LPN-J. R1 very agitated and anxious. Nurse came out of med room and R1 had a Thrombo Embolic Deterrent (TED) stocking tightly wrapped around neck. Three staff intervened and removed the TED stocking. R1 yelled "let me out of here". Staff monitored, redirected and R1 calmed down. Review of progress note dated 5/23/2015 (no time) by RN-F. R1 is anxious, talking about committing suicide. Stated, "if I only had a gun". Review of progress note dated 5/28/2015 at 10:15 a.m. by RN-A. Fax sent to MD-D to update on 5/21 and 5/23/2015 behavior. Review of progress note dated 5/28/2015 at 3:00 p.m. by RN-A. Irritable, crying after fire alarm as could not go through fire door. Upset with other residents, stating, "I wish I could just die, I wish I were dead". Review of progress note dated 5/28/2015 at 6:00 p.m. by SW-K. Discussed R1's recent pattern of wrapping items around neck x's 3 in last month along with statements of self harm. Dr. felt 72 hour hold for a geriatric psychiatric review would be best for R1. Family member notified and R1 was transferred to the hospital for evaluation. Interview of Nursing Assistant - B (NA)-B on 6/23/2015 at 1:30 p.m. NA-B said that she worked with R1 frequently. NA-B said that R1 had talked about wanting to die about three months ago. She said she reported this to the charge nurse.	F 157		

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F 157	Continued From page 4 Interview of NA-C on 6/23/2015 at 11:30 a.m. NA-C said that R1 started making statements like "I am going to get a gun and shoot myself", about three months ago. NA-C said she reported the statements to the charge nurses when they occurred. Interview of Registered Nurse A (RN)-A on 6/23/2015 at 10:30 a.m. RN-A said s/he noted that R1's aggressive behavior had decreased after the resident was started on Seroquel. RN-A was aware of R1's self harm behavior but did not notify the physician or family until 5/28/2015. RN-A said that R1 was hospitalized the same day the physician and family were notified. RN-A said when there is a change in condition the nursing staff change the care plan and notify the physician and family. Interview of family member-L (FM)-L on 6/29/2015 at 10:00 a.m. FM-L said that staff from the nursing home called on 5/28/2015 at 4:30 p.m. and told her that R1 had attempted suicide several times in the past month and MD-D had placed R1 on a 72 hour hold in a geriatric psychiatric hospital for a psychiatric evaluation. No family member had been notified of R1's suicide attempts or statements at the onset. FM-L said that R1 had never attempted suicide or expressed suicidal statements before. FM-L said that prior to this the facility had been very good about communicating any changes or concerns regarding R1. Interview of Medical Doctor-D (MD)-D on 7/10/2015 at 9:10 a.m. MD-D said s/he was R1's primary physician. MD-D said that R1 was diagnosed with severe dementia and failure to thrive. R1 was in the memory care unit due to her	F 157		

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F 157	Continued From page 5 dementia and difficult to manage behaviors such as aggressive, assaultive behavior and removing clothes in public areas. MD-D said s/he prescribed Remeron for R1's depression when R1 was admitted and R1 did well for three to four months. The last two to three months R1's aggressive behavior had increased. On 4/21/2015 s/he ordered Seroquel 12.5 mg. at bedtime to address the change in behavior. MD-D said that s/he was not informed of R1's suicide attempts or statements during the next five weeks. S/he said that s/he could have adjusted the medications to address the behaviors. MD-D said she was notified on 5/28/2015 of R1's self harm behavior and talk and ordered a 72 hour hold in a geriatric psychiatric unit. MD-D said that the facility was usually very good about keeping him/her updated on the residents' conditions. S/he said the facility communicated changes in the residents' conditions by faxing a note to the clinic, phone calls and during rounds at the facility. There were multiple missed opportunities to report R1's suicidal behavior.	F 157		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide medically-related social services by not assessing or care planning the	F 250		

