Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

<u>Facility</u>:
Hugo GW LLC
5607 North 150th Street
Hugo, Minnesota 55038
Washington County

Report #: HL23369005

Date: May 5, 2015

Date of Visit: January 27, 2015
Time of Visit: 10:00 a.m. – 3:00 p.m.

By: Lisa Jacobsen, R.N., Special Investigator

Type of Facility:
- ☐ Nursing Home
- ☐ SLF
- ☐ Hospital
- ☐ HHA
- ☐ ICF/IID
- ☐ Other: ____________
- ☒ Home Care Provider/Assisted Living
- ☐ Home Care

☐ Facility Self Report ☒ Complaint

Allegation(s): **It is alleged** that neglect of supervision occurred, when Client #1 hit and pushed down Client #2, causing injury to her/his arms and knuckles. Facility is aware of this, but does not have protocols in place to prevent reoccurrence.

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)

- [x] State Licensing Rules for Home Care (MN Rules Chapter 4668)
- [ ] State Statutes for Maltreatment of Minors (MN Statutes, section 626.556)
- [x] State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
- [x] State Statutes Chapters 144 and 144A

Conclusion:

Minnesota Vulnerable Adults Act (MN 626.557)

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

[ ] Abuse [x] Neglect [ ] Financial Exploitation was:

(•) Substantiated ( ) Not Substantiated ( ) Inconclusive based on the following information:

Based on the preponderance of evidence, neglect of supervision occurred when staff failed to reassess Client #1's aggressive behaviors in a timely manner and implement interventions to assist in keeping the clients of the facility safe.

The facility was a locked memory care unit where 25 clients resided. The facility staffed three unlicensed staff persons to pass medications and assist with personal care on the day and evening shifts. Two unlicensed persons worked the overnight shift.

Client #1 had dementia, ambulated independently and wandered throughout the facility. The client had aggressive behaviors towards staff and other clients. Interventions for staff to follow when the client displayed aggressive behaviors, were to remove the client and/or others from the situation, approach in a calm manner and medication management.

Client #2 had dementia, was oriented to person with forgetfulness and had some impaired decision making. Client #2 did not have any identified behaviors.

Client #1 went into Client #2's room and attempted to take Client #2's walker. Client #2 screamed for help and pushed the walker towards Client #1 in an attempt to get Client #1 to leave her/his room. Client #1 threw Client #2's walker aside, grabbed Client #2's arm and hit Client #2 in the head knocking Client #2's eyeglasses off. Staff arrived and the clients were separated. Client #1 was given a p.r.n. (pro ra nata or as needed) antipsychotic medication and Client #2 was given a p.r.n. anti-anxiety medication. Client #2 was noted to have bruises on her/his right forearm and on top of the right hand.

Client #1 was unable to be interviewed due to cognitive deficits.

Client #2 was interviewed and stated Client #1 came into her/his room grabbed her/his arm and pushed her/him down in the chair. Client #1 knocked Client #2's glasses off her/his face when Client #1 hit Client #2 in the head. Client #2 stated s/he was afraid of Client #1 and stated s/he puts her/his walker in front of the entrance to her/his room to try and keep Client #1 out of her/his room.

Staff stated they tried to check on Client #1 frequently, but that it was difficult because Client #1 wandered about the facility independently in and out of other clients' rooms. Staff stated that Client #1 would wander into

other clients' rooms and the clients would yell at Client #1 and Client #1 would become aggressive towards the clients. Four of four staff stated they were not aware of plan/interventions to keep Client #1 and the other clients of the facility safe when Client #1 became aggressive, except for administering a p.r.n. antipsychotic medication to Client #1, which at times was not effective.

The registered nurse was not informed of the recent incident between Client #1 and Client #2 until two days after the incident occurred. Client #1's physician ordered a psychiatric/behavioral inpatient evaluation. Client #1 was transferred to the hospital for evaluation. The hospital did not have any inpatient behavioral health beds available, so a psychiatric evaluation was not done. Client #1 had a urinary tract infection and was started on an antibiotic and returned to the facility three days later.

Incidents for the six months prior to the incident when Client #1 aggressed towards Client #2 were reviewed and revealed Client #1 had been involved in six other incidents involving other clients. The incidents involved Client #1 grabbing a client's finger, almost breaking it, poking a client in the eyebrow with a pen, hitting a client over the head with a picture frame, breaking the glass in the picture frame and hitting a client in the face with her/his fist knocking a client's eyeglasses off. The only change in Client #1's plan during this time was to increase the client's antipsychotic medication.

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 is responsible for the neglect. Although the facility had policies related to calling the nurse when there were incidents involving a client, more than one staff did not follow the policy. Although the registered nurse indicated there were additional interventions to implement when Client #1 started displaying anxiousness/agitation, direct care staff was not aware of these interventions therefore the interventions were not implemented.

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:

State Licensing Rules for Home Care (MN Rules Chapter 4668) – Compliance Met

The facility was found to be in compliance with State Licensing Rules for Home Care (MN Rules Chapter 4668). No state licensing orders were issued.

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.

State Statutes Chapters 144 & 144A – Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☒ Yes ☐ No If no, specify: ___________

(State licensing orders will be available on the MDH website.)

Facility Corrective Action:

The facility took the following corrective action(s):

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

Other pertinent medical records:

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

☒ Police Report

Additional facility records:

☐ Resident/Family Council Minutes
☒ Staff Time Sheets, Schedules, etc.
☒ Facility Internal Investigation Reports
☐ Call Light Audits
☐ Personnel Records/Background Check, etc.
☒ Facility In-service Records
☒ Facility Policies and Procedures
☐ Other, specify: ________

Number of additional resident(s) reviewed: 0

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: ________

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: ________

Did you interview additional residents: ○ Yes ● No

Total number of resident interviews: ________

Interview with staff: ● Yes ○ No ○ N/A Specify: ________

Tennessen Warning given as required: ● Yes ○ No

Total number of staff interviews: 7

Physician interviewed: ○ Yes ● No

Nurse Practitioner interviewed: ○ Yes ● No

Interview with Alleged Perpetrator(s): ○ Yes ○ No ● N/A Specify: No alleged perpetrator identified

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 ________

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

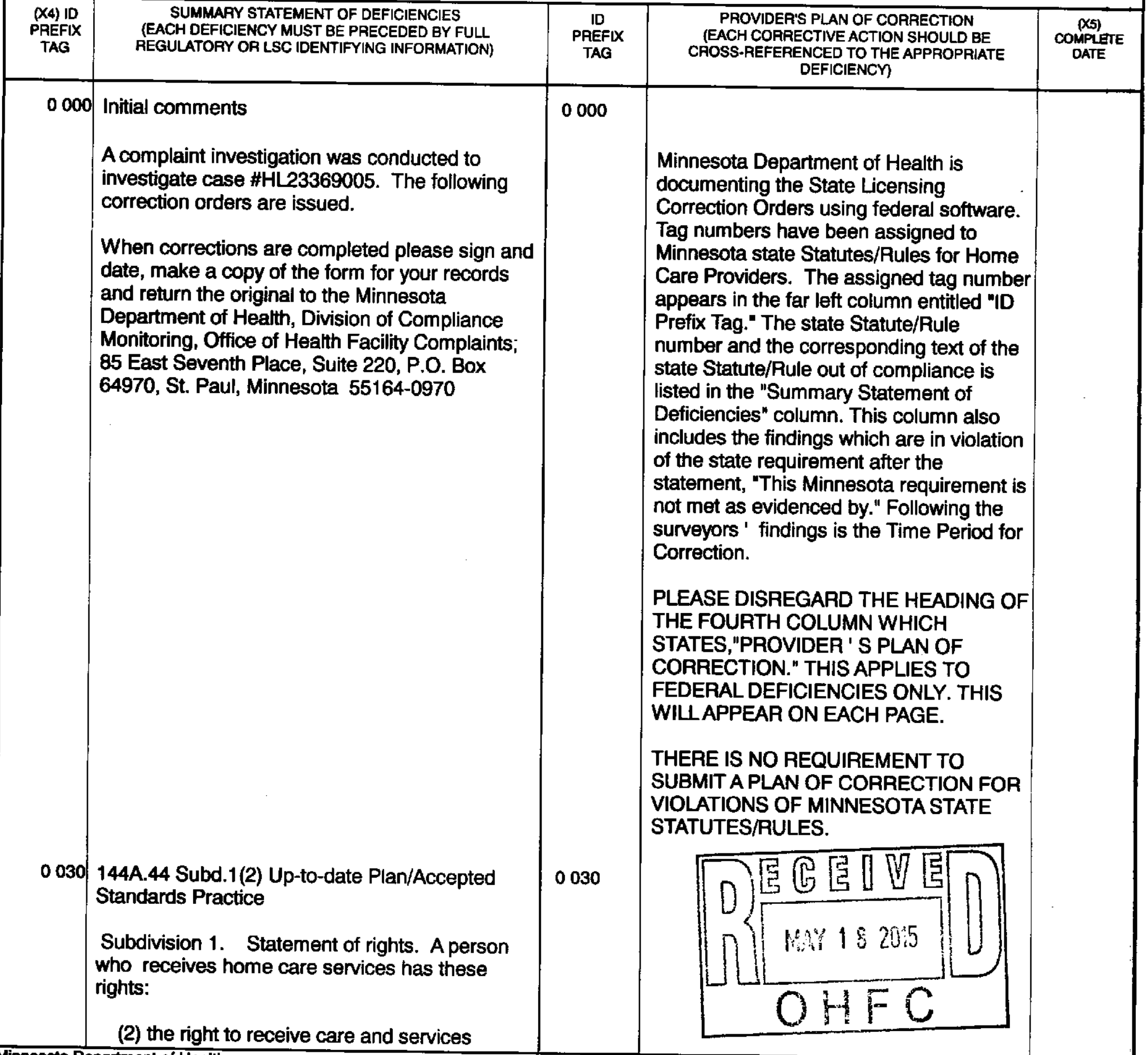
☐ Call Light ☐ Other: ________

Was any involved equipment inspected: ○ Yes ○ No ● N/A

Was equipment being operated in safe manner: ○ Yes ○ No ● N/A

Were photographs taken: ○ Yes ● No Specify: ________

xc: Health Regulation Division – Home Care and Assisted Living Program
Washington County Sheriff
Washington County Attorney
Hugo City Attorney



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H23369	A. BUILDING: ___ B. WING ___	C 04/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUGO GW LLC	5607 NORTH 150TH STREET HUGO, MN 55038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial comments A complaint investigation was conducted to investigate case #HL23369005. The following correction orders are issued. When corrections are completed please sign and date, make a copy of the form for your records and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Office of Health Facility Complaints; 85 East Seventh Place, Suite 220, P.O. Box 64970, St. Paul, Minnesota 55164-0970	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state Statutes/Rules for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute/Rule number and the corresponding text of the state Statute/Rule out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER ' S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
0 030	144A.44 Subd.1(2) Up-to-date Plan/Accepted Standards Practice Subdivision 1. Statement of rights. A person who receives home care services has these rights: (2) the right to receive care and services	0 030	RECEIVED MAY 18 2015 OHFC	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Regional Vice President (X6) DATE: 5/12/15

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0 030	Continued From page 1 according to a suitable and up-to-date plan, and subject to accepted medical or nursing standards, to take an active part in creating and changing the plan and evaluating care and services; This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to provide adequate supervision according to a client's plan for one of one client (C1) reviewed, who displayed aggressive behaviors towards other clients. The findings included: C1's record was reviewed. C1's Vulnerability Assessment and Plan reviewed at the time of the onsite visit, dated November 6, 2014 indicated the client had dementia, ambulated independently and wandered throughout the facility. The assessment further indicated the client posed a potential risk to others, because of threatening behaviors and physical violence and potential harm towards others. C1's behaviors were described as aggressive behaviors towards others. The plan listed the following interventions: to re-direct, remove the client and/or others from the situation, approach in a calm manner, and medication management. A Resident Behavior Analysis form dated August 7, 2014 at 7:30 p.m., indicated a client was sitting at the table yelling and C1 was found holding the client's wrists down. Staff intervened and got C1 away from the other client. C1 was given a p.r.n.	0 030		

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0 030	Continued From page 2 (pro ra nata or as necessary) antipsychotic medication. A Resident Behavior Analysis form dated September 2, 2014 at 6:45 p.m., indicated staff heard a client screaming. C1 had poked the client in the eyebrow with a pen. The client had no visible injury but kept rubbing the area as if she was in pain. C1 was removed from the area. Documentation indicated that no p.r.n. antipsychotic medication was given as it was not in stock. A Resident Behavior Analysis form dated September 16, 2014 at 5:30 p.m. indicated during dinner, C1 was eating other client's food, moving chairs and disrupting other clients' dinner. Staff gave C1 more food and a p.r.n. antipsychotic medication. A Resident Behavior Analysis form dated September 19, 2014 at 2:30 p.m., indicated C1 was reported to have been sitting on a chair when he was hit by another client. C1 then grabbed the client and tried to break the client's finger. The client's were separated and C1 was redirected. A Resident Behavior Analysis form dated November 17, 2014 at 5:00 p.m. indicated staff heard a client screaming. C1 had hit a client over the head with a picture frame. Glass was all over the floor and the client was screaming at C1. The client stated C1 came into her room. The client told C1 to get out and pushed C1 with her walker to attempt to get C1 out and C1 hit the client. C1 was given a p.r.n. antipsychotic medication. A progress note dated January 2, 2015 indicated that on December 30, 2014, C1 was involved in an altercation with a female client. C1 used his	0 030		

