Electronically Delivered

March 6, 2025

Licensee
SCMC Courage Cottage
409 East 1st Street
Morris, MN 56267

RE: Project Number(s) SL21272016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 7, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21272	A. BUILDING: _____ B. WING _____	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCMC COURAGE COTTAGE	409 EAST 1ST STREET MORRIS, MN 56267

(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 ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL21272 On February 3, 2025, through Februaury 5, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were three (3) resident(s); all of whom were receiving services under the Assisted Living Facility license.	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 for Home Care Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute 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. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144A.474 SUBDIVISION 11 (b)(1)(2).	
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630		

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0 630	Continued From page 1 (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement an individual abuse prevention plan (IAPP) to contain all the required information for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On February 4, 2025, at 9:10 a.m., the surveyor observed unlicensed personnel (ULP)-C administer medications to R1. R1 was admitted to the licensee on March 6, 2023, with diagnoses including dementia.	0 630		

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0 630	Continued From page 2 R1's Service Plan dated January 1, 2025, indicated R1 received services including ambulation, bathing assist, denture care, CPAP/BIPAP, dressing, housekeeping, laundry, medication administration, medication set up, oxygen, vitals, skin care, and safety measures. R1's resident record included an IAPP which contained: - statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults, abuse includes self-abuse; and - an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults R1's record included an IAPP which lacked: - the resident's risk of abusing other vulnerable adults. On February 4, 2025, at 11:17 a.m., registered nurse (RN)-B verified the missing criteria from R1's IAPP and stated that she would fix within their software system as she is able to input within the assessment. The licensee's Individual Abuse Prevention Plans policy dated August 11, 2021, read "4. The individual abuse prevention plan will include b. the resident's risk of abusing other vulnerable adults." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control	0 660		

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0 660	Continued From page 3 (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included a facility TB risk assessment worksheet for health care settings licensed by the Minnesota department of health (MDH). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 660		

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0 660	Continued From page 4 On February 3, 2025, surveyor requested the licensee's TB Risk Assessment. On January 3, 2025, at 1:22 p.m., and received the licensee's handmade TB Annual Risk Assessment one sided worksheet dated January 9, 2025, indicated "Risk Level: Minimal". Licensee lacked a completed TB Risk Assessment worksheet for health care settings licensed by the Minnesota department of health (MDH). Licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they were unaware of the required worksheet. The licensee's TB Prevention and Control policy dated April 3, 2024, read "Will establish and maintain a TB prevention and control program based on the most current guidelines issued by the CDC and the MDH. 2.MN Department of Health TB Risk Assessment." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to	0 680		

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0 680	Continued From page 5 all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) plan with all of the required content and failed to post an emergency preparedness plan prominently. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 680		

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0 680	Continued From page 6 cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the facility tour on February 3, 2025, at 10:50 a.m., llicensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and registered nurse (RN)-B were not able to locate licensee's EPP upon request form the surveyor and was not aware the EPP required to be posted prominently. On February 4, 2025, at 10:44 a.m. surveyor review the EPP with LALD/CNS-A and RN-D. RN-D stated they had oversight of the EPP and updated the EPP every two years. The EPP lacked the following required content: - development and maintain update annually; -process of EPP collaboration included local, tribal regional, state, and federal response; -development of EPP policies and procedures reviewed and updated annually; - a communication plan that included: - names/contact information: staff, entities providing services under agreement, residents' physicians, other facilities, and volunteers; - contact information for the following: - Federal, State, tribal, regional & local EP staff; - State Licensing and Certification Agency; - MN Office of Ombudsman for LTC; and - Other sources of assistance -subsistence needs for staff and residents; -procedure for tracking staff; -policies and procedures for volunteers; -arrangement with other facilities; and -primary/alternat means for communications.	0 680		

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0 680	Continued From page 7 On February 4, 2025, at 10:58 a.m., RN-D was unaware that some of the required information had been missing from the EPP binder. Licensee's Emergency Operations Plan policy dated August 27, 2024, read "the annual evaluation of the emergency operations plan will include a review of the scope according to the current MN department of health standards." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		

MN Department of Health
Food, Pools, and Lodging Services
PO Box 64975
St. Paul, MN 55164-0975
218-332-5150

Type: Full
Date: *02/03/25*
Time: 16:06:52
Report: 7935251009

Food and Beverage Establishment Inspection Report

Location:

Dba Scmc Courage Cottage
409 East 1st Street
Morris, MN56267
Stevens County, 75

Establishment Info:

ID #: 0038079
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3205855134
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: Fridge
Violation Issued: No

Process/Item: Receiving
Temperature: 165 Degrees Fahrenheit - Location: Soup
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
0	0	0	0

Type: Full
Date: *02/03/25*
Time: 16:06:52
Report: 7935251009
Dba Scmc Courage Cottage

Food and Beverage Establishment Inspection Report

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the MN Department of Health inspection report number 7935251009 of 02/03/25.

Certified Food Protection Manager: Dena Carbert

Certification Number: 107111 Expires: 08/03/27

Signed: _____
Establishment Representative

Signed: _____
Rebecca Tonneson
Public Health San Supervisor
Fergus Falls District Office
218-332-5142
rebecca.tonneson@state.mn.us