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F 250	Continued From page 6 resident's change in behavior when s/he expressed suicidal ideation multiple times and attempted suicide on three separate occasions over a five week period for 1 of 3 (R1)residents reviewed. Findings: Review of R1's record of admission revealed that R1 was admitted to the facility on 10/6/2014. R1's diagnosis included left hip fracture with surgical repair, osteoporosis, adult failure to thrive and dementia. Review of R1's plan of care dated April, 2015 revealed that R1 expressed delusional thoughts and had short and long term memory loss. R1 exhibited behavior such as undressing in public areas, hitting, kicking pinching and yelling sarcastic comments. Review of progress note dated 4/10/2015 at 10:00 a.m. by Social Worker- K (SW)-K. Completed Brief Interview for Mental Status(BIMS) and Patient Health Questionnaire (PHQ). R1 scored 3/15 on BIMS. Reported trouble sleeping and feeling bad about self. R1's mood/temperament changes when upset, unable to redirect. Review of progress note dated 4/20/2015 at 9:30 a.m. by RN-A, OK this AM, behaviors during bath were hitting, swearing, pinching. While attempting to dress R1 pulled staff hair, pinched, kicked, grabbed pen off counter and tried to stab a staff member. Talking loudly, telling other residents not to do things or they will kill them. Threw everything off of the counter. Continued to yell out "watch out, they are going to beat you". While	F 250		

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F 250	Continued From page 7 staff attempted to redirect to a quieter area R1 struck the staff member. Fax sent to MD regarding behaviors. Review of progress note dated 4/22/2015 at 10:00 a.m. by RN-A. Reviewed mood, behavior and delusional thoughts with MD-D. Due to delusional thoughts causing her to have anger and behaviors MD-D ordered Seroquel, 12.5 mg. at bedtime. Family called and RN reviewed Seroquel, the risks and side effects. The family member agreed to allow Seroquel to be administered to R1. (Monitoring for side effects to Seroquel is not addressed on the April 2015 care plan.) Review of progress note dated 4/24/2015 at 5:30 p.m. by LPN - H. The resident was very upset this afternoon, refused to eat supper. R1 opened front of blouse and tied the sleeves around her waist and neck. The resident tied blouse in a knot and started to pull it tight. nursing assistant tried to undo the knot and R1 loudly stated, "why don't you help me, pull it tighter". Writer explained to her that she should not do this and R1 replied," What, commit suicide, why not get a good knot on there and pull it tight". Writer and a nursing assistant were able to remove blouse. R1 continued to yell. Review of progress note dated 4/24/2015 at 6:00 p.m. by RN-I. R1 took chair pad alarm cord off chair and wrapped cord around neck. Staff intervened and removed the cord and applied Tabs to shirt instead of pad. Review of progress note dated 4/27/2015 at 10:30 a.m. by RN-F. Improvement in behaviors since start of Seroquel, bath today, was calm	F 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245407	A. BUILDING _____ B. WING _____	C 07/20/2015

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F 250	Continued From page 8 without any resistance. Review of progress note dated 5/21/2015 at 8:00 p.m. by LPN-J. R1 very agitated and anxious. Nurse came out of med room and R1 had a Thrombo Embolic Deterrent (TED) stocking tightly wrapped around neck. Three staff intervened and removed the TED stocking. R1 yelled "let me out of here". Staff monitored, redirected and R1 calmed down. Review of progress note dated 5/23/2015 (no time) by RN-F. R1 is anxious, talking about committing suicide. Stated, "if I only had a gun". Review of progress note dated 5/28/2015 at 10:15 a.m. by RN-A. Fax sent to MD-D to update on 5/21 and 5/23/2015 behavior. Review of progress note dated 5/28/2015 at 3:00 p.m. by RN-A. Irritable, crying after fire alarm as could not go through fire door. Upset with other residents, stating, "I wish I could just die, I wish I were dead". Review of progress note dated 5/28/2015 at 6:00 p.m. by SW-K. Discussed R1's recent pattern of wrapping items around neck x's 3 in last month along with statements of self harm. Dr. felt 72 hour hold for a geriatric psychiatric review would be best for R1. Family member notified and R1 was transferred to the hospital for evaluation. On 5/28/2015 the care plan was finally updated related to the resident's suicidal statements and attempts and in the problem section of the care plan it indicated thoughts/expressions of suicide. the goal was that the resident would be free from self harm. The interventions added included	F 250		

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F 250	Continued From page 9 observe the resident's moods, assess for self harm and treat, asses for plans of self harm and to remove from self harm. Interview of Nursing Assistant - B (NA)-B on 6/23/2015 at 1:30 p.m. NA-B said that she worked with R1 frequently. NA-B said that R1 had talked about wanting to die about three months ago. She said she reported this to the charge nurse. She said that she was present when R1 tied the TED stocking around her neck. It was very tight when they found her and R1 did not want to stop. NA-B and one other staff removed the sock. They watched R1 closely and informed the next shift to monitor closely. NA-B said that the NA's use the care plan to know what to do for each resident. The NA's receive a copy of the kardex at the start of their shift. Interview of NA-C on 6/23/2015 at 11:30 a.m. NA-C said that R1 started making statements like "I am going to get a gun and shoot myself", about three months ago. NA-C said she reported the statements to the charge nurses when they occurred. NA-C was on duty the evening R1 attempted to choke self with a TED stocking. She said that they removed the stocking and spent time with R1. NA-C said that after that incident the staff tried to keep R1 in the dayroom, The staff noted that R1 calmed down when she folded clothes. They had a basket of clothes that R1 would fold multiple times while in the dayroom. When R1 went to her bedroom the staff checked on her every 5-10 minutes. NA-C didn't know if this was on the care plan. Interview of Registered Nurse A (RN)-A on 6/23/2015 at 10:30 a.m. RN-A said s/he noted that R1's aggressive behavior had decreased	F 250		

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F 250	Continued From page 10 after the resident was started on Seroquel. RN-A was aware of R1's self harm behavior but did not notify the physician or family until 5/28/2015. RN-A said that R1 had made statements about wanting to die at different times while in the facility. RN-A said that R1's behavior was an ongoing issue. RN-A said that the change in behavior would have normally been reported to the physician. RN-A said that R1 was hospitalized the same day the physician and family were notified. RN-A said there are several ways that information is shared between shifts. At the change of each shift there is a verbal report, there is a 24 hour report sheet that all staff have access to and documentation in the medical record. RN-A said when there is a change in condition the nursing staff change the care plan and notify the physician and family. Interview of family member-L (FM)-L on 6/29/2015 at 10:00 a.m. FM-L said that staff from the nursing home called on 5/28/2015 at 4:30 p.m. and told her that R1 had attempted suicide several times in the past month and MD-D had placed R1 on a 72 hour hold in a geriatric psychiatric hospital for a psychiatric evaluation. No family member had been notified of R1's suicide attempts or statements at the onset. FM-L said that R1 had never attempted suicide or expressed suicidal statements before. FM-L said that prior to this the facility had been very good about communicating any changes or concerns regarding R1. Interview of Medical Doctor-D (MD)-D on 7/10/2015 at 9:10 a.m. MD-D said s/he was R1's primary physician. MD-D said that R1 was diagnosed with severe dementia and failure to thrive. R1 was in the memory care unit due to her	F 250		

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F 250	Continued From page 11 dementia and difficult to manage behaviors such as aggressive, assaultive behavior and removing clothes in public areas. MD-D said s/he prescribed Remeron for R1's depression when R1 was admitted and R1 did well for three to four months. The last two to three months R1's aggressive behavior had increased. On 4/21/2015 s/he ordered Seroquel 12.5 mg. at bedtime to address the change in behavior. MD-D said that s/he was not informed of R1's suicide attempts or statements during the next five weeks. S/he said that s/he could have adjusted the medications to address the behaviors. MD-D said she was notified on 5/28/2015 of R1's self harm behavior and talk and ordered a 72 hour hold in a geriatric psychiatric unit. MD-D said that the facility was usually very good about keeping him/her updated on the residents' conditions. S/he said the facility communicated changes in the residents' conditions by faxing a note to the clinic, phone calls and during rounds at the facility. There were multiple missed opportunities to report R1's suicidal behavior. The facility did not have a policy on responding to suicide ideation or attempts.	F 250		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER 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. 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. 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. INITIAL COMMENTS: A complaint investigation was conducted to investigate complaint #H5407008. As a result, the following correction orders are issued. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at	2 000		

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2 000	Continued From page 1 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The An abbreviated standard survey was conducted to investigate case State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications;	2 265		

