



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 6, 2025

Administrator
Mayo Clinic Health System - Lake City
500 West Grant Street
Lake City, MN 55041

RE: CCN: 245218
Cycle Start Date: December 18, 2024

Dear Administrator:

On December 18, 2024, a survey was completed at your facility by the Minnesota Department of Health 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 actual harm that was not immediate jeopardy (Level G).

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS location.

- Civil money penalty, (42 CFR 488.430 through 488.444).

You will receive a formal notice from the CMS location only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$12,924; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

The CMS location may notify you of their determination regarding any imposed remedies.

DEPARTMENT CONTACT

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

Lisa Krebs, Regional Operations Supervisor, Rapid Response

Health Regulation Division

Minnesota Department of Health

Rochester District Office

3425 40th Avenue NW, Suite 115

Rochester, MN 55901

Email: Lisa.Krebs@state.mn.us

Office (507) 206-2728

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)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Sincerely,



Holly Zahler, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

Orville L. Freeman Building | HRD 3A 3rd Floor

Office: 651-201-4384

Email: holly.zahler@state.mn.us

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/06/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245218	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/18/2024
NAME OF PROVIDER OR SUPPLIER MAYO CLINIC HEALTH SYSTEM - LAKE CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 500 WEST GRANT STREET LAKE CITY, MN 55041		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS On 12/17/24 and 12/18/24, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following complaint was reviewed: H52182602C (MN108987) and a deficiency was issued at F760 at PAST NON-COMPLIANCE. Although the provider had implemented corrective action prior to survey, a G-level deficiency was sustained prior to the survey. No plan of correction is required for a finding of past non-compliance; however, the facility must acknowledge receipt of the electronic documents.	F 000			
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were administered to the correct resident for 1 of 3 residents (R1) reviewed for medication errors. This failure resulted in actual harm when R1 became hypotensive that required treatment in the emergency department (ED) and ongoing symptom monitoring and treatment. The facility had implemented appropriate corrective action prior to the onsite investigation so the deficiency is being cited at past non-compliance.	F 760	Past noncompliance: no plan of correction required.		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F 760	<p>Continued From page 1</p> <p>Findings include:</p> <p>R1's quarterly Minimum Data Set (MDS) dated 10/17/24, identified R1's cognition was intact and had diagnoses of chronic kidney disease stage 3b (moderate to severe loss of kidney function) and hyponatremia (low blood sodium).</p> <p>R1's order summary dated 11/18/24, identified R1 was to receive the following oral medications in the morning: acetaminophen (for back pain)1000 milligrams (mg), aspirin (for stroke prophylaxis) 81 mg, citalopram (for depression)10 mg, and multivitamin.</p> <p>R1's medication administration record (MAR) dated 12/10/24, identified none of the above scheduled am medications were given, a "9" was documented and indicated, "other, see nurses note."</p> <p>R4's order summary dated 12/4/24, identified R4 was to receive the following oral medications in the morning: lisinopril (for high blood pressure) 10 mg, calcium 500+D tablet (for osteoporosis) 500-10 mg-micrograms (mcg), and sennoside-docusate sodium (for constipation) 8.6-50 mg tablet.</p> <p>R4's medication administration record (MAR) dated 12/10/24, identified lisinopril, calcium 500+D and sennoside-docusate sodium were given at 6:47 a.m.</p> <p>R1's Medication/Treatment Error Report dated 12/10/24 at 8:30 a.m., identified lisinopril was given to the wrong resident, the nurse was new and on their own for the first time today. Immediate effects noted were R1 reported</p>	F 760		

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F 760	<p>Continued From page 2</p> <p>dizziness and a drop in blood pressure (normal blood pressure range is below 120/80 but above 90/60). Provider notified at 8:30 a.m. and ordered to check blood pressure every 30 minutes until systolic blood pressure (SBP) was greater than 90, push fluids, send to emergency department (ED) if SBP stays in the 70's and symptomatic with dizziness and hypertension. R1's Medication Error/Event Root Cause Analysis form dated 12/10/24, identified the error category E level (an error that could have caused temporary harm).</p> <p>R1's progress note dated 12/10/24 at 8:25 a.m., identified R1 was dizzy, weak, not feeling well and hypotensive. Blood pressure (B/P) 72/40, encouraged and assisted with pushing fluids, notified on call provider by phone, new order to check blood pressure every 30 minutes, if remained symptomatic and systolic remained in 70's send to ER. R1 inadvertently received 10mg lisinopril this am. Family members came to care center to visit and were updated on the situation.</p> <p>R1's progress note dated 12/10/24 at 9:20 a.m., identified R1 was sent to the ED with family accompanying for diagnosis of hypotension. Blood pressure was re-checked and was 64/43, continued to have symptoms of dizziness and would not drink fluids with encouragement and assistance.</p> <p>R1's Vitals summary identified the following blood pressures: 12/10/24: -8:33 a.m., was 72/40. -9:00 a.m., was 64/43. -9:20 a.m., was 88/52.</p> <p>R1's Emergency Department (ED) summary</p>	F 760		

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F 760	Continued From page 3 dated 12/10/24, at 9:28 a.m., identified R1's blood pressure was 89/49 and the reason for visit was hypotension (care center called and stated R1 was given lisinopril in error and pressures were 60's/40's with dizziness). Assessment and plan identified evaluation for hypotension due to receiving lisinopril in error at 6:47 a.m., antihypertensive effect of lisinopril started within 2 hours and will peak at 6 hours, gave IV fluids in attempt at improvement of hypotension. At 10:51 a.m., R1 has no urge to urinate, gave another liter of fluids, blood pressure still low at 74/45, nausea was better. At 12:02 p.m., blood pressure 82/47 progressive improvement, lowest blood pressure earlier was 68/44. At 12:23 p.m., R1 has no urge to urinate, felt better after receiving 2 liters of fluids, gave another liter of fluids and monitor blood pressure closely. At 12:53 p.m., blood pressure 97/51, at 2:35 p.m., blood pressure 102/61 improved with sitting, and at 2:45 p.m. blood pressure 121/63 increased with movement. At 2:48 p.m. Zofran given for nausea. At 3:09 p.m., R1 hypotensive again at rest, R1 would like to go back to the care center as soon as possible, will hold off on anymore fluids, no lightheadedness with standing. At 3:32 p.m., R1 had a liter of watery output from ileostomy while at ER, will give does of albumin to attempt at improvement of hypotension at rest. At 5:12 p.m., mean arterial pressures (MAP's) - (represents the average pressure in your arteries throughout the cardiac cycle, indicating how well your organs are being perfused with blood, most people need a MAP of at least 60 to ensure blood flow to vital organs) consistently remaining in the 60's. R1 would like to be discharged home will have nursing home staff monitor blood pressure this evening and tomorrow morning. Return to ER with concerning signs and symptoms, R1	F 760		

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F 760	<p>Continued From page 4 discharged back to nursing home at 5:35 p.m.</p> <p>R1's progress note dated 12/10/24 at 5:50 p.m., identified R1 returned to the facility via wheelchair at 5:30 p.m. with family present. R1 received 3L of IV fluids and 500 ml of albumin. Output of 1300 ml out of ostomy. Resident asymptomatic at this time, just weak and tired.</p> <p>R1's progress note dated 12/11/24 at 10:16 a.m., identified blood pressures were 72/45 and 69/35. After pushing fluids and eating blood pressure was 90/53. R1 was seated at the edge of her bed for all blood pressures. Denied dizziness, nausea, vertigo, or any other symptoms. R1 reported feeling tired.</p> <p>R1's progress note dated 12/11/24 at 10:47 a.m., identified R1 was asymptomatic and felt better. Blood pressure was 88/58 while lying in bed. reported no urine output since yesterday, new order to check blood pressure every 4 hours and as needed, if symptomatic and SBP <80 notify provider.</p> <p>R1's Video Nurse Practitioner visit dated 12/11/24, identified an evaluation regarding concern about acute urinary retention with hypotension noted over the past 24 hours. R1's blood pressure was 76/43. R1 continued to have poor urinary output was continent of urine and stated she had gone twice this afternoon. R1 had post void bladder scan which noted retention of 322 ml. New Orders to check basic metabolic panel (BMP) (blood test to monitor blood pressure and kidney disease) and post void bladder scan for 3 days to assess decreased urinary output. With each post void scan, if >300 milliliters (ml) then in and out Cath to completely</p>	F 760		

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F 760	<p>Continued From page 5 empty bladder.</p> <p>R1's Vitals summary identified the following blood pressures: 12/10/24 at 9:36 p.m., was 88/52. 12/11/24: -12:31 p.m., was 76/43. -6:23 p.m., was 97/46. -9:23 p.m., was 87/48. 12/12/24: -2:32 a.m., was 94/51. -4:53 a.m., was 119/59. -10:00 a.m., was 111/64.</p> <p>During an observation and interview on 12/17/24 at 2:35 p.m. R1 was lying in bed with a blanket covering her. R1 stated one of the staff gave her the wrong medication, it was a blood pressure medication. R1 indicated on the morning of 12/10/24, she got up at 6:15 a.m., was given her pills, and then a short while later she started to feel dizzy and weak. When she went to the bathroom to get ready for the day, she looked in the mirror and could not see herself, everything was fuzzy, that's when she told, "the girls," she was nauseated and would not be able to eat breakfast. R1 indicated at some point they were checking her blood pressure over and over and it was pretty low, so they sent her to the ER. R1 stated she was scared because she did not feel right from getting the wrong medication and had to spend most of the day in the ER and was given several IV fluids. R1 stated ever since she was given the wrong medication, she has been weak, had not had an appetite and both legs between her knees and her hips hurt even when she wasn't doing anything but lying in bed. R1 indicated she never had the leg pain until the day they gave her the wrong medication. R1 stated</p>	F 760		

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F 760	<p>Continued From page 6</p> <p>she had the pain if she stood too long and stated the left leg had gotten better but not the right leg, R1 stated the pain was a steady pain and was experiencing it in her right leg at this time.</p> <p>During a phone interview on 12/17/24 at 1:58 p.m., registered nurse (RN)-B indicated on 12/10/24, it was his first day to independently pass medications. RN-A stated he had mistakenly given R1 lisinopril that was meant for R1's roommate. RN-A stated he didn't realize it until R1 was exhibiting hypotension, dizziness, nausea, blurred vision, lightheadedness, and weakness. RN-A verified R1 was sent to the ED for treatment of hypotension. RN-A stated he was educated on the medication administration policy, the 5 rights of medication, and had additional training.</p> <p>During an interview on 12/18/24 at 9:18 a.m., registered nurse (RN)-A stated RN-B told her on 12/10/24 around 8:30 a.m., that he had given R1 lisinopril in error that was meant for R4. She was given the medications at 6:47 a.m. RN-A stated R1 was assessed and noted to be weak, dizzy, and nauseated with systolic blood pressures in the 70's. RN-A indicated she called the provider to notify of R1's medication error was given new orders to monitor blood pressures and to send to the ER if blood pressures did not come up. RN-A stated R1 was being monitored closely by nursing staff and the providers and was sent to the ER at around 9:30 a.m. RN-A stated RN-B was immediately supervised for the remainder of the shift, was re-educated, and had additional training.</p> <p>During an interview on 12/18/24 at 12:24 p.m., director of nursing (DON) indicated on 12/10/24</p>	F 760		

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F 760	<p>Continued From page 7</p> <p>R1 had received her roommate's lisinopril that caused R1 to be transferred to the ER to be treated for hypotension. DON indicated this was a significant medication error because of the adverse side effect of hypotension. DON indicated RN-B was responsible for the medication error, root cause was incorrect -RN-B was immediately re-educated, had another nurse assist him that day. DON indicated immediately all staff were re-educated on the 5 rights of medication and the medication administration policy had been performing medication administration audits to ensure compliance.</p> <p>During a phone interview on 12/18/24 at 1:04 p.m., consultant pharmacist (CP)-A indicated if a resident without the diagnosis of high blood pressure was given lisinopril in error the resident would need to be monitored closely for low blood pressure and would be considered a significant medication error. CP-A indicated the effects of 10 mg of lisinopril would take effect within 2 hours of ingestion, peak at 6 hours and can last for up to 24 hours. CP-A stated lisinopril can lead to dehydration and side effects would be nausea, dizziness, fatigue, and headache.</p> <p>During an interview on 12/17/24 at 1:40 p.m., medical director (MD)-A stated R1 was given 10 mg of lisinopril on 12/10/24 that resulted in a significant medication error. MD-A indicated R1 had kidney disease and had to be sent to the ER to have her blood pressures monitored along with her kidney function and was treated with IV fluids and IV albumin; albumin can help raise blood pressure by drawing fluid back into circulation. MD-A stated after the ER visit R1 was having trouble with not making any urine which was a sign of the kidneys not working properly. MD-A</p>	F 760		

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F 760	<p>Continued From page 8</p> <p>further stated there will be further assessments, labs, and monitoring for R1 to return to baseline.</p> <p>Facility policy, Medication Administration Guidelines revised 3/10/23, identified Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. 7. Residents are identified before medication is administered using two methods of identification. Methods of identification include a) By checking the resident's name band, b) By asking a reliable resident for his or her first and last name, c) By referring to the photo attached to the EMAR record and d) If necessary, verifying resident identification with other facility personnel ... 10. Check for the five rights: the right resident, the right medication, the right dosage, the right route, and the right time ... 17. Medications supplied for one resident are never administered to another resident.</p> <p>During the onsite visit on 12/17/24 and 12/18/24, the facility's corrective actions were verified as implemented on 12/10/24, prior to the survey visit, therefor this deficient practice is being cited as Past Non-compliance. Corrective actions included:</p> <ul style="list-style-type: none"> -On 12/10/24, the facility completed an investigation and causal analysis -On 12/10/24, RN-B was immediately re-educated and supervised. -On 12/10/24, provided educated to licenses and unlicensed staff regarding giving medications as ordered and medication administration policy. 	F 760		



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Electronically delivered
January 6, 2025

Administrator
Mayo Clinic Health System - Lake City
500 West Grant Street
Lake City, MN 55041

Re: Event ID: 37FQ11

Dear Administrator:

The above facility survey was completed on December 18, 2024, 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,

A handwritten signature in black ink that reads 'H. Zahler'.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Minnesota Department of Health

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(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
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2 000	<p>Initial Comments</p> <p style="text-align: center;">*****ATTENTION*****</p> <p style="text-align: center;">NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: On 12/17/24 through 12/18/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaint was reviewed: H52182602C (MN108987). NO licensing orders</p>	2 000		
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Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00770	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/18/2024
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2 000	Continued From page 1 were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. 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		

Minnesota Department of Health

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2 000	Continued From page 2	2 000		

Minnesota Department of Health

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2 000	Continued From page 3	2 000		

Minnesota Department of Health

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2 000	Continued From page 4	2 000		

Minnesota Department of Health

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2 000	Continued From page 5	2 000		

Minnesota Department of Health

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2 000	Continued From page 6	2 000		

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2 000	Continued From page 7	2 000		

Minnesota Department of Health

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2 000	Continued From page 8	2 000		

Minnesota Department of Health

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2 000	Continued From page 9	2 000		

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2 000	Continued From page 10 H52182602C (MN108987)	2 000		