



*Protecting, Maintaining and Improving the Health of Minnesotans*

Certified Mail # 7010 0780 0000 9011 0417

October 1, 2010

Mr. Michael Bond, Administrator  
Mn Veterans Home - Luverne  
1300 North Kniss, Po Box 539  
Luverne, MN 56156

Re: Enclosed State Nursing Home Licensing Orders - Project Number SL00411017

Dear Mr. Bond:

The above facility was surveyed on August 30, 2010 through September 1, 2010 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The 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 Nursing Homes.

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 and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction

Mn Veterans Home - Luverne

October 1, 2010

Page 2

and 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.

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 12 Civic Ctr Plaza 2105 Mankato Mn 56001. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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.

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.

Please feel free to call me with any questions.

Sincerely,



Maria King, RN, Unit Supervisor  
Licensing and Certification Program  
Division of Compliance Monitoring  
Telephone: 507-344-2716 Fax: 507-344-2723

Enclosure(s)

cc: Original - Facility  
~~Licensing and Certification File~~

SL00411017

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  00411	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  09/01/2010 <i>CB</i>
NAME OF PROVIDER OR SUPPLIER  MN VETERANS HOME - LUVERNE		STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
2 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: On August 30th, 31st and September 1st 2010, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to: Minnesota Department of Health, Division of</p>	2 000		

Minnesota Department of Health

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

9JYY11

If continuation sheet 1 of 7

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  00411	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  09/01/2010
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2 000	Continued From page 1  Compliance Monitoring, Licensing and Certification Program; 12 Civic Center Plaza, Suite 2105, Mankato, Minnesota 56001.	2 000		
2 540	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment  Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care as defined in part 4658.0405.  Subp. 2. Information gathered. The comprehensive resident assessment must include at least the following information: A. medically defined conditions and prior medical history; B. medical status measurement; C. physical and mental functional status; D. sensory and physical impairments; E. nutritional status and requirements; F. special treatments or procedures; G. mental and psychosocial status; H. discharge potential; I. dental condition; J. activities potential; K. rehabilitation potential; L. cognitive status; M. drug therapy; and N. resident preferences.  This MN Requirement is not met as evidenced	2 540		

Minnesota Department of Health

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2 540	<p>Continued From page 2</p> <p>by: Based on observation, interview and record review the facility failed to comprehensively assess skin conditions for 2 of 3 residents (R2 and R11) in the sample who were observed to have bruising and skin tears.</p> <p>The findings include: R11 failed to have his skin assessed to identify potential causative factors for excessive bruising on bilateral lower portions of his upper extremities.</p> <p>During observation of resident cares on 8/31/10 at 5:10 p.m. R11 was noted to have extensive bruising on bilateral lower arms. The resident had multiple bruises of different stages of healing. During interview with the resident on 8/30/10 at 6:15 pm the resident stated he noticed the bruising got worse a few months ago when he started a different medication but he could not recall the medication or the date it started. The resident stated the bruising occurred quite frequently and he felt it was related to him bumping his arms when wheeling in his wheelchair.</p> <p>During review of the R11's medical record on 8/31/10 at 11:00 a.m. it was noted the resident medical record lacked any documentation about R11's bruising on his arms in the active care plan, weekly skin assessment or quarterly skin assessments. R11's Care Plan dated 4/16/10 identified the resident with skin concerns including: edema, history of stasis ulcers and herpes zoster. The care plan lacked identification of any concerns with bruising.</p> <p>During review of the resident's weekly skin notes from 7/1/10 to present it was noted there was no documentation identifying the bruising on the</p>	2 540		

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2 540	Continued From page 3  arms of R11. The resident's initial skin assessment dated 4/15/10 failed to identify any bruising or discoloration on his arms.  During interview with the assistant Director of Nursing (ADON) on 9/1/10 at 9:30 a.m. she verified the medical record lacked any documentation about the bruising. She stated staff had failed to document the bruising.  R2 failed to have his skin comprehensively assessed to identify causes for bruising and skin tears.  During observation of resident cares on 9/1/10 at 11:00 a.m. R2 was noted to have bruising on bilateral lower portions of upper extremities and was noted to have two transparent dressings on his arms with fluid under them.  During interview with the ADON on 9/1/10 at 1:15 p.m. she stated she was unaware how the wounds or bruising occurred and verified the resident's medical record lacked any documentation of when or how the injuries may have occurred. R2's progress notes from 8/20/10 failed to identify any skin bruising or skin tears. R2's active plan of care dated 7/27/10 failed to identify bruising or skin tear concerns. A Skin Risk Factor assessment dated 7/26/10 indicated that R2 was at risk for development of pressure ulcers but failed to identify any concerns with bruising or skin tears.  During interview with the Director of Nursing (DON) on 9/1/10 at 1:30 p.m. she verified the medical record lacked any documentation on how or when the bruising and skin tears occurred. She further stated she did not investigate the injuries because she did not feel the injuries were	2 540		