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0 030	Continued From page 3 fist to hit the female client's eye glasses off. No injuries were noted to the female client. A Resident Behavior Analysis form dated January 17, 2015 at 4:00 p.m. indicated C1 was very agitated and wandering around the facility. C1 went in to C2's room and tried to take C2's walker. C1 screamed for help. The clients were separated and C1 was given a p.r.n. antipsychotic medication and C2 was given a p.r.n. antianxiety medication. An incident report completed the following day January 18, 2015 regarding the January 17, 2015 incident between C1 and C2 indicated that C2 pushed her walker towards C1 to get C1 to leave her room. C1 threw C2's walker aside, grabbed C2's arm and hit C2 in her head knocking her glasses off. C2 was noted to have bruises on her forearm and wrist. A progress note dated January 19, 2015 indicated C1's physician was notified regarding the C1's increased aggressiveness and the physician ordered that the client have a inpatient psychiatric/behavioral evaluation. C1 was transferred to the hospital A progress note dated January 22, 2015 indicated C1 returned to the facility. A psychiatric/behavioral evaluation was not completed, as there was not an inpatient bed available, although C1 did have a urinary tract infection which was treated. When interviewed March 19, 2015 at 10:16 a.m., unlicensed person (ULP)-B stated that C1 hit out at staff and other clients. ULP-B stated staff checked on C1 frequently, but C1 wandered around the facility independently which made it	0 030		

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0 030	Continued From page 4	0 030		

difficult. ULP-B stated staff did the best they could to supervise the client. ULP-B stated staff gave C1 a p.r.n. medication for his behaviors, but a lot of times the medication did not help.

When interviewed March 17, 2015 at 3:05 p.m., ULP-C1 stated C1's agitation had a lot to do with how the other clients reacted to C1's behaviors. If other clients became upset and yelled at C2 when he wandered into their room, C2 would become aggressive toward the clients. When questioned what the plan/interventions were to keep C1 and other clients safe when C1 displayed aggressive behaviors, ULP-C stated she was not aware of a plan.

When interviewed March 17, 2015 at 1:55 p.m., ULP-F stated C1's dementia was advanced, and he frequently wandered into other client's rooms which upset the other clients. The other clients would tell C1 to get out of their room, and C1 would "snap" and become aggressive towards the other clients. When questioned what the plan/interventions were to keep C1 and other client safe when C1 displayed aggressive behaviors, ULP-F stated to give C1 a p.r.n. antipsychotic medication. ULP-F stated it was difficult, because staff could not predict when C1 was going to become agitated, as there were no warning signs.

When interviewed March 17, 2015 at 2:20 p.m., ULP-G stated C1 became agitated and aggressive towards other clients when the other clients would yell at him for taking their personal items or coming into their room. ULP-G stated she was not aware of any plan/interventions to keep C1 and the other client's safe when C1 became aggressive. ULP-G stated when she worked she tried to keep a close eye on C1.

Minnesota Department of Health

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0 030	Continued From page 5 When interviewed March 31, 2015 at 9:00 a.m., registered nurse (RN)-A stated the facility could not provide 1:1 staff for the client. If staff noticed the client moving furniture around or increased wandering, staff were to assist C1 to a quiet area to listen to music, because music seemed to calm C1. When questioned where this intervention was listed, so that staff were aware of the intervention and were able to implement it, RN-A stated it was on the individualized service plan. When questioned as what plan was implemented after C1 returned to the facility on January 22, 2015 from the hospital, RN-A stated staff kept a closer eye on C1 when he was in public areas. Interventions for staff to remove C1 to a quiet area to listen to music was not listed on C1's Vulnerability Assessment reviewed at the time of the onsite visit, nor was the intervention listed on C1's service schedule, which is the schedule the direct care staff utilize when assisting the clients. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 030		
0 085	144A.44 Subd.1(13) Served by people who are competent Subdivision 1. Statement of rights. A person who receives home care services has these rights: (13) the right to be served by people who are properly trained and competent to perform their duties;	0 085		

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0 085	Continued From page 6 This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure that unlicensed staff were properly trained and competent to perform their duties when an incident occurred between clients for two of two clients (C1 and C2) reviewed. The findings included: C1's record was reviewed. C1's Vulnerability Assessment and Plan dated November 6, 2014 indicated the client had dementia, ambulated independently and wandered throughout the facility. The assessment further indicated the client posed a potential risk to others, because of threatening behaviors and physical violence and potential harm towards others. The plan on the assessment indicated staff were to re-direct, remove the client and/or others from the situation, approach in a calm manner and medication management. C2's record was reviewed. C2's registered nurse (RN) assessment dated July 29, 2014 indicated C2 was alert, oriented to person, was forgetful and had some impaired decision-making. C2's Vulnerability Assessment and Plan dated July 29, 2014 did not identify any behaviors. A Resident Behavior Analysis form dated January 17, 2015 at 4:00 p.m. indicated C1 was very agitated and wandering around the facility. C1 went in to C2's room and tried to take C2's walker. C2 screamed for help. The client's were	0 085		

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0 085	Continued From page 7	0 085		

separated and C1 was given a pro ra nata (p.r.n.) or whenever necessary antipsychotic medication and C2 was given a p.r.n. antianxiety medication.

An incident report completed the following day January 18, 2015 regarding the January 17, 2015 incident between C1 and C2 indicated that C2 pushed her walker towards C1 to get C1 to leave her room. C1 threw C2's walker aside, grabbed C2's arm and hit C2 in her head knocking her glasses off. C2 was noted to have bruises on her forearm and wrist.

When interviewed March 17, 2015 at 3:05 p.m., ULP-C stated she heard C2 screaming, ran to C2's room and saw C1 pushing C2's walker away. ULP-C stated C1 was very agitated and C2 was crying. ULP-C stated staff are to call the nurse and the house manager when incidents such as this occurred. ULP-C stated she did not call the nurse or the house manager.

When interviewed March 17, 2015 at 1:55 P.M., ULP-F stated she heard C2 screaming and found C1 in C2's room and C1 was agitated. ULP-F stated the clients were separated. ULP-F stated C2 had bruising on her arms from C1 grabbing C2's arm. ULP-F stated she did not call the nurse to notify her of the incident, but thought that ULP-C called the nurse.

When interviewed March 17, 2015 at 2:20 p.m., ULP-G stated she reported to work the following morning on January 18, 2015 and noticed that C2 had bruises on her arms. ULP-G asked C2 what happened and C2 reported that C1 had come into her room and grabbed her walker. C2 grabbed her walker back and pushed it at C1 and C1 grabbed C2's arm causing the bruising. ULP-G stated the incident had not been documented so

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H23369	A. BUILDING: ______ B. WING ______	C 04/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUGO GW LLC	5607 NORTH 150TH STREET HUGO, MN 55038

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 085	Continued From page 8	0 085		

she documented it on an incident report.

When interviewed March 31, 2015 at 9:05 a.m., registered nurse (RN)-A stated she did not become aware of the incident between C1 and C2 until January 19, 2015 (two days later). RN-A stated neither she nor the house manager received a call from staff regarding the incident. RN-A stated any incident that occurs staff are to call the nurse and the house manager. RN-A stated had she known about the incident sooner, she would have contacted C1's physician sooner for a psychological evaluation and transfer to an inpatient unit for evaluation.

The facility's policy titled "Reporting Incidents involving Clients" which was undated, indicated that whenever there is an incident involving a client, the staff present shall immediately contact the person in charge, the RN and the House Manager. The staff present will take any emergency actions necessary for the client and then will complete an incident report as soon as possible.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
H23369	A. Building B. Wing	7/2/2015

Name of Facility	Street Address, City, State, Zip Code
HUGO GW LLC	5607 NORTH 150TH STREET HUGO, MN 55038

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix 00030 Reg. # 144A.44 Subd.1(2) LSC	Correction Completed 07/02/2015	ID Prefix 00085 Reg. # 144A.44 Subd.1(13) LSC	Correction Completed 07/02/2015	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	Date:	Signature of Surveyor:	Date:
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
4/2/2015				