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2 265	Continued From page 2 C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to inform the resident's family member and physician when the resident began making suicidal statements and gestures for one of three resident's (R1) reviewed. Findings include: Review of R1's record of admission revealed that R1 was admitted to the facility on 10/6/2014. R1's diagnosis included left hip fracture with surgical repair, osteoporosis, adult failure to thrive and dementia. Review of R1's plan of care dated April, 2015 revealed that R1 expressed delusional thoughts and had short and long term memory loss. R1 exhibited inappropriate behavior such as undressing in public areas, hitting, kicking pinching and yelling sarcastic comments. Review of progress note dated 4/10/2015 at 10:00 a.m. by Social Worker- K (SW)-K. Completed Brief Interview for Mental Status(BIMS) and Patient Health Questionnaire (PHQ). R1 scored 3/15 on BIMS. Reported	2 265		

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2 265	Continued From page 3 trouble sleeping and feeling bad about self. R1's mood/temperament changes when upset, unable to redirect. Review of progress note dated 4/13/2015 at 9:00 a.m. by Registered Nurse- F (RN)-F. Fax sent to Medical Doctor - D (MD)-D requesting a urinalysis/urine culture (UA/UC) due to increased agitation and refusing of medications. (4/16/2015 UA/UC neg.) Review of progress note dated 4/22/2015 at 10:00 a.m. by RN-A. Reviewed mood, behavior and delusional thoughts with MD-D. Due to delusional thoughts causing her to have anger and behaviors MD-D ordered Seroquel, 12.5 mg. at bedtime. Family called and RN reviewed Seroquel, the risks and side effects. The family member agreed to allow Seroquel to be administered to R1. Review of progress note dated 4/24/2015 at 5:30 p.m. by LPN - H. The resident was very upset this afternoon, refused to eat supper. R1 opened front of blouse and tied the sleeves around her waist and neck. The resident tied blouse in a knot and started to pull it tight. nursing assistant tried to undo the knot and R1 loudly stated, "why don't you help me, pull it tighter". Writer explained to her that she should not do this and R1 replied," What, commit suicide, why not get a good knot on there and pull it tight". Writer and nursing assistant were able to remove blouse. R1 continued to yell. Review of progress note dated 4/24/2015 at 6:00 p.m. by RN-I. R1 took chair pad alarm cord off chair and wrapped cord around neck. Staff intervened and removed the cord and applied Tabs to shirt instead of pad.	2 265		

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2 265	Continued From page 4 Review of progress note dated 4/27/2015 at 10:30 a.m. by RN-F. Improvement in behaviors since start of Seroquel, bath today, was calm without any resistance. Review of progress note dated 5/21/2015 at 8:00 p.m. by LPN-J. R1 very agitated and anxious. Nurse came out of med room and R1 had a Thrombo Embolic Deterrent (TED) stocking tightly wrapped around neck. Three staff intervened and removed the TED stocking. R1 yelled "let me out of here". Staff monitored, redirected and R1 calmed down. Review of progress note dated 5/23/2015 (no time) by RN-F. R1 is anxious, talking about committing suicide. Stated, "if I only had a gun". Review of progress note dated 5/28/2015 at 10:15 a.m. by RN-A. Fax sent to MD-D to update on 5/21 and 5/23/2015 behavior. Review of progress note dated 5/28/2015 at 3:00 p.m. by RN-A. Irritable, crying after fire alarm as could not go through fire door. Upset with other residents, stating, "I wish I could just die, I wish I were dead". Review of progress note dated 5/28/2015 at 6:00 p.m. by SW-K. Discussed R1's recent pattern of wrapping items around neck x's 3 in last month along with statements of self harm. Dr. felt 72 hour hold for a geriatric psychiatric review would be best for R1. Family member notified and R1 was transferred to the hospital for evaluation. Interview of Nursing Assistant - B (NA)-B on 6/23/2015 at 1:30 p.m. NA-B said that she worked with R1 frequently. NA-B said that R1 had	2 265		

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2 265	Continued From page 5 talked about wanting to die about three months ago. She said she reported this to the charge nurse. Interview of NA-C on 6/23/2015 at 11:30 a.m. NA-C said that R1 started making statements like "I am going to get a gun and shoot myself", about three months ago. NA-C said she reported the statements to the charge nurses when they occurred. Interview of Registered Nurse A (RN)-A on 6/23/2015 at 10:30 a.m. RN-A said s/he noted that R1's aggressive behavior had decreased after the resident was started on Seroquel. RN-A was aware of R1's self harm behavior but did not notify the physician or family until 5/28/2015. RN-A said that R1 was hospitalized the same day the physician and family were notified. RN-A said when there is a change in condition the nursing staff change the care plan and notify the physician and family. Interview of family member-L (FM)-L on 6/29/2015 at 10:00 a.m. FM-L said that staff from the nursing home called on 5/28/2015 at 4:30 p.m. and told her that R1 had attempted suicide several times in the past month and MD-D had placed R1 on a 72 hour hold in a geriatric psychiatric hospital for a psychiatric evaluation. No family member had been notified of R1's suicide attempts or statements at the onset. FM-L said that R1 had never attempted suicide or expressed suicidal statements before. FM-L said that prior to this the facility had been very good about communicating any changes or concerns regarding R1. Interview of Medical Doctor-D (MD)-D on 7/10/2015 at 9:10 a.m. MD-D said s/he was R1's	2 265		

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2 265	Continued From page 6 primary physician. MD-D said that R1 was diagnosed with severe dementia and failure to thrive. R1 was in the memory care unit due to her dementia and difficult to manage behaviors such as aggressive, assaultive behavior and removing clothes in public areas. MD-D said s/he prescribed Remeron for R1's depression when R1 was admitted and R1 did well for three to four months. The last two to three months R1's aggressive behavior had increased. On 4/21/2015 s/he ordered Seroquel 12.5 mg. at bedtime to address the change in behavior. MD-D said that s/he was not informed of R1's suicide attempts or statements during the next five weeks. S/he said that s/he could have adjusted the medications to address the behaviors. MD-D said she was notified on 5/28/2015 of R1's self harm behavior and talk and ordered a 72 hour hold in a geriatric psychiatric unit. MD-D said that the facility was usually very good about keeping him/her updated on the residents' conditions. S/he said the facility communicated changes in the residents' conditions by faxing a note to the clinic, phone calls and during rounds at the facility. There were multiple missed opportunities to report R1's suicidal behavior. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing could evaluate notification of Physician policies/procedures and update/revise as needed. Audits could be done to ensure staff are notifying the Physician as needed. Staff training could be provided to ensure the policies and procedures are followed as written. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 265		

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21480	Continued From page 7	21480		
21480	MN Rule 4658.1005 Subp. 2 Social Services; Social Worker Subp. 2. Social worker. A nursing home must employ a qualified social worker or a social services designee. A nursing home with more than 120 beds must have at least one filled qualified social worker position. The person or persons filling the qualified social worker position must be assigned full time to the social services of the nursing home and must fill at least one full-time equivalent position of at least 35 hours per week. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide medically-related social services by not assessing or care planning the resident's change in behavior when s/he expressed suicidal ideation multiple times and attempted suicide on three separate occasions over a five week period for 1 of 3 (R1)residents reviewed. Findings: Review of R1's record of admission revealed that R1 was admitted to the facility on 10/6/2014. R1's diagnosis included left hip fracture with surgical repair, osteoporosis, adult failure to thrive and dementia. Review of R1's plan of care dated April, 2015 revealed that R1 expressed delusional thoughts and had short and long term memory loss. R1 exhibited behavior such as undressing in public areas, hitting, kicking pinching and yelling sarcastic comments.	21480		