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2 540	Continued From page 4 suspicious or severe.  At 1:45 p.m. R2's wounds were observed with LPN (licensed practical nurse)-C. LPN-C removed the transparent dressings and cleaned the sites and it was noted the resident had only one small skin tear on his right lower arm. The wound measured approximately 2 cm in length and was closed. The LPN stated she was not sure when the dressings were put on and was not aware how R2 had acquired the wounds.  The facility failed to assess R2 to identify risk factors for bruising and skin tears and failed to have a system in place to monitor progression of the wounds once they developed. The facility failed to demonstrate any knowledge of how the wounds occurred and failed to put interventions in place based on a comprehensive assessment to prevent further bruising or skin tears.  SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could review and revise policies and procedures pertaining to resident assessment to assure they comply with the regulations. The Director of Nursing could retrain staff and could develop an auditing program to ensure compliance.  TIME PERIOD FOR CORRECTION: Twenty-One (21) days	2 540		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin  Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there	21565		

Minnesota Department of Health

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21565	<p>Continued From page 5</p> <p>is a written order from the attending physician.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview and record review the facility failed to assess the ability to self administer medications for 1 of 10 residents (R10) in the sample who was observed to self administer a Combivent unit dosed inhaler.</p> <p>Findings include: During observation of medication administration on 8/31/10 at 8:00 a.m. Licensed Practical Nurse (LPN)-A was observed to administer oral and inhalation medications to R10. During the observation, which occurred in the main dining room, R10 was handed his Combivent unit dose inhaler and to then self administer 2 puffs in rapid succession without deeply inhaling or pausing between puffs. LPN-A failed to teach the resident how to appropriately self administer the medication and failed to intervene when he conducted the process inappropriately.</p> <p>The Nursing Drug Handbook 2010 identified patient teaching for the administration of Combivent inhalers to include having the patient: Shake the inhaler. Clear nasal passages and throat. Breathe out, expelling as much air from lungs as possible. Place mouthpiece well into mouth, seal lips around mouthpiece, and inhale deeply as you release the dose from the inhaler. Hold breath for several seconds, remove mouthpiece, and exhale slowly.</p> <p>The patient teaching section also identified if the prescriber ordered more than 1 inhalation of the medication the patient should be instructed to wait at least 2 minutes between doses.</p>	21565		



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21565	<p>Continued From page 6</p> <p>During interview with the Assistant Director of Nursing (ADON) on 9/1/10 at 11:00 a.m. she stated she had reviewed the resident's medical record and the record lacked any assessment for self administration of medications. She stated the resident should not have self administered his medications unless he had been assessed to be safe to do so.</p> <p>The facility failed to assess R10 for his ability for self-administration of medications and failed to intervene when he inappropriately self administered his Combivent inhaler.</p> <p><b>SUGGESTED METHOD OF CORRECTION:</b> The Director of Nursing could review and revise the policies and procedures related to resident self-administration of medications. The Director of Nursing could educate the appropriate personnel to these policies and could appoint a designee to monitor the procedures to ensure ongoing compliance.</p> <p><b>TIME PERIOD FOR CORRECTION:</b> Fourteen (14) days.</p>	21565			

7/7/10  
00411

**Minnesota Department Of Health  
Division of Compliance Monitoring  
Licensing and Certification Program**

INFORMATIONAL MEMORANDUM

**RECEIVED**  
  
OCT 15 2010  
  
COMPLIANCE MONITORING DIVISION  
LICENSE AND CERTIFICATION

**PROVIDER:** Mn Veterans Home - Luverne  
1300 North Kniss, Po Box 539  
Luverne, MN 56156

**DATE OF SURVEY:** August 30, 2010 through September 1, 2010

**BEDS LICENSED:**

HOSP: \_\_\_\_\_ NH: 85 BCH: \_\_\_\_\_ SLFA: \_\_\_\_\_ SLFB: \_\_\_\_\_

**CENSUS:**

HOSP: \_\_\_\_\_ NH: 83 BCH: \_\_\_\_\_ SLF: \_\_\_\_\_

**BEDS CERTIFIED:**

SNF/18: \_\_\_\_\_ SNF 18/19: \_\_\_\_\_ NFI: \_\_\_\_\_ NFII: \_\_\_\_\_ ICF/MR: \_\_\_\_\_ OTHER: Veterans Home

