Electronically Delivered

October 22, 2025

Licensee
Moose Lake Village Assisted Living
300 Talbot Drive
Moose Lake, MN 55767

RE: Project Number(s) SL30390016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 30, 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 . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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,

Jessie Chenze, Supervisor
State Evaluation Team
Email: Jessie.Chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

KKM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30390	A. BUILDING: _____ B. WING _____	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOOSE LAKE VILLAGE ASSISTED LI	300 TALBOT DRIVE MOOSE LAKE, MN 55767

(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 *****ATTENTION***** 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: SL30390016-0 On September 29, 2025, through September 30, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 19 residents; 19 residents receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been 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 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 evaluators ' 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 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A,	0 480		

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0 480	Continued From page 2 existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 30, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee	0 480		

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0 480	Continued From page 3 within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the requirements of the Minnesota State Fire Code. This had the potential to directly affect all 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) and was 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). Findings include: On a facility tour on September 30, 2025, from 10:20 a.m. to 11:30 a.m., with director of maintenance (DM)-F, the following observations were made of non-compliance with the requirements of the Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511: The smoke alarm was tested by DM-F, during the	0 775		

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0 775	Continued From page 4 tour and did not function as required during the test in resident room seven in the 300 building. It was also observed the date on the back of the same alarm indicated the alarms was manufactured August 11, 2004. The smoke alarm was tested by DM-F, during the tour and did not function as required during the test in resident room four in the 500 building. It was also observed the date on the back of the same alarm indicated the alarms was manufactured November 9, 2012. It was explained to DM-F, that all smoke alarms are required to be replaced every 10 years and maintained in operational condition according to manufactures instructions and MSFC in Minnesota Rules Chapter 7511. The smoke detector tied into the building fire alarm system was covered with plastic in the mechanical room of the 500 building. It was explained to DM-F, that smoke detectors are required to be maintained free of obstructions that prevent the detection of smoke in the event of a fire. There was combustible storage (wood dresser) in the exit corridor of the 300 building. It was explained to DM-F, that storage shall be kept clear of the exit corridors to maintain full and immediate use of the exit path at all times. The was storage items located in front of the closet doors and the electrical panel located in the closet at the end of the corridor of the 500 building. It was explained to DM-F, that electrical panels shall be kept clear of obstructions that prevent immediate access to the panel in the	0 775		

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0 775	Continued From page 5 event of an emergency. During the facility tour DM-F, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) days.	0 775		
0 790 SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to identify location of fire extinguishers as required throughout the facility. This deficient condition had the ability to affect all staff, visitors, and 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 790		

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0 790	Continued From page 6 or has potential to affect a large portion or all of the residents). The findings include: On a facility tour on September 30, 2025, from 10:20 a.m. to 11:30 a.m., with director of maintenance (DM)-F, it was observed that the required fire extinguishers were inside a closet in the kitchen and the laundry room with no signage on the door indicating the location of the extinguisher. It was explained that at least one fire extinguisher with minimum 2-A:10-B:C rating is required to be provided, mounted, maintained, and located within 75 feet of travel throughout the facility in accordance with Minnesota State Fire Code Section 906. It was further explained the extinguisher is not in plain sight the door of the room or space it is located shall include signage indicating the location of the extinguisher. Fire extinguishers are required to be mounted at least 4 inches off the floor and not higher than 60 inches from the floor to the top of the extinguisher. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly, and annually replaced with a new extinguisher (of current year manufacture date) or serviced by a certified technician. During the facility tour DM-F, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) days.	0 790		

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0 800	Continued From page 7	0 800		
0 800 SS=A	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to affect a limited number of residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) 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). Findings include: On a facility tour on September 30, 2025, from 10:20 a.m. to 11:30 a.m., with director of maintenance (DM)-F, the surveyor made the following observations of facility disrepair:	0 800		

