Electronically delivered
January 4, 2023

Administrator
MN Veterans Home - Luverne
1300 North Kniss
Luverne, MN  56156

RE: CCN: 245631
Cycle Start Date: December 14, 2022

Dear Administrator:

On December 14, 2022, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition.  The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 14, 2023.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 14, 2023.  They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 14, 2023.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated.  Please note that the denial of payment for

new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

- Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

## NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by March 14, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Mn Veterans Home - Luverne will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 14, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

## ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same

deficient practice.

- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

## DEPARTMENT CONTACT

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

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

## PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

## VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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

## FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE

SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 14, 2023 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health

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

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
January 4, 2023

Administrator
MN Veterans Home - Luverne
1300 North Kniss
Luverne, MN  56156

Re: State Nursing Home Licensing Orders
Event ID: 1HKL11

Dear Administrator:

The above facility was surveyed on December 12, 2022 through December 14, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. 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 or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction 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.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must 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. 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:

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

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 feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245631 | A. BUILDING _____ B. WING _____ | C 12/14/2022 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>On 12/12/22 through 12/14/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.<br><br>The following complaints were found to be UNSUBSTANTIATED: H56316426C (MN86027), H56316429C (MN86293), H56316430C (MN87232), and H56316433C (MN85971).<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.<br><br>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained. | F 000 | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 01/06/2023 |

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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| | 00411 | A. BUILDING: _____ B. WING _____ | 12/14/2022 |

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| MN VETERANS HOME - LUVERNE | 1300 NORTH KNISS LUVERNE, MN 56156 |

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| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>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.<br><br>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.<br><br>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.<br><br>INITIAL COMMENTS:<br>On 12/12/22 through 12/14/22, a standard licensing survey was conducted completed at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. The following licensing orders were issued: 0900, 1375, and 1535. Please indicate in | 2 000 | | |

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| 2 000 | Continued From page 1<br>your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.<br><br>The following complaints were found to be UNSUBSTANTIATED: H56316426C (MN86027), H56316429C (MN86293), H56316430C (MN87232), and H56316433C (MN85971).<br><br>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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction.<br><br>You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must 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 | 2 000 | | |

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| 2 000 | Continued From page 2<br>the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.<br><br>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. | 2 000 | | |
| 2 900 | MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers<br><br>Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that:<br><br>A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and<br><br>B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review the facility failed to comprehensively reassess nursing interventions and notify a provider of a new and worsening pressure ulcer for 1 of 1 (R35) resident. | 2 900 | Corrected | 1/27/23 |

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| 2 900 | Continued From page 3<br><br>Findings include:<br><br>R35's quarterly Minimum Data Set (MDS) dated 10/14/22, indicated R35 was unable to complete the Brief Interview for Mental Status (BIMS). R35 felt or appeared down, depressed or hopeless for 12-14 days during the assessment period and exhibited no behaviors. R35 required supervision after set-up for eating and extensive assistance of two staff for all other activities of daily living (ADLs). R35 was frequently incontinent of bowel and bladder but was not on a toileting program. R35 also reported no pain during the assessment period. R35 was at risk for pressure ulcers and had a stage 2 (partial thickness loss of skin presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister) pressure ulcer at the time of the assessment<br><br>R35's diagnoses included congestive heart failure (CHF), chronic obstructive pulmonary edema (COPD), chronic kidney disease (CKD), dementia, failure to thrive, benign prostatic hyperplasia (BPH) with lower urinary tract symptoms (an enlarged prostate gland causing urine retention and increased frequency to urinate), above the knee amputation right leg and constipation.<br><br>R35's Care Area Assessment (CAA) dated 1/11/22, indicated R35 triggered for ADLs, urinary incontinence, nutritional status, and pressure ulcers.<br><br>R35's care plan dated 12/12/22, indicated R35 was frequently incontinent of bowel and bladder. Interventions included R35 wearing an incontinent brief at all times, and staff assisting R35 with his | 2 900 | | |

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| 2 900 | Continued From page 4<br><br>toileting needs upon rising, before and after meals, at bedtime and as needed. The care plan also indicated R35 had an open area on his right buttocks and was at risk for further breakdown related to decreased mobility, noncompliance with repositioning, cervical spine stenosis (a narrowing of the spinal column in the neck), swelling to R35's lower extremity, and an above the knee amputation to R35's right leg. R35 had a history of open areas on both buttocks, the tip of his penis, and bleeding hemorrhoids. Interventions included to follow the facility skin protocol for documentation and treatment to an open area on R35's left buttock, keeping skin clean, dry and free from pressure, reposition R35 every two hours, and assess and document R35's skin condition weekly per facility protocol. The care plan also indicated R35 had a nutrition-hydration potential for less than body requirements related to left vocal cord and larynx paralysis, dementia, failure to thrive, depression and a history of weight loss; however, the care plan lacked nutritional interventions to address R35's skin breakdown.<br><br>R35's nursing orders dated 12/7/22, indicated to reposition R35 into bed after breakfast and after noon meal for at least an hour then R35 may go to his recliner. Apply Triad to small open area on left buttocks two times a day.<br><br>R35's treatment administration record (TAR) dated October and November 2022, indicated R35 had Triad cream applied to his left buttock twice a day beginning on 10/28/22, at 8:00 p.m. to 11/12/22, at 11:37 a.m.<br><br>R35's TAR dated December 2022, indicated R35 had Triad cream applied to a small open area on his left buttocks twice a day for assessment from | 2 900 | | |

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| 2 900 | Continued From page 5<br><br>12/7/22, at 8:00 p.m. to 12/14/22, at 7:00 a.m. R35's Skin & Wound Evaluation dated 10/28/22, indicated R35 had a new, open lesion on his left buttock that was acquired at the facility. The wound bed was filled with 100% granulation (new tissue on a wound to indicate healing) with light exudate (drainage). The edges were flush with the wound bed or had a sloping edge, and there was no induration (thickened skin or tissue indicating a possible infection) or swelling. The temperature surrounding the wound was normal. Interventions included a cushion and Triad cream (a wound dressing cream). The evaluation lacked wound bed measurements and no notification to the provider, resident/responsible party, dietician, and/or therapy was indicated.<br><br>R35's Skin & Wound Evaluation dated 11/5/22, indicated R35's open lesion on his left buttock remained 100% filled with granulated tissue, with light serous (thin, yellowish) drainage. The wound edges were flush with the wound bed with no induration. The surrounding tissue was blanchable (whitening of external tissue upon compression) and a normal temperature, with no swelling. Interventions included using a generic wound cleanser, incontinence management, a turning and repositioning program, and applying Triad cream. The evaluation also indicated the wound was improving. The evaluation lacked wound bed measurements and no notification to the provider, resident/responsible party, dietician, and/or therapy was indicated.<br><br>R35's Skin & Wound Evaluation dated 11/13/22, indicated R35's open lesion on his left buttock measured a total area of 0.5 centimeters (cm), a length of 0.6 cm by a width of 0.6 cm. The evaluation lacked indication of the wound bed tissue, presence or absence of exudate, wound | 2 900 | | |

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| 2 900 | Continued From page 6<br><br>edge description, presence or absence of induration or swelling. Interventions included using a generic wound cleanser and a film membrane. The evaluation further indicated the wound had resolved and no notification to the provider, resident/responsible party, dietician, and/or therapy was indicated.<br><br>R35's Skin & Wound Evaluation dated 12/7/22, indicated R35 had a new, open lesion on his left buttock acquired at the facility. The wound measured a total area of 0.2 cm squared, a length of 0.4 cm by a width of 0.6 cm. The wound bed was filled 100% with granulated tissue with no exudate. The evaluation further indicated R35's pain was 0/10. The evaluation lacked indication of the wound edges, surrounding tissue, or the presence or absence of induration or swelling. The evaluation also lacked interventions and no notification to the provider, resident/responsible party, dietician, and/or therapy was indicated.<br><br>R35's Skin & Wound Evaluation dated 12/10/22, indicated R35's open lesion on his left buttock measured a total area of 0.4 cm squared by a length of 0.7 cm and a width of 0.7 cm (worsening from three days before). The wound bed was 100% filled with granulated tissue, however, the evaluation also indicated the wound bed had an unknown amount of epithelial tissue (new skin generation). The wound had no exudate, and the wound edges were flush with the wound bed. The surrounding tissue was fragile and at risk for breakdown, but intact. The wound had no induration or swelling and was a normal temperature. The evaluation further indicated R35's pain was 4/10 with an occasional moan or groan. R35 also indicated he was sad/frightened/frown and was tense. Interventions | 2 900 | | |