**NAME(S) AND TITLE(S) OF PERSONS INTERVIEWED:** Michael Bond, Administrator; Sandy Klingenberg, DON; Missy Verbrugge, ADON; Chris Myers, RN, Infection Control/Staff Development; ruth BARber, Dietary Supervisor/RD; Margene Behrens, RN; Niki Buss, RN; Debbie Campbell, HST; Shirley Connor, Recreation Coord; Stacy Dykstra, LPN; Teresa Kooiman, HST; Lois Leslie, HST; Nancy Lodes, RN; Nancy Lofthus, SW; Lynette Springman, Recreation; Ruth Spronk, LPN; Lacey Sik, HST; Lynn Somnis LPN; Linette Eischens, HST; Dorothy Erickson, RN; Twana Hartz, Homemaker; Sharon Hulstein, HST; Shirley Johnson, HST; Melinda Top, HST; Arla VanRoekel, RN; Kris Weidert, HST; Angela Meyer, Medical Record Tech; Linda McGinty, Unit Secretary; Sandy Kelm, Personnel; Larry Gielen, Maintenance Foreman; Becky VanderPoel, Account Clerk.

**SUBJECT:** Biennial Licensing Survey

**ITEMS NOTED AND DISCUSSED:**

An unannounced visit was made to determine compliance with state licensing regulations. The results of the survey were delineated during an exit conference. Refer to Exit Conference Attendance Sheet (HR116) for the names of the individuals attending the exit conference.

The exit conference was tape recorded.

SL00411017

Minnesota Department of Health  
Licensing and Certification Program

FACILITY MN VETERANS HOME - LUVERNE DATE 9/1/10

Indicate the name and title for each surveyor/supervisor on site during the survey, even those not present at the exit.

Surveyors Names and Titles

NAME Please Print	TITLE
Michele M. Chappuis	HFE Nurse Evaluator II
Joseph Garvey	HFE Nurse Evaluator II
Kathryn M. Serie	HFE Nurse Evaluator II

Exit Conference Attendees

SIGNATURE	TITLE
Mike Bow	Administrator
Annal Regano	Business Manager
Santha Kalam	Personnel
Larry Gilder	Maint
Sage Taylor	Don
Missy Verbrugge	ADON
Shirley Connor	Rec. Coord
Ruth Mason	Volunteer Services Coord
Chris Myers	Education Coordinator
Greth Barber	R.D. R.D. - dietary supervisor

**SURVEY TEAM COMPOSITION AND WORKLOAD REPORT**

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Office of Financial Management, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D.C. 20503.

Provider/Supplier Number: \_\_\_\_\_ Provider/Supplier Name: MN VETERANS HOME - LUVERNE

Type of Survey (select all that apply):

<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-------------------------------------	--------------------------	--------------------------	--------------------------

- A Complaint Investigation
- B Dumping Investigation
- C Federal Monitoring
- D Follow-up Visit
- E Initial Certification
- F Inspection of Care
- G Validation
- H Life safety Code
- I Recertification
- J Sanction/Hearing
- K State License
- L Chow

Extent of Survey (Select all that apply):

<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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- A Routine/Standard (all providers/suppliers)
- B Extended Survey (HHA or long term care facility)
- C Partial Extended Survey (HHA)
- D Other Survey

**SURVEY TEAM AND WORKLOAD DATA**

Please enter the workload information for each surveyor. Use the surveyor's information number.

Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. Team Leader 02980	08-30-2010	09-01-2010	1.00	1.00	19.00	2.00	4.00	2.00
2. 03048	08-30-2010	08-31-2010	0.00	2.00	10.50	2.50	3.00	0.00
3. 22113	08-30-2010	09-01-2010	0.50	1.50	17.50	2.00	3.00	4.00
4.								
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours ..... 0.00

Total Clerical/Data Entry Hours ..... 3.25

Was Statement of Deficiencies given to the provider on-site at completion of the survey? ..... Y



## Track & Confirm

### Search Results

Label/Receipt Number: 7010 0780 0000 9011 0417

Service(s): **Certified Mail™**

Status: **Delivered**

Your item was delivered at 9:09 am on October 04, 2010 in LUVERNE, MN 56156.

### Track & Confirm

Enter Label/Receipt Number.

[Go >](#)

### Detailed Results:

- **Delivered, October 04, 2010, 9:09 am, LUVERNE, MN 56156**
- **Notice Left, October 02, 2010, 8:16 am, LUVERNE, MN 56156**
- **Arrival at Unit, October 02, 2010, 8:15 am, LUVERNE, MN 56156**

### Notification Options

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FOIA