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21480	Continued From page 8 Review of progress note dated 4/10/2015 at 10:00 a.m. by Social Worker- K (SW)-K. Completed Brief Interview for Mental Status(BIMS) and Patient Health Questionnaire (PHQ). R1 scored 3/15 on BIMS. Reported trouble sleeping and feeling bad about self. R1's mood/temperament changes when upset, unable to redirect. Review of progress note dated 4/20/2015 at 9:30 a.m. by RN-A, OK this AM, behaviors during bath were hitting, swearing, pinching. While attempting to dress R1 pulled staff hair, pinched, kicked, grabbed pen off counter and tried to stab a staff member. Talking loudly, telling other residents not to do things or they will kill them. Threw everything off of the counter. Continued to yell out "watch out, they are going to beat you". While staff attempted to redirect to a quieter area R1 struck the staff member. Fax sent to MD regarding behaviors. Review of progress note dated 4/22/2015 at 10:00 a.m. by RN-A. Reviewed mood, behavior and delusional thoughts with MD-D. Due to delusional thoughts causing her to have anger and behaviors MD-D ordered Seroquel, 12.5 mg. at bedtime. Family called and RN reviewed Seroquel, the risks and side effects. The family member agreed to allow Seroquel to be administered to R1. (Monitoring for side effects to Seroquel is not addressed on the April 2015 care plan.) Review of progress note dated 4/24/2015 at 5:30 p.m. by LPN - H. The resident was very upset this afternoon, refused to eat supper. R1 opened front of blouse and tied the sleeves around her waist and neck. The resident tied blouse in a knot and	21480		

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	00045	A. BUILDING: _____ B. WING _____	C 07/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21480	Continued From page 9 started to pull it tight. nursing assistant tried to undo the knot and R1 loudly stated, "why don't you help me, pull it tighter". Writer explained to her that she should not do this and R1 replied," What, commit suicide, why not get a good knot on there and pull it tight". Writer and a nursing assistant were able to remove blouse. R1 continued to yell. Review of progress note dated 4/24/2015 at 6:00 p.m. by RN-I. R1 took chair pad alarm cord off chair and wrapped cord around neck. Staff intervened and removed the cord and applied Tabs to shirt instead of pad. Review of progress note dated 4/27/2015 at 10:30 a.m. by RN-F. Improvement in behaviors since start of Seroquel, bath today, was calm without any resistance. Review of progress note dated 5/21/2015 at 8:00 p.m. by LPN-J. R1 very agitated and anxious. Nurse came out of med room and R1 had a Thrombo Embolic Deterrent (TED) stocking tightly wrapped around neck. Three staff intervened and removed the TED stocking. R1 yelled "let me out of here". Staff monitored, redirected and R1 calmed down. Review of progress note dated 5/23/2015 (no time) by RN-F. R1 is anxious, talking about committing suicide. Stated, "if I only had a gun". Review of progress note dated 5/28/2015 at 10:15 a.m. by RN-A. Fax sent to MD-D to update on 5/21 and 5/23/2015 behavior. Review of progress note dated 5/28/2015 at 3:00 p.m. by RN-A. Irritable, crying after fire alarm as could not go through fire door. Upset with other	21480		

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21480	Continued From page 10 residents, stating, "I wish I could just die, I wish I were dead". Review of progress note dated 5/28/2015 at 6:00 p.m. by SW-K. Discussed R1's recent pattern of wrapping items around neck x's 3 in last month along with statements of self harm. Dr. felt 72 hour hold for a geriatric psychiatric review would be best for R1. Family member notified and R1 was transferred to the hospital for evaluation. On 5/28/2015 the care plan was finally updated related to the resident's suicidal statements and attempts and in the problem section of the care plan it indicated thoughts/expressions of suicide. the goal was that the resident would be free from self harm. The interventions added included observe the resident's moods, assess for self harm and treat, asses for plans of self harm and to remove from self harm. Interview of Nursing Assistant - B (NA)-B on 6/23/2015 at 1:30 p.m. NA-B said that she worked with R1 frequently. NA-B said that R1 had talked about wanting to die about three months ago. She said she reported this to the charge nurse. She said that she was present when R1 tied the TED stocking around her neck. It was very tight when they found her and R1 did not want to stop. NA-B and one other staff removed the sock. They watched R1 closely and informed the next shift to monitor closely. NA-B said that the NA's use the care plan to know what to do for each resident. The NA's receive a copy of the kardex at the start of their shift. Interview of NA-C on 6/23/2015 at 11:30 a.m. NA-C said that R1 started making statements like "I am going to get a gun and shoot myself", about three months ago. NA-C said she reported the	21480		

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21480	Continued From page 11 statements to the charge nurses when they occurred. NA-C was on duty the evening R1 attempted to choke self with a TED stocking. She said that they removed the stocking and spent time with R1. NA-C said that after that incident the staff tried to keep R1 in the dayroom, The staff noted that R1 calmed down when she folded clothes. They had a basket of clothes that R1 would fold multiple times while in the dayroom. When R1 went to her bedroom the staff checked on her every 5-10 minutes. NA-C didn't know if this was on the care plan. Interview of Registered Nurse A (RN)-A on 6/23/2015 at 10:30 a.m. RN-A said s/he noted that R1's aggressive behavior had decreased after the resident was started on Seroquel. RN-A was aware of R1's self harm behavior but did not notify the physician or family until 5/28/2015. RN-A said that R1 had made statements about wanting to die at different times while in the facility. RN-A said that R1's behavior was an ongoing issue. RN-A said that the change in behavior would have normally been reported to the physician. RN-A said that R1 was hospitalized the same day the physician and family were notified. RN-A said there are several ways that information is shared between shifts. At the change of each shift there is a verbal report, there is a 24 hour report sheet that all staff have access to and documentation in the medical record. RN-A said when there is a change in condition the nursing staff change the care plan and notify the physician and family. Interview of family member-L (FM)-L on 6/29/2015 at 10:00 a.m. FM-L said that staff from the nursing home called on 5/28/2015 at 4:30 p.m. and told her that R1 had attempted suicide several times in the past month and MD-D had	21480		

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21480	Continued From page 12 placed R1 on a 72 hour hold in a geriatric psychiatric hospital for a psychiatric evaluation. No family member had been notified of R1's suicide attempts or statements at the onset. FM-L said that R1 had never attempted suicide or expressed suicidal statements before. FM-L said that prior to this the facility had been very good about communicating any changes or concerns regarding R1. Interview of Medical Doctor-D (MD)-D on 7/10/2015 at 9:10 a.m. MD-D said s/he was R1's primary physician. MD-D said that R1 was diagnosed with severe dementia and failure to thrive. R1 was in the memory care unit due to her dementia and difficult to manage behaviors such as aggressive, assaultive behavior and removing clothes in public areas. MD-D said s/he prescribed Remeron for R1's depression when R1 was admitted and R1 did well for three to four months. The last two to three months R1's aggressive behavior had increased. On 4/21/2015 s/he ordered Seroquel 12.5 mg. at bedtime to address the change in behavior. MD-D said that s/he was not informed of R1's suicide attempts or statements during the next five weeks. S/he said that s/he could have adjusted the medications to address the behaviors. MD-D said she was notified on 5/28/2015 of R1's self harm behavior and talk and ordered a 72 hour hold in a geriatric psychiatric unit. MD-D said that the facility was usually very good about keeping him/her updated on the residents' conditions. S/he said the facility communicated changes in the residents' conditions by faxing a note to the clinic, phone calls and during rounds at the facility. There were multiple missed opportunities to report R1's suicidal behavior. The facility did not have a policy on responding to	21480		

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21480	Continued From page 13 suicide ideation or attempts. SUGGESTED METHOD FOR CORRECTION: The Administrator, Director of Nursing (DON), Social Services Director or designee(s) could, as a team, review and revise the policies and procedures addressing medically-related social services and management of suicidal residents. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21480		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245407 Y1	A. Building B. Wing Y2	9/1/2015 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN LUTHERAN HOME	201 SOUTH COUNTY ROAD 5 SPRINGFIELD, MN 56087

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0157 Reg. # 483.10(b)(11) LSC	Correction Completed 08/29/2015	ID Prefix F0250 Reg. # 483.15(g)(1) LSC	Correction Completed 08/29/2015	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
7/20/2015	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
00045	A. Building B. Wing	9/1/2015

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHN LUTHERAN HOME	201 SOUTH COUNTY ROAD 5 SPRINGFIELD, MN 56087

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20265 Reg. # MN Rule 4658.0085 LSC	Correction Completed 08/29/2015	ID Prefix 21480 Reg. # MN Rule 4658.1005 Subp. 2 LSC	Correction Completed 08/29/2015	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 7/20/2015	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

 EVENT ID: I4EE12