



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 13, 2024

Administrator
Avera Granite Falls Care Center
250 Jordan Drive
Granite Falls, MN 56241

RE: CCN: 245243
Cycle Start Date: May 2, 2024

Dear Administrator:

On May 2, 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 immediate jeopardy (Level J),

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).

REMOVAL OF IMMEDIATE JEOPARDY

On April 30, 2024, the situation of immediate jeopardy to potential health and safety cited at F678 was removed.

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(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- 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

Avera Granite Falls Care Center

May 13, 2024

Page 2

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 \$11,995; 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.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective May 2, 2024. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Avera Granite Falls Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective May 2, 2024. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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, Rapid Response Supervisor
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at

Avera Granite Falls Care Center

May 13, 2024

Page 4

(312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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://forms.web.health.state.mn.us/form/NHDisputeResolution>

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, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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

PRINTED: 05/13/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/02/2024
--	---	--	---

NAME OF PROVIDER OR SUPPLIER AVERA GRANITE FALLS CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 250 JORDAN DRIVE GRANITE FALLS, MN 56241
--	--

(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	<p>INITIAL COMMENTS</p> <p>On 5/2/24, 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.</p> <p>The following complaint was reviewed: H52433434C (MN00102827) and a deficiency was issued at F678 at PAST NON-COMPLIANCE.</p> <p>Although the provider had implemented corrective action prior to survey, immediate jeopardy 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.</p>	F 000	Past noncompliance: no plan of correction required.	
F 678 SS=J	<p>Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3)</p> <p>§483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow physician orders for full code and did not initiate cardiopulmonary resuscitation (CPR) as per the residents wishes for 1 of 3 residents (R1) who wanted CPR. R1 was found without a pulse or respirations, staff did not initiate CPR and R1 expired and resulted in an immediate jeopardy (IJ). The facility</p>	F 678	Past noncompliance: no plan of correction required.	

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

Electronically Signed

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.

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

PRINTED: 05/13/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/02/2024
NAME OF PROVIDER OR SUPPLIER avera granite falls care center		STREET ADDRESS, CITY, STATE, ZIP CODE 250 JORDAN DRIVE GRANITE FALLS, MN 56241		
(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 678	<p>Continued From page 1</p> <p>implemented immediate corrective action prior to survey and IJ was issued at past noncompliance.</p> <p>The IJ began on 4/22/24, at approximately 1:00 a.m. when R1 was noted to have no respirations with a fast heart rate, and CPR was not initiated. The administrator and director of nursing (DON) were notified of the immediate jeopardy on 5/2/24 at 4:27 p.m. The facility implemented corrective action on 4/30/24, and the IJ was issued at past non compliance.</p> <p>Findings included:</p> <p>R1's 5-day Minimum Data Set (MDS) dated 4/12/24, indicated intact cognition, diagnoses of coronary artery disease (CAD), heart failure, high blood pressure and anxiety.</p> <p>R1's physician order dated 1/17/2024, included Full Code start date 1/17/2024. The record did not include a corresponding POLST (physician order for life sustaining treatment) or signed advanced directives.</p> <p>R1's care plan printed on 5/2/24, did not include R1's code status.</p> <p>Review of R1 progress notes dated 4/6/24, included R1 will remain a full code with high risk of rehospitalization.</p> