Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
March 15, 2021

Administrator
Stewartville Care Center
120 Fourth Street Northeast
Stewartville, MN 55976

RE: CCN: 245349
Cycle Start Date: January 21, 2021

Dear Administrator:

On March 9, 2021, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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Electronically delivered
February 2, 2021

Administrator
Stewartville Care Center
120 Fourth Street Northeast
Stewartville, MN 55976

RE: CCN: 245349
Cycle Start Date: January 21, 2021

Dear Administrator:

On January 21, 2021, a survey was completed at your facility by the Minnesota Departments 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by April 21, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by July 21, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 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.

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.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245349	A. BUILDING ______ B. WING ______	C 01/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEWARTVILLE CARE CENTER	120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976

(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
E 000	Initial Comments A COVID-19 Focused Infection Control survey was conducted on 1/20/21-2/21/21 , at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility was in full compliance Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 1/20/21-1/21/21, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found to be IN compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be UNSUBSTANTIATED: H5349040C. In addition, a COVID-19 Focused Infection Control survey was conducted at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was determined NOT to be in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/10/2021

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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F 000	Continued From page 1 Upon receipt of an acceptable electronic POC, a revisit of your facility will be conducted to validate substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-	F 883		3/3/21

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F 883	Continued From page 2 (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to provide evidence pneumococcal vaccinations were up to date for 1 of 5 residents (R6) reviewed for vaccinations. Findings include: R6's quarterly Minimum Data Set (MDS) assessment dated 11/4/20, indicated an admission date of 7/1/19. The MDS further indicated the resident had a date of birth (DOB) of 10/7/48 (72 years old) and was up to date on her pneumococcal vaccination.	F 883	Federal Regulation 483.80(d)(1)(2) Tag F883 Influenza and Pneumonia Immunizations Stewartville Care Center has policies and procedures that reflect the regulations and standards of practice for tracking and administering immunizations to residents currently residing in the facility as well as pending and new admissions. The Pneumococcal Vaccine policy was reviewed and found to be consistent with current regulations.	

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F 883	Continued From page 3 R6's MDS Admission Data Sheet dated 7/1/19, indicated the resident had received the pneumonia vaccine but did not include when and where completed. The form further did not identify which pneumococcal vaccines had been administered prior to admission. When interviewed on 1/21/21, at approximately 4:00 p.m. the director of nursing (DON) confirmed R6's medical record did not include evidence pneumococcal vaccinations had been completed. The policy titled Pneumococcal Vaccine, revised August 2016, included: Prior to or upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident has already been vaccinated. Assessments of pneumococcal vaccination status will be conducted within five (5) working days of the resident's admission if not conducted prior to admission.	F 883	The Minimum Data Set (MDS) Collection Sheet used at the time of admission gathers information regarding vaccine status including date and place of the resident□s most recent vaccine. If the resident or their representative indicate that pneumococcal vaccines are current, the facility will request verifying documentation if not already received in referral paperwork. The staff will review available vaccine information to ensure the pneumococcal vaccine is current and vaccine data will be entered to the Preventive Medicine section of the resident□s MATRIX electronic health record to ensure ready access for future review. If pneumococcal vaccine information is not available or out of date at the time of admission, the Facility Infection Preventionist will research the pneumococcal vaccination history using the Minnesota Immunization Information Connection (MIIC) system. If no current pneumococcal vaccine information is found, the resident and/or their representative will be provided information to ensure they understand the benefits and potential side effects of the vaccine as well as their right to consent to or refuse the vaccine. If consent is received, the facility will contact the resident□s primary provider to obtain orders for administration of the appropriate pneumococcal vaccine; if the vaccine is declined, the facility will notify the resident□s primary provider of the	