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| 2 900 | Continued From page 7<br><br>included using a generic wound cleanser and a film membrane. Although R35's wound size and pain had increased, the evaluation indicated R35's wound was stable and no notification to the provider, resident/responsible party, dietician, and/or therapy was indicated.<br><br>During an interview on 12/14/22, at 1:28 p.m. registered nurse (RN)-C stated the pressure ulcer on R35's left buttock appeared to be worse and stated a provider should have been notified whenever a resident developed a new, open skin lesion (pressure ulcer). RN-C stated the interventions for R35's pressure ulcer were nursing orders and confirmed there was no indication a provider had been notified of R35's new, open lesion, or that it had worsened despite the nursing interventions.<br><br>During an interview on 12/14/22, at 3:55 p.m. medical doctor (MD)-A stated she was unaware of R35's worsening pressure ulcer on his left buttock and verified there was no mention of the wound during the last provider's assessment in December 2022.<br><br>No facility policy related to pressure ulcers was provided by the end of the survey.<br><br>SUGGESTED METHOD OF CORRECTION:<br>The director of nursing (DON) or designee, should review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate | 2 900 | | |

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| 2 900 | Continued From page 8<br><br>care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 900 | | |
| 21375 | MN Rule 4658.0800 Subp. 1 Infection Control; Program<br><br>Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review the facility failed to conduct infection control surveillance immediately upon discovering 2 staff members developed COVID-19-like symptoms, to prevent the spread of COVID-19 according to Centers for Disease Control and Prevention (CDC) guidelines. This deficient practice had the potential to effect 39 out of 62 residents at the facility. The facility also failed to ensure all staff COVID-19 rapid self-test results were documented according to CDC guidelines and failed to appropriately disinfect 1 of 1 glucometer in between resident use.<br><br>Finding include:<br><br>SURVEILLANCE | 21375 | Corrected | 1/27/23 |

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| 21375 | Continued From page 9<br><br>Review of the Employee Illness Tracking Form dated 12/11/22, indicated RN-M called in sick for her shift from 3:00 p.m. to 11:00 p.m. due to symptoms including a cough, muscles aches, and a sore throat. The symptoms began on 12/10/22, and her COVID-19 test was negative.<br><br>During an interview on 12/13/22, at 1:46 p.m. nursing assistant (NA)-A stated prior to her overnight shift on Friday, 12/9/22, she began feeling dizzy and thought she had a fever. NA-A called the facility and was advised by registered nurse (RN)-D to go to the emergency room (ER) to be tested for COVID-19. NA-A tested positive for COVID-19 that evening and notified licensed practical nurse (LPN)-D of the results. NA-A called the facility again on 12/10/22, to ensure her shift for that night was also covered and notified RN-E of her positive COVID-19 result the night before. RN-E advised NA-A that she was already aware of her positive COVID-19 test and her weekend shifts were covered. NA-A was told to call back on Monday 12/12/22, to advise the director of nursing (DON) that she had tested positive for COVID-19.<br><br>During an interview on 12/13/22, at 3:42 p.m. RN-D stated NA-A called her at the facility on 12/9/22, and told RN-D she had a low grade fever despite taking Tylenol, and her ears were plugged. NA-A stated she would not be coming into work that night and RN-D advised NA-A to go to the ER because COVID-19 and influenza were "going around." RN-D stated staff could test themselves with a rapid COVID-19 test if they were feeling "ill"; however, RN-D did not know if there was a policy for staff testing or if there was a log to record the test results on. RN-D further stated she did not know the policy for staff leaving if they began feeling ill while at the facility and | 21375 | | |