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0 800	Continued From page 8 The toilet water was continually running when entering the room in the bathrooms of resident sleeping rooms four and seven of the 300 building. It was explained that plumbing toilet fixtures are required to be maintained to automatically stop the flow of water after flushing as designed and installed at the time of construction. The exterior right side bottom door trim had a hole burrowed into it exposing the interior wall cavity caused by a rodent. It was explained that exterior trim and finish material is required to be maintained as designed and installed to prevent weather elements and animals from entering the wall cavity. During the facility tour DM-F, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and	0 810		

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0 810	Continued From page 9 (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide required evacuation drills. This had the potential to directly affect all 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 810		

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0 810	Continued From page 10 or has potential to affect a large portion or all of the residents). The findings include: On September 30, 2025, at 9:00 a.m., licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-A, and director of maintenance (DM)-F, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. DRILLS Record review of the available documentation indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by providing documentation evacuation drills were completed September 1, 2025, September 2, 2025, and July 1, 2025, only. No further documentation was provided. It was explained to LALD/CNS-A, that evacuation drills are required to be completed every other month and twice per year per shift. During an interview on September 30, 2025, at 9:45 a.m., LALD/CNS-A, stated documentation was not available indicating drills were complete every other month and twice per shift for the previous year. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		

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01490	Continued From page 11	01490		
01490 SS=F	144G.63 Subd. 4 Training required relating to dementia, menta All direct care staff and supervisors providing direct services must demonstrate an understanding of the training specified in section 144G.64. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct care staff received the required two hours of initial training on mental illness and de-escalation topics for two of three employees (licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, (unlicensed personnel) ULP-C). This had the potential to affect all residents and staff. 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on September 29, 2025, at 11:53 a.m., LALD/CNS-A stated human resource director (HRD)-G was responsible for assigning employee training and maintaining employee records.	01490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30390	A. BUILDING: _____ B. WING _____	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOOSE LAKE VILLAGE ASSISTED LI	300 TALBOT DRIVE MOOSE LAKE, MN 55767

(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
01490	Continued From page 12 LALD/CNS-A LALD/CNS-A was hired November 5, 2019, to supervise and provide direct care services to the residents of the licensee. During the course of the survey September 29, 2025, through September 30, 2025, the surveyor observed LALD/CNS-A provide care and services to the residents of the facility. LALD/CNS-A's employee record lacked documentation LALD/CNS-A completed the required training on mental illness and de-escalation topics which became effective July 1, 2025. ULP-C ULP-C was hired July 13, 2021, to provide direct care services to the residents of the licensee. On September 29, 2025, at 11:35 a.m., the surveyor observed ULP-C administering R2's scheduled medications. ULP-C's employee record included ULP-C completed 0.5 hours of de-escalation techniques and one hour of Understanding Trauma Informed Care training; however, ULP-C's record lacked evidence ULP-C completed the required initial two hours of training in mental illness and de-escalation topics which became effective July 1, 2025. On September 30, 2025, at 11:20 a.m., HRD-G stated she assigned Relias training courses (web-based training program) for all employees. HRD-G stated when assigning employee annual training, HRD-G stated she was unaware all	01490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30390	A. BUILDING: _____ B. WING _____	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOOSE LAKE VILLAGE ASSISTED LI	300 TALBOT DRIVE MOOSE LAKE, MN 55767

(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
01490	Continued From page 13 employees first needed to take the initial two hours of initial training courses on mental health and de-escalating and stated only 1.5 hours were being assigned. HRD-G stated not all staff have been assigned mental illness and de-escalating training and annual training was assigned according to hire date. The licensee's De-escalating Techniques and Procedures policy dated July 1, 2025, indicated de-escalation training would be provided upon hire and annually per the employee's individual job position and need for de-escalation skills, No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01490		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan.	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30390	A. BUILDING: _____ B. WING _____	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOOSE LAKE VILLAGE ASSISTED LI	300 TALBOT DRIVE MOOSE LAKE, MN 55767

(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
01640	Continued From page 14 (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan was revised to reflect current services provided for one of two residents (R2). 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: During the entrance conference on September 29, 2025, at 11:53 a.m., licensed assisted living director/ clinical nurse supervisor (LALD/CNS)-A stated the licensee was familiar with current minimum assisted living requirements. R2's diagnoses included hypertension (high blood pressure), dyspnea (shortness of breath), atrial fibrillation (irregular heartbeat), fracture of right radius (forearm bone) and vertebra (spine). On September 29, 2025, at 11:44 a.m., the surveyor observed unlicensed personnel (ULP)-C	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30390	A. BUILDING: _____ B. WING _____	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOOSE LAKE VILLAGE ASSISTED LI	300 TALBOT DRIVE MOOSE LAKE, MN 55767

(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
01640	Continued From page 15 put on R2's compression stockings. R2's Resident Service Plan/Agreement dated August 8, 2025, indicated R2 received the following services: weekly showers, dressing and grooming twice a day, medication administration, oxygen assistance, ambulation, transfers, laundry and housekeeping. R2's Individualized Treatment and Therapy Plan dated August 22, 2025, indicated R2 did not receive any treatment or therapy services. R2's Progress Notes dated September 2, 2025, indicated R2 requested to stop assistance with morning and evening cares, assistance with oxygen and transfers and to keep all other services. New service agreement completed and printed for resident review. R2's prescriber orders dated September 11, 2025, included orders to decrease continuous oxygen 0.5 liters per minute and ok to do trials of not wearing oxygen during the day and compression stockings were ordered August 21, 2025. R2's September 2025, Service Checkoff List indicated R2 was scheduled and received the following services and were stopped on September 2, 2025: -dressing assistance; -ambulation assistance; -oxygen assistance; and -removal of compression stockings. R2's record lacked an updated services plan to reflect current services provided by the licensee.	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30390	A. BUILDING: _____ B. WING _____	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOOSE LAKE VILLAGE ASSISTED LI	300 TALBOT DRIVE MOOSE LAKE, MN 55767

(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
01640	Continued From page 16 On September 29, 2025, at 2:50 p.m., LALD/CNS-A stated R2 had made a couple of changes to R2's services since admission. LALD/CNS-A stated LALD/CNS-A believed R2 was provided an updated service plan to review and sign; however, LALD/CNS-A provided R2 a new service plan on September 29, 2025, to sign after the surveyor inquired if R2 had an updated service plan after September 2, 2025, when R2's services had been changed. The licensee's Service Plan Contents AL MN policy dated February 7, 2025, indicated all assisted living residents have an up-to-date service plan identifying services to be provided based on the assessment by the registered nurse (RN). Service plans would include: -description of the services provided; -fees for services; -frequency of each service according to resident assessment and resident preferences; -schedule and methods of monitoring assessments; -schedule and methods of monitoring staff providing services; and -identification of staff or categories of staff who will provide the services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) day	01640		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30390	A. BUILDING: _____ B. WING _____	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOOSE LAKE VILLAGE ASSISTED LI	300 TALBOT DRIVE MOOSE LAKE, MN 55767

(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
01730	Continued From page 17 staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30390	A. BUILDING: _____ B. WING _____	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOOSE LAKE VILLAGE ASSISTED LI	300 TALBOT DRIVE MOOSE LAKE, MN 55767

(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
01730	Continued From page 18 medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the registered nurse failed to ensure an individual medication management plan was followed for one of two residents (R2) whose medications were managed and stored by the licensee. 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: R2's diagnoses included hypertension (high blood pressure), dyspnea (shortness of breath), atrial fibrillation (irregular heartbeat), fracture of right radius (forearm bone) and vertebra (spine). R2's Service Plan/Agreement dated August 8, 2025, indicated R2 received medication administration services. R2's 14-day assessment dated August 22, 2025, indicated R2's skin included redness on left inner thigh and between buttocks cheeks, R2 was unable to self-administer medication and required medication administration by the licensee.	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30390	A. BUILDING: _____ B. WING _____	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOOSE LAKE VILLAGE ASSISTED LI	300 TALBOT DRIVE MOOSE LAKE, MN 55767

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01730	Continued From page 19 R2's Individual Medication Management Plan dated August 22, 2025, indicated R2's medications were ordered by the licensed nurse and stored in the nursing office closet. R2's prescriber orders dated September 11, 2025, included Calmoseptine ointment (used to treat skin irritation) twice daily as needed to affected areas. R2's September 2025, Medication Sheet included Calmoseptine ointment and to apply topically to affected areas twice a day as needed On September 30, 2025, at 7:10 a.m., during a medication administration observation, ULP-E asked R2 if R2 needed her cream put on her buttocks. R2 stated a new tube of cream was delivered from the pharmacy and staff brought the new tube of cream and put it in R2's dresser drawer and an opened tube of cream was in R2's bathroom. ULP-E removed the new unopened Calmoseptine cream from R2's dresser drawer and opened tube of Calmoseptine from R2's bathroom and stated the creams should be kept in the nursing office. ULP-E removed R2's creams and put the creams in the secured closet in the nursing office. ULP-E stated R2's Calmoseptine should not have been in R2's room unless directed otherwise by the nurse. On February 20, 2025, at 9:47 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R2 had a few changes to services since R2's admission; however, the licensee continued to store and administer R2's medications. The licensee's MN Medication Management	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30390	A. BUILDING: _____ B. WING _____	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOOSE LAKE VILLAGE ASSISTED LI	300 TALBOT DRIVE MOOSE LAKE, MN 55767

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01730	Continued From page 20 Services-AL policy dated November 4, 2024, indicated based on the nursing assessment, the registered nurse (RN) would develop an individualized medication management plan for each resident receiving any type of medication management services, consistent with current practice standards and guidelines, and will develop specific procedures for medication management services that staff would provide. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		

Duluth District Office
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55802
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Moose Lake Village Assisted LI
300 Talbot Drive
Moose Lake, MN 55767
Carlton County
Parcel:

Phone:

License Info

License: HFID 30390

Risk:
License:
Expires on:
CFPM: THERESA HEAVIRLAND
CFPM #: FM107154; Exp: 1/25/2027

Inspection Info

Report Number: F1027251081
Inspection Type: Full - Single
Date: 9/30/2025 Time: 10:30 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 1
Total Priority 2 Orders: 0
Total Priority 3 Orders: 1
Delivery: Emailed

! **New Order: 3-300B Protection from Contamination: cross-contamination, eggs**
3-302.11A(1) *Priority Level: Priority 1 CFP#: 15*
MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.
COMMENT: RAW EGGS WERE STORED OVER READY TO EAT FOODS IN UPRIGHT COOLER IN 300 BUILDING KITCHEN. MANAGER MOVED EGGS TO BOTTOM SHELF. COS
Comply By: Complied On Site Originally Issued On: 9/30/2025

New Order: 3-300B Protection from Contamination: cross-contamination, eggs
3-302.12 *Priority Level: Priority 3 CFP#: 37*
MN Rule 4626.0240 Properly label all working containers holding food or food ingredients that are removed from original packages with the common name of the food. Label the food in English and any other languages used by employees who handle food.
COMMENT: AT TIME OF INSPECTION A CONTAINER OF SUGAR IN THE 300 BUILDING KITCHEN WAS NOT LABELED. MANAGER PLACED A LABEL ON CONTAINER. COS
Comply By: Complied On Site Originally Issued On: 9/30/2025

Food & Beverage General Comment

DISCUSSED EMPLOYEE ILLNESS AND EXCLUSIONS, REQUIRED SANITIZER STRENGTHS, AND AVOIDING BARE HAND CONTACT WITH READY TO EAT FOODS.

