Electronically delivered
August 31, 2021

Administrator
Park Health A Villa Center
4415 West 36 1/2 Street
Saint Louis Park, MN 55416

RE: CCN: 245083
Cycle Start Date: August 10, 2021

Dear Administrator:

On August 10, 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) 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:

Jamie Perell, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: jamie.perell@state.mn.us
Office: (651) 245-8094

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 November 10, 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 February 10, 2022 (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,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245083	A. BUILDING _____ B. WING _____	C 08/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK HEALTH A VILLA CENTER	**4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416**

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F 000	INITIAL COMMENTS On 8/6/21 through 8/10/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5083106C (MN75576), with a deficiency cited at 0557. H5083102C (MN75285), with a deficiency cited at 0689. The following complaints were found to be UNSUBSTANTIATED H5083105C (MN75585) H5083104C (MN75456 & 75459) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including:	F 557		9/17/21

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

Electronically Signed | 09/03/2021

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F 557	Continued From page 1 §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to ensure staff supported the request for assistance of residents for 1 of 3 residents (R2) reviewed for dignity. R2 was told by staff to not use her call light so often, and she should be sleeping and not watching television, which caused resident anxiety about reaching out for further assistance. Findings include: R2's quarterly Minimum Data Set (MDS) dated 7/19/21, showed a brief inventory mental status (BIMS) score of 15 indicating R2 had intact cognition. Diagnosis included diabetes mellitus with foot ulcer, morbid obesity, atherosclerotic heart disease (a build-up of plaque in the arteries), muscle weakness, and abnormality of gait. R2 required 2-person extensive assistance with dressing and personal hygiene, and the use of a lift for all transferring. Investigation report dated 8/9/21, indicated R2 had reported that NA-C hollered at her for not sleeping. NA-C was immediately suspended and will no longer be able to pick up shifts for this facility from her staffing agency. R2 reported feeling safe, her physician was notified, and R2 was offered psychological services through Associated Clinic of Psychology.	F 557	R2 continues to reside at facility and was offered psychological services. All residents have the potential to be affected by the same deficient practice. After investigation, perpetrator's agency has been called and notified we will no longer allow her into the facility, and updated them on outcome of investigation. Residents were interviewed and no further concerns were brought forward. Incident was isolated. All staff will be educated on treating resident with respect and dignity including while answering call lights, choice of bedtime and ability watch TV at an appropriately level as they choose. Audits will be of 5 residents weekly X 4weeks to ensure they are being treated with dignity and respect and reviewed at Quality Assurance Meeting (QAPI) monthly to determine if any trends are identified and recommendations made for continued audits and monitoring needs. Completion Date 9/17/2021.	

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Upon interview with R2 on 8/10/21, at 1:08 p.m. R2 reported that NA-C came into her room along with another nursing assistant at 11:00 p.m. one day last week and changed R2's clothing and incontinence brief for bed. The same night around 1:00 a.m. R2 needed to use the bathroom and NA-C and the same nursing assistant assisted her. At about 1:30 a.m. R2 turned on her call light again as her remote control had fallen onto the floor. NA-C came into the room alone and stated, "don't you ever sleep? You call us all night; you should not be watching television when you should be sleeping." R2 stated "I felt like a child." R2 reported always having television on for white background noise. R2 reported she didn't sleep the rest of the night and was anxious about having to turn her call light on again for assistance while NA-C was still working.

Upon interview on 8/9/21, at 2:36 p.m. NA-C reported that she isn't allowed in "that facility" anymore. The NA-C reported the nights are too busy for the staff. NA-C stated that R2 is morbidly obese and uses her call light all night. NA-C reported she was simply telling R2 that "staff are very busy and not to call all night and that R2 should be sleeping because it doesn't help for a television to be on during the night."

Upon interview with the Administrator on 8/9/21, at 3:15 p.m. she reported that NA-C is pool staff and has received training. The training documents that are sent to the agency prior to working their first shift. NA-C did complete this training. The staffing agency makes sure the pool staff read and sign the forms that talk about expectations, abuse policies and facility specific information. Upon arrival of the first shift the pool staff have an on-floor skills training. This training

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is signed off by DON or ADON for orientation. The administrator stated, "it is expected pool staff treat the residents the same as the regular staff treat the residents." NA-C had been removed from the schedule and will not be returning to the facility.

Upon interview director of nursing (DON) on 8/10/21, 10:21 a.m. reported that all pool staff are trained via forms policies/expectations sent to staffing agency. The facility does not go over the forms with the pool staff prior to working at the facility. The DON remarked that the NA-C has worked at the facility for many months with any incidents. The DON stated pool staff have the safe expectations as the facility staff, they are expected to following rules and guidelines, do rounds, do cares, treat with dignity, and respect and communicate with nurses NA-C appropriately.

Pool training Acknowledgement of Receipt reads "I acknowledge that I received a copy of the Code of Conduct for Villa's Compliance Program. I agree to conduct myself in in conformity with all of its requirements, to adhere to the spirit and letter of the Code of Conduct and to cooperate with management in carrying out the important objectives of this compliance form."

Code of Conduct letter dated 2013, reads "Taking care of people is important work. It is at Villa's core and delivering care and services that we each can be proud of is our first priority. Consistent with this value is recognition that taking care of people is without shortcuts or ignorance of Villa policies, procedures and guidelines or State and Federal requirements. When short cuts are taken, or requirements are

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F 557	Continued From page 4 shown the due respect and attention, standards will be enforced with accompanying consequences. Simply put, aberrant behavior will be addressed swiftly and constructively. Operating with integrity is not something."	F 557		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure adequate supervision and care planned interventions for a resident who was assessed to be cognitively impaired and an elopement risk for 1 of 3 residents. R1 was found outside on the patio on the first floor in the smoking area wanting to smoke, then days later eloped from the facility and made his way to a hospital where he was discharged to the community. Findings include: R1's admission minimum data set (MDS) assessment dated 5/25/21, indicated a Brief Interview for Mental Status (BIMS) score of 2 indicating severe cognitive impairment. R1 required extensive assistance with dressing, hygiene, and toileting. R1 was a 2-person assist for transfers and ambulation in room due to	F 689	R1 is no longer in the facility. All cognitively impaired with elopement risk have the potential to be affected. All residents have been assessed, and measures are in place as needed per elopement assessment. Elopement drills were conducted on each shift for 2 days and once a week thereafter. Staff responded appropriately. All new residents will be assessed upon admission for elopement risk, reviewed quarterly and as needed. All staff will be educated on elopement assessment and interventions. Designee will complete audit on 5 residents weekly for 4 weeks on elopement assessments and care planning interventions. Administrator/designee will bring all audits through Quality Assurance Meeting	9/17/21

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F 689	Continued From page 5 unsteady gait. R1 had a walker. R1's diagnosis included metabolic encephalopathy (neurological disorder of the brain), dysphagia (difficulty swallowing), alcohol dependent, muscle weakness, abnormalities of gait and mobility, and malnutrition. R1's care plan dated 7/15/21, indicated R1 had communication problem, interventions included anticipating and meeting needs to and observe for non-verbal cues that would indicate needs or understanding such as nodding, facial grimaces and shaking head. The interventions for R1's non-compliance with smoking rules for a cognitively impaired smoker included offering smoking cessation support and not allowing R1 outside to smoke cigarettes due to his inability to ambulate safely through the elevator and lower level to smoking area. On 7/23/21 R1's progress note indicated R1 went to the smoking area unattended. R1 ambulated from his room on the second floor through the basement door to the outdoor patio. He stated he was going to smoke; however, R1 did not have any smoking materials at the facility. R1 had been exit seeking throughout the day, watching the entry way. R1 was deemed to be an unsafe smoker due to a diagnosis of encephalopathy. A wander guard was placed on R1. R1's smoking assessment dated 7/23/21, indicated R1 was an unsafe smoker. "Resident has impaired awareness and orientation, including inability to understand facility safe smoking policy." R1 had a score of a 3 on smoking assessment. A score of 3-9 indicated an unsafe smoker.	F 689	(QAPI) monthly to determine if any trends are identified and recommendations made for continued audits and monitoring needs. Completion Date 9/17/2021.	

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R1's elopement assessment dated 7/25/21, indicated R1 was assessed to be an elopement risk with a score of 14, total score equal to or greater than 6 indicates an elopement risk. R1 was ambulatory, was cognitively impaired, attempted to exit unit or facility. Interdisciplinary team "perceived they needed to be doing something as he wandered aimlessly about the facility."

Alert Note dated 7/28/21, at 10:29 p.m. indicated R1 was not in his room at 6:32 p.m. R1 was last visually observed at 6:10 p.m. after nursing assistant (NA)-A picked up his dinner tray. He was lying in bed with his blanket on. The inhouse supervisor called a "Code White" drill. The facility searched all rooms and closets on the first and second levels. The building parameter was searched along with the immediate community. The police were notified.

Investigation summary dated 8/2/21, indicated on 7/28/21, R1 was last seen in his bed at 6:15 p.m. NA-A had entered another residents room, heard the alarm sounding and went immediately to the Northwest door. NA-A checked his surroundings to ensure there was not a resident around. NA-A checked to see if there was a resident or staff who had triggered the alarm but did not see anymore. NA-A went back to R1's room to see if he was there and realized he was not. Code White was called. The DON and Administrator were notified. The building and the surrounding areas were searched. The police and R1's sister were notified. Local shelters and hospitals were called multiple times. R1 was previously homeless. R1 navigated to downtown Minneapolis and was taken to Hennepin County Medical Center emergency department around

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midnight. The hospital provider discharged R1 home to the community from the emergency department around 2:00 a.m. per R1's choice. Due to the efforts to locate R1 on 07/28/21 Hennepin County Medical Center became aware R1 was a resident of the facility. On 7/29/21, 7:30 a.m. the clinical liaison from Hennepin County Medical Center notified the facility that R1 was located at Hennepin County Medical Center again, was safe and ready for discharge.

Upon interview on 8/6/21, at 10:07 a.m. NA-B reported when an alarm sounds all staff goes immediately to the concern. If a resident is not seen the staff will go out the door and look around. Staff will notify the supervisor immediately. For the residents who wear a wanderguard, those residents are redirected away from any exits, to try to avoid an elopement. The elopement is a Code White. If Staff are not aware of where the incident is, staff attempt to go where the sound is coming from. NA-B reported staff are aware which residents are on elopement risk by the elopement book and a photo each elopement risk resident at both nursing stations. "We check on them every 30 minutes." NA-B verified the 30 minutes checks are not on any staff worksheets, care plan, or documented anywhere.

Upon interview on 8/6/21, at 10:46 a.m. licensed practical nurse (LPN)-A reported all residents are assessed at admission for elopement, if there are concerns the concerns are care planned and a wanderguard is placed on the resident. LPN-A reported R1's elopement happened around 6:30 p.m. LPN-A was onsite by 7:00 p.m. until 9:30 p.m. 911 was called immediately. Staff searched around outside, called local hospitals,

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and followed up with local shelters as resident had been homeless. R1 was found and taken to Hennepin County Medical Center and discharged to the Salvation Army Shelter. R1 did not have identifying information that he lived at facility. R1 was discharged from our facility and admitted to another A villa location. LPN-A stated following the incident the facility felt that it was more appropriate for him there. R1 really wants to smoke and it's not conducive for him at this facility,

Upon interview on 8/6/21, at 1:14 p.m. registered nurse (RN)-B reported the interventions the facility had for elopement risk residents is they are given a room assignment across from the nurse's station and a picture of the residents at risk for elopement are posted at both nurse's stations. (RN)-B stated staff are to check frequently for residents' whereabouts and if elopement risk residents are wandering. The staff are to read specific triggers and redirection techniques for residents who are exit seeking. RN-B verified there are no specific times to "check frequently" and no documentation required.

Upon interview at 8/6/21, at 1:48 p.m. the social worker (SW) reported the night of the elopement all administration staff were immediately called back into the building with various duties. The SW went driving around the vicinity, checked parked cars, apartments nearby, and stores asking about R1. On 8/7/21, in the morning the facility found out that R1 "somehow showed up at HCMC." R1 showed up at HCMC and staff did not know where he lived. R1 was discharged and ended up at a Salvation Army. R1 left the Salvation Army and again presented to the

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emergency department at HCMC. Upon hospital discharge R1 reported not wanting to go back to Park Health A Villa. R1 kept talking about wanting to be able to smoke. It was suggested that R1 got to a facility where R1 can smoke in a safe environment. Both facilities agreed with the transfer.

On 8/9/21, at 11:29 a.m. the administrator reported staff had just been with R1 when the door alarm went off, staff went to the door, did a stairway and building sweep. They were unable to find R1, a Code white was called, the administration staff arrived, and the search for R1 continued. In personeEducation was performed with all staff on each shift covering elopement. Staff are to answer all alarms, oxygen, door, and fire. The administrator verified staff had been verbally told to check on the residents assessed for elopement concerns about every 30 minutes, however they see them at mealtimes, during med passes, with activities, during cares and as they walk by rooms. Safety checks are not documented.

Upon interview on 8/10/21, at 11:54 a.m. NA-A reported on the night R1 eloped NA-A left R1's room and by the time NA-A got to the exit door another co-worker was already there. NA-A did room checks first for the residents who are at risk for elopement and then did a complete building sweep and notified staff. NA-A reported receiving hands on training following the elopement and the facility did drills. NA-A verified there is no confirmed times to check on elopement risk residents for safety.

Wandering and Elopement Guideline dated 3/16/17, indicated after an evaluation is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245083	A. BUILDING _____ B. WING _____	C 08/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK HEALTH A VILLA CENTER	**4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 10 completed and a resident is deemed an elopement risk a plan of care will be developed that will identify the elopement risk. A resident centered specific interventions to minimize or prevent exit seeking and/or wandering behaviors. A plan to anticipate and meet physical, physiological, environment and psychological influences. A plan that evaluates the identified risk with implemented measure to provide safety and security.	F 689		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 31, 2021

Administrator
Park Health A Villa Center
4415 West 36 1/2 Street
Saint Louis Park, MN 55416

Re: State Nursing Home Licensing Orders
Event ID: EU0S11

Dear Administrator:

The above facility was surveyed on August 6, 2021 through August 10, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Jamie Perell, Unit Supervisor
Metro B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: jamie.perell@state.mn.us
Office: (651) 245-8094

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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