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| 21375 | Continued From page 10<br><br>assumed "it would be based on how bad the symptoms are."<br><br>During an interview on 12/13/22, at 3:08 p.m. RN-E stated NA-A called her on Saturday 12/10/22, and told RN-E she tested positive for COVID-19 the previous evening. RN-E advised NA-A to call back on Monday 12/12/22, to notify the DON of her test results. RN-E stated she covered NA-A's shift herself on Saturday 12/10/22; however, RN-E stated she began having a sore throat on the evening of 12/10/22, and called in sick on 12/11/22. RN-E performed a rapid COVID-19 test on herself at the facility on 12/10/22 when the sore throat began but since the results were negative, RN-E finished working her shift. RN-E stated she had developed a dry cough and did not know if she needed to take another COVID-19 test prior to her next shift that week.<br><br>During an interview on 12/13/22, at 3:52 p.m. the infection preventionist (IP) stated she was unaware of NA-A's positive COVID-19 result until 12/12/22, when she checked the "ill slips" in her mailbox. The IP stated she would have expected the staff to notify herself, the DON, the assistant director of nursing (ADON), and/or the administrator as soon as they were aware of the positive result so they could conduct contact tracing to determine if other staff and/or residents had a high-risk exposure. The IP was unaware of a policy or procedure related to ongoing testing of symptomatic staff whose initial test for COVID-19 was negative. The IP further stated anytime a staff performed a rapid self-test for COVID-19, they should document the result on the Staff BinaxNOW Rapid Test Log. The IP verified the log lacked documentation of any test results for the month of December 2022. | 21375 | | |

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| 21375 | Continued From page 11<br><br>During an interview on 12/14/22, at 10:00 a.m. the IP stated RN-E was also positive for COVID-19. Although RN-E had called in sick on Sunday 12/11/22, with symptoms of a cough, muscle aches, and a sore throat, the IP did not expect staff to notify her or other management team members, nor did she feel she needed to interview RN-E immediately to determine if other staff and/or residents could have had a high risk exposure because RN-E's rapid self-test at the time of symptom onset, was negative.<br><br>During an interview on 12/12/22, at 1:31 p.m. the DON stated she was informed that morning of NA-A's positive COVID-19 test result on 12/10/22, and would have expected to be notified immediately to determine if other staff or residents had a high risk exposure and might require testing. The DON further stated staff had recently been trained to perform their own rapid COVID-19 tests and to log all results on the Staff BinaxNOW Rapid Test Log.<br><br>Centers for Medicare & Medicaid Services (CMS) QSO-20-38-NH dated 9/23/22, indicated swift identification of confirmed COVID-19 cases allowed facilities to take immediate action to remove exposure risks to nursing home residents and staff. Facilities must test any individual with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19. Testing for COVID-19 must be consistent with current standards of practice and each instance of testing must be documented that the testing was completed and include the results of each staff test. The facility is required to obtain documentation that the COVID-19 tests were completed. Regardless of staff vaccination status, staff are to report a positive viral test for | 21375 | | |

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| 21375 | Continued From page 12<br><br>SARS-CoV-2, symptoms of COVID-19, or a high-risk exposure to someone with SARS-CoV-2 to the facility. Staff with signs or symptoms of COVID-19, regardless of vaccination status, must be tested as soon as possible and are expected to be restricted from the facility pending the results. Staff who do not test positive, but have symptoms, should follow the facility guidelines to determine when they can return to work.<br><br>Review of the RN/LPN Meeting Minutes November 16, 2022, competencies for BinaxNOW were completed for all staff in attendance. Staff were able to test staff if they came "to work symptomatic or have symptoms start during their work shift." All staff testing results completed at the facility were to be recorded on the Staff BinaxNOW Rapid Test Log clipboard by the main entrance.<br><br>Review of the Staff BinaxNOW Rapid Test Log indicated no test results were documented for the month of December 2022.<br><br>Review of the facility Infection Prevention and Control Program policy dated 2/1/21, indicated any emerging pathogens that are identified that pose a risk to residents or staff, will be managed according to the CDC and Minnesota Department of Health (MDH) guidelines. The facility will maintain an active line list to readily identify outbreaks as they occur. The facility will adhere to federal and state standards to protect healthcare workers against transmission of infections agents.<br><br>A facility policy related to staff testing for COVID-19 was requested but not received.<br><br>GLUCOMETER DISINFECTION | 21375 | | |

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| 21375 | Continued From page 13<br><br>Observation on 12/13/22 at 11:50 a.m. of R7's blood sugar check with licensed practical nurse (LPN\)-C identified she obtained a multi-resident use glucometer from a tub on her medication cart. LPN-C then proceeded to check R7's blood glucose. LPN-C then brought the contaminated glucometer back to her cart, and proceeded to wipe it with a Sani-wipe disinfecting cloth for approximately 15-20 seconds and placed it back into the container on her medication cart.<br><br>Interview and manufacturer label review on 12/13/22 at 1:29 p.m., identified LPN-C noted the Sani-wipe container had a 1 minute wet-contact time. LPN-C stated she thought the product disinfected after 1 min, and was unaware the product needed to remain wet for 1 min to ensure appropriate disinfection.<br><br>Review of the March 2010, Blood Glucose Monitoring Cleaning policy identified after use, staff were to place the monitor back into the tote and allow the solution to dry for 2 minutes. There was no indication the policy had been updated to follow current manufactures guidelines on the label for wet-contact time.<br><br>SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee should review/revise facility policies to ensure they contain all components of an infection control program, including daily cumulative tracking and trending of all illnesses in the facility, immediate implementation precautions to mitigate COVID-19 transmission, and ensure staff confirmed or suspected of COVID-19 are prohibited from working with symptoms of COVID-19.<br><br>The DON (Director of Nursing) or designee | 21375 | | |

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| 21375 | Continued From page 14<br><br>should review/revise facility policies to ensure appropriate disinfection of glucometers occur between resident use. The DON or designee could educate all staff on existing or revised policies and perform measurable audits to ensure the policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring.<br><br>Time Period for Correction: Twenty-one (21) days. | 21375 | | |
| 21535 | MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General<br><br>Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:<br>A. in excessive dose, including duplicate drug therapy;<br>B. for excessive duration;<br>C. without adequate indications for its use; or<br>D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued.<br>In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not | 21535 | | 1/27/23 |

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| 21535 | Continued From page 15<br>subject to frequent change.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure 1 of 1 resident (R22) had an appropriate diagnosis for narcotic pain medication use.<br><br>Findings include:<br><br>Observation on 12/13/22 at 2:07 p.m., of R22 identified R22 appeared to be easily confused.<br><br>R22's current, undated medical diagnoses list identified R22 had chronic obstructive pulmonary disease (COPD), a history of pneumonia, depression, phobic anxiety disorder, dementia without behavioral disturbances, and adult failure to thrive. There were no diagnoses to indicated R22 had a diagnosis of terminal dyspnea.<br><br>R22's 11/26/22, physician order identified oxycodone HCL concentrate (narcotic pain medication), with instructions to give R22 0.25 milliliters (ml) orally every 6 hours as needed for dyspnea (difficulty breathing). There was no indication R22 had an order for end-of life treatment.<br><br>Review of the August, 2021, article: How Successful Is Parenteral Oxycodone for Relieving Terminal Cancer Dyspnea Compared With Morphine? A Multicenter Prospective Observational Study, located at https://pubmed.ncbi.nlm.nih.gov/33290857/#:~:text=Conclusion%3A%20Parenteral%20oxycodone%20may%20be,than%20morphine%20for%20terminal%20dyspnea, identified the conclusion was | 21535 | Corrected | |

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| 21535 | Continued From page 16<br><br>noted to whereas "oxycodone may be equally effective and safe as morphine in the treatment of terminal dyspnea in cancer patients. Future randomized controlled trials should confirm the efficacy and safety of opioids other than morphine for terminal dyspnea". There was no mention of appropriate use for routing dyspnea in the absence of a terminal diagnosis.<br><br>R22's pharmacy reviews identified R22 had no pharmacy review after the 11/26/22 order above to assist the facility in identifying appropriate associated diagnoses with medication management.<br><br>R22's 11/25/2022, physician visit note identified R22 was 90-day post hospital from having pneumonia. R22 was noted as having had quite a bit of behaviors. R22's family was refusing the Ativan (anti-anxiety medication). R22 has also had some pain which was generalized and noted to be "everywhere". R22 was refusing. The hospital recommended Roxanol at that time for his shortness of breath (related to his COPD). "His morphine had helped with that but [R22] was refusing" that medication. R22 was also noted to be hallucinating. There was no mention of the new order for oxycodone for R22's pain.<br><br>R22's progress notes identified on 11/26/22 at 2:25 p.m., staff noted they received call from the emergency room where R22 was sent for medical examination ER that they discussed R22's morphine use. Staff were directed to discontinue that and start oxycodone. The ER doctor discussed the medication regimen with R22's spouse, and she was in agreement. There was no indication staff clarified the order as to the purpose of R22's newly ordered pain medication to identify an appropriate diagnosis was | 21535 | | |

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| MN VETERANS HOME - LUVERNE | 1300 NORTH KNISS LUVERNE, MN 56156 |

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|---|---|---|---|---|
| 21535 | Continued From page 17<br>associated.<br><br>R22's 11/28/22, psychiatric note noted "apparently there is talk of consideration of palliative care, but the meeting is sched for tomorrow".<br><br>Interview on 12/14/22 at 12:44 p.m. with the assistant director of nursing (ADON) identified the palliative care meeting was rescheduled to 1/6/23 because R22 was sick. R22 often refused his morphine because "he didn't like the way the morphine made him feel". R22 had sometimes complained of tailbone pain. There was discussion of hospice, but R22 has declined. The ADON agreed dyspnea was not an approved diagnosis for narcotic pain medication in the absence of a terminal diagnosis.<br><br>Review of the 11/30/22, Medication Management policy identified each resident's drug regimen was to be free of unnecessary drugs. An unnecessary drug was a drug that had no adequate indications for use.<br><br>SUGGESTED METHOD OF CORRECTION:<br>The director of nursing (DON) or designee and the consulting pharmacist should develop and/or revise policies to monitor medications for adequate indications for use to treat a specific condition(s) as diagnosed and documented in the clinical record to ensure each resident's entire drug medication regimen is managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being and be consistent with manufacturer's recommendations and/or clinical practice guidelines, clinical standards of practice, medication references, clinical studies or evidence-based review articles that are published | 21535 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00411 | A. BUILDING: _____ B. WING _____ | 12/14/2022 |

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

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|---|---|---|---|---|
| 21535 | Continued From page 18<br><br>in medical and/or pharmacy journals. The director of nursing (DON) or designee and the consulting pharmacist should educate physicians and staff on the importance of ensuring medication ordered is appropriate for each resident's use. Audits should be developed to monitor medications for adequate indications for use and appropriate timeframe's for a specific and measurable amount of time. The DON and/or designee should take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring.<br><br>TIME PERIOD FOR CORRECTION: 21 DAYS | 21535 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245631 | A. BUILDING **01 - MAIN BLDG**<br>B. WING _____ | **12/13/2022** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **MN VETERANS HOME - LUVERNE** | **1300 NORTH KNISS**<br>**LUVERNE, MN 56156** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 12/13/2022. At the time of this survey, Minnesota Veterans Home-Luverne was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code.<br><br>The Minnesota Veterans Home consists of two (2) building additions to the original nursing home and were constructed as follows:<br>The 2009 addition is one-story, has no basement, is fully fire sprinkler protected, and is of Type V(000) construction;<br>The 2011 addition is one-story, has no basement, is fully fire sprinkler protected, and is of Type V(000) construction.<br><br>The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. All resident rooms have automatic, hard-wired smoke detectors connected to the fire alarm system. The facility is fully sprinklered.<br><br>The facility has a capacity of 85 beds and had a census of 62 at time of the survey.<br><br>The requirements at 42 CFR, Subpart 483.70(a), | K 000 | | |

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

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 245631 | A. BUILDING **01 - MAIN BLDG**<br>B. WING _____ | **12/13/2022** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **MN VETERANS HOME - LUVERNE** | **1300 NORTH KNISS**<br>**LUVERNE, MN 56156** |

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|---|---|---|---|---|
| K 000 | Continued From page 1<br>are MET. | K 000 | | |

DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
February 15, 2023

Administrator
MN Veterans Home - Luverne
1300 North Kniss
Luverne, MN  56156

RE: CCN: 245631
Cycle Start Date: December 14, 2022

Dear Administrator:

On January 4, 2023, we notified you a remedy was imposed. On January 30, 2023 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of January 27, 2023.

As authorized by CMS the remedy of:

- Mandatory Denial of Payment for new Medicare and Medicaid admissions effective March 14, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of January 4, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 14, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on January 27, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

DEPARTMENT OF HEALTH

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Electronically delivered

February 15, 2023

Administrator
MN Veterans Home - Luverne
1300 North Kniss
Luverne, MN  56156

Re: Reinspection Results
Event ID:  1HKL12

Dear Administrator:

On January 30, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 14, 2022.  At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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