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F 883	Continued From page 4	F 883	declination. Resident six (R6) received the Polyvalent, PNEUMOVAX¿ 23 vaccine on February 5, 2021. An audit of the pneumococcal vaccination status for all current residents was completed February 9, 2021. All residents benefit by tracking and administering the pneumococcal vaccine in a timely manner. The licensed nursing staff will be reeducated on the vaccine regulations and related facility policies before March 3, 2021. Confirmation of the documented current pneumococcal vaccination status will be verified prior to coding on the MDS. The Facility Infection Preventionist will audit new admissions electronic medication record for pneumococcal vaccine information within five days of admission ongoing. To further monitor compliance, the Director of Nursing will audit the records of all new admissions to ensure appropriate tracking and documenting of vaccinations through April 21, 2021. Compliance for adherence to this plan will be the responsibility of the Director of Nursing with overall compliance being the responsibility of the Facility Administrator. Compliance will be reviewed at the March 2021 Quarterly Quality Assurance and Performance Improvement (QAPI) meeting.	
F 885 SS=F	Reporting-Residents,Representatives&Families CFR(s): 483.80(g)(3)(i)-(iii)	F 885		3/3/21

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F 885	Continued From page 5 §483.80(g) COVID-19 reporting. The facility must— §483.80(g)(3) Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must— (i) Not include personally identifiable information; (ii) Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and (iii) Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to appropriately inform residents, their representatives, and families by 5:00 p.m. the next calendar day following the occurrence of a single confirmed COVID-19 infection, or when three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other during the facility's outbreak. This had potential to affect all 37 residents residing in the facility.	F 885	Federal Regulation 483.80(g) Tag F885 COVID-19 Reporting Stewartville Care Center has developed and implemented COVID-19 related policies that comply with federal and state regulations. The facility policy, Reporting COVID-19" was reviewed and found to be current and consistent with the regulatory requirements.	

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F 885

Continued From page 6

Findings include:

During an interview on 1/21/21, at 1:05 p.m., the director of nursing (DON) stated the facility was not doing, and she was unaware of the requirement, to inform all residents, their representatives, and families by 5:00 p.m. the next calendar day following the occurrence of a single confirmed Covid-19 infection or of three or more residents or staff with new onset of respiratory symptoms that occurred within 72 hours of each other. Nor was the DON aware the facility was required to provide cumulative updates to residents, their representatives, and families at least weekly or by 5:00 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed Covid-19 infection is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occurs within 72 hours of each other.

During record review, an untitled document identified 43 staff persons who had tested positive for Covid-19 from 11/6/20, through 1/14/21. During an interview on 1/20/21, at 1:17 p.m., the DON stated there had been no communication to residents, resident representatives, and families regarding these staff outbreaks.

During record review, an untitled document identified 44 residents who had tested positive for Covid-19 from 11/24/20, through 1/14/21. The only communication provided to residents, resident representatives and families regarding these outbreaks was one phone call placed to resident representatives on 11/24/20. An email

F 885

To comply with COVID reporting requirements, on January 29, 2021, a letter dated January 27, 2021 was sent via the US Postal Service to all resident representatives. The letter addressed the following:

- Number of current COVID positive residents
- Number of current COVID positive staff members
- Number of COVID recovered residents
- Number of COVID recovered staff members
- Information on current and planned visitation guidance
- COVID vaccination update
- Ongoing COVID infection control mitigation efforts
- General facility information

Also included in the mailing was a Communication Method Preference questionnaire and a facility addressed stamped envelope for return. Resident families/legal representatives will be contacted regarding COVID information according to the overall preferred method indicated on the questionnaires that are returned. All residents and families/legal representatives may be impacted by and benefit from awareness of the presence of COVID/respiratory symptoms.

The facility currently has no residents or staff testing positive for COVID-19 nor does it currently have three or more

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F 885	Continued From page 7 template dated 11/24/20, was provided for review, which included the script used by individuals who placed the calls. The script read: "Hi, this is_________ from the facility. Just letting you know that we have contracted our first active case of Covid amongst the facility residents. If it was your loved one that is positive we have let you know that. Absolutely no visits are allowed at this time unless death is imminent." The script was signed by the licensed social worker (LSW-A). The script did not include information on mitigating actions taken by the facility to prevent or reduce the risk of transmission. In addition, accompanying the script were handwritten names of resident representatives and family members who were contacted by the facility. During an interview on 1/20/21, at 1:17 p.m., the DON stated there had been no other communication to residents, resident representatives, and families regarding these resident outbreaks. During a telephone interview on 1/21/21, at 2:15 p.m. when asked if the facility informed her when staff persons or residents tested positive for Covid-19, family member (FM)-A stated the facility had only informed her that her family member tested positive. "We mostly hear by word of mouth when someone has Covid." FM-A stated she would like to know if cases were increasing or decreasing, and what was being done to prevent Covid-19 in the facility. FM-A stated she received newsletters from the facility, but did not recall that the newsletters mentioned staff persons or residents having Covid-19. In addition, she did not recall receiving a phone call in November from the facility telling her about an outbreak. The name of FM-A's family member	F 885	residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. If the facility experiences a future occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other the Director of Nursing will coordinate the communication to resident representatives/family members by 5:00 p.m. the next calendar day and at least weekly for the duration of the outbreak. The Facility Infection Preventionist will coordinate the communication to residents in the facility. No personally identifiable information will be disclosed; mitigating actions taken by the facility will be addressed as well as cumulative updates on the number of residents and staff with identified COVID infections/respiratory symptoms. Licensed nursing, activity, social service and support staff who may be expected to participate in the notification process will be educated on this plan before March 3, 2021. To ensure compliance, in the event of positive staff or resident COVID tests or three or more staff or residents with respiratory symptoms, the Infection Preventionist/designee will monitor whether residents and families/legal representatives were notified of the	

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F 885	Continued From page 8 who resides at the facility was not on the 11/24/20, list as being called. During an interview on 1/21/21, at 2:40 p.m., registered nurse (RN-A) stated the facility did not tell residents when there was a positive staff person or resident; "we only tell a resident when they test positive." Facility policy titled Reporting Covid-19, with revised date of 5/6/20, indicated: Residents, their representatives, and families of those residing in the facility will be notified by 5:00 p.m. the next calendar day following the occurrence of either a single confirmed infection of Covid-19 or three or more residents or staff with new onset of respiratory symptoms within 72 hours of each other. This information was not to include personally identifiable information; it was to include information on mitigating action implemented to prevent or reduce the risk of transmission including if normal operations of the facility would be altered. In addition, the information would include any cumulative updates for the resident, resident representatives, and families at least weekly or by 5:00 p.m. the next calendar day following the subsequent occurrence of either a single confirmed infection of Covid-19, or three or more residents or staff with new-onset of respiratory symptoms within 72 hours of each other.	F 885	testing results/respiratory symptoms in a timely manner. Audits will be ongoing while the pandemic notification requirements are being enforced. Tracking of the audits will be maintained by the Director of Nursing. If noncompliance is noted, additional auditing will be done and staff education provided. This plan and compliance to it will then also be reviewed at the March 2021 Quarterly Quality Assurance and Performance Improvement (QAPI) Meeting. Compliance for adherence to this plan will be the responsibility of the Director of Nursing with overall compliance being the responsibility of the Facility Administrator.	

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
February 2, 2021

Administrator
Stewartville Care Center
120 Fourth Street Northeast
Stewartville, MN 55976

Re: Event ID: FKQM11

Dear Administrator:

The above facility survey was completed on January 21, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00429	A. BUILDING: ______ B. WING ______	C 01/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEWARTVILLE CARE CENTER	**120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments	2 000		

*****ATTENTION******

NH LICENSING CORRECTION ORDER

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.

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.

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.

INITIAL COMMENTS:
On 1/20/21 - 1/21/21, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be IN compliance with the MN State Licensure.

The following complaint was found to be UNSUBSTANTIATED:

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 H5349040C The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		