PASTEURIZED EGGS AND JUICE ARE OFFERED. DISCUSSED THAT ALL MEATS ARE FULLY COOKED TO REQUIRED TEMPERATURE FOR HIGHLY SUSCEPTIBLE POPULATION.

AT TIME OF INSPECTION DISH MACHINE IN 300 BUILDING KITCHEN NEEDED REPAIR. DISHES WERE BEING SANITIZED IN DISH MACHINE IN 500 BUILDING KITCHEN.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Duluth District Office inspection report number F1027251081 from 9/30/2025

Ian Harrison

THERESA HEAVIRLAND
MANAGER

Ian Harrison,
Public Health Sanitarian 3
218-302-6170
ian.harrison@state.mn.us

Duluth District Office
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55802

Temperature Observations/Recordings

Establishment Info

Moose Lake Village Assisted LI
Moose Lake
County/Group: Carlton County

Inspection Info

Report Number: F1027251081
Inspection Type: Full
Date: 9/30/2025
Time: 10:30 AM

Equipment Temperature: Product/Item/Unit: 300 KITCHEN-THERMOMETER**; Temperature Process:**
Location: Upright Cooler at 39 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: 300 KITCHEN-MILK**; Temperature Process:**
Location: Upright Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: 300 KITCHEN-THERMOMETER**; Temperature Process:**
Location: Upright Cooler at 35 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: 300 KITCHEN-SLICED CHEESE**; Temperature Process:**
Location: Upright Cooler at 39 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: 300 KITCHEN-ALL FOODS FROZEN**; Temperature Process:**
Location: Upright Freezer at Degrees F.
Comment: 3 UPRIGHT FREEZERS
Violation Issued?: No

Food Temperature: Product/Item/Unit: 300 KITCHEN-ALL FOODS FROZEN**; Temperature Process:**
Location: Chest Freezer at Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: 500 KITCHEN-ALL FOODS FROZEN**; Temperature Process:**
Location: Upright Freezer at Degrees F.
Comment: 5 UPRIGHT FREEZERS
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: 500 KITCHEN-THERMOMETER**; Temperature Process:**
Location: Upright Cooler at 34 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: 500 KITCHEN-THERMOMETER**; Temperature Process:**
Location: Upright Cooler at 36 Degrees F.
Comment:
Violation Issued?: No

<u>Food Temperature</u>: Product/Item/Unit: 500 KITCHEN-BUTTER**; Temperature Process:**
Location: Upright Cooler at 41 Degrees F.
Comment:
Violation Issued?: No

<u>Equipment Temperature</u>: Product/Item/Unit: 500 KITCHEN-THERMOMETER**; Temperature Process:**
Location: Upright Cooler at 33 Degrees F.
Comment:
Violation Issued?: No

<u>Food Temperature</u>: Product/Item/Unit: 500 KITCHEN-PEARS**; Temperature Process:**
Location: Upright Cooler at 39 Degrees F.
Comment:
Violation Issued?: No

Duluth District Office
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55802

Sanitizer Observations/Recordings

Establishment Info

Moose Lake Village Assisted LI
Moose Lake
County/Group: Carlton County

Inspection Info

Report Number: F1027251081
Inspection Type: Full
Date: 9/30/2025
Time: 10:30 AM

Sanitizing Chemical: Product: Quaternary Ammonia**; Sanitizing Process:** Pre-Soaked Towelettes
Location: Equal To 400 PPM
Comment: 300 KITCHEN
Violation Issued?: No

Sanitizing Equipment: Product: Hot Water**; Sanitizing Process:** Dish Machine
Location: Equal To 165 Degrees F.
Comment: 500 KITCHEN
Violation Issued?: No

Sanitizing Chemical: Product: Quaternary Ammonia**; Sanitizing Process:** Pre-Soaked Towelettes
Location: Equal To 400 PPM
Comment: 500 KITCHEN
Violation Issued?: No

Minnesota (MDH) Version
EH Manager; RPT: F1027251081

Food Establishment Inspection Report

Duluth District Office
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55802

No. of Risk Factor/Intervention/Violations	1	Date: 9/30/2025
No. of Repeat Risk Factor/Intervention/Violations		Time: 10:30 AM
Score (optional)		Dur: min

Establishment:	Address:	City/State:	Zip:	Phone:
Moose Lake Village Assisted LI	300 Talbot Drive	Moose Lake, MN	55767	
License/Permit #:	**Permit Holder:**	**Purpose of Inspection:**	**Est. Type:**	**Risk Category:**
HFID 30390		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Designated compliance status (IN, OUT, N/O, N/A) for each numbered item

IN=in compliance **OUT**=not in compliance **N/O**=not observed **N/A**=not applicable

Mark "X" in appropriate box for COS and/or R

COS=corrected on-site during inspection **R**=repeat violation

	Compliance Status		COS	R
	Supervision			
1	IN	Person in charge present, demonstrate knowledge and performs duties		
2	IN	Certified Food Protection Manager		
	Employee Health			
3	IN	knowledge, responsibiities, and reporting		
4	IN	Proper use of restriction and exclusion		
5	IN	Response to vomiting, diarrheal events		
	Good Hygienic Practices			
6	IN	Proper eating, tasting, drinking, tobacco use		
7	IN	No discharge from eyes, nose, and mouth		
	Preventing Contamination by Hands			
8	IN	Hands clean and properly washed		
9	N/O	No bare hand contact with RTE foods, alternatives		
10	IN	Adequate handwashing sinks supplied and access		
	Approved Source			
11	IN	Food obtained from approved source		
12	N/O	Food Received at proper temperature		
13	IN	Food in good condition, safe & unadulterated		
14	N/A	Records available: shellstock tags, parasite dest.		
	Protection From Contamination			
15	OUT	Food separated and protected	X	
16	IN	Food-contact surfaces; cleaned & sanitized		
17	IN	Proper Disposition of returned, previously served, reconditioned,& unsafe food		

	Compliance Status		COS	R
	Time/Temperature Control for Safety			
18	N/O	Proper cooking time & temperatures		
19	N/O	Proper reheating procedures for hot holding		
20	N/O	Proper cooling time and temperature		
21	N/O	Proper hot holding temperatures		
22	IN	Proper cold holding temperatures		
23	IN	Proper date marking & disposition		
24	N/A	Time as public health control;procedures & record		
	Consumer Advisory			
25	N/A	Consumer advisory provided for raw or undercooked foods		
	Highly Susceptible Populations			
26	IN	Pasteurized foods used; prohibited foods not offered		
	Food/Color Additives and Toxic Substances			
27	N/A	Food additives; approved & properly used		
28	IN	Toxic substances properly identified;stored;used		
	Conformance with Approved Procedures			
29	N/A	Compliance with variance, specialized processes & HACCP plan		

Risk factors are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health Interventions are control measures to prevent foodborne illness or injury

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" or OUT in box if numbered item is **not** in compliance Mark "X" in appropriate box for COS and/or R **COS**=corrected on-site during inspection **R**=repeat violation

			COS	R
		Safe Food and Water		
30	N/A	Pasteurized eggs used where required		
31		Water & ice from approved source		
32	N/A	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	N/O	Plant food properly cooked for hot holding		
35	IN	Approved thawing methods used		
36		Thermometers provided & accurate		
		Food Identification		
37	X	Food properly labeled; original container	X	
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present; no unauthorized person		
39		Contamination prevented during food prep, storage, & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
		Proper Use of Utensils		
43		In-use utensils; Properly stored		
44		Utensils, equipment & linens; properly stored, dried, handled		
45		Single-use & single-service articles, properly stored and used		
46		Gloves used properly		
		Utensils, Equipment and Vending		
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, used; test strips		
49		Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities; properly constructed, supplied & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing and plan review		

Person in Charge (signature)

Inspector (signature) [redacted]

Follow-up: Follow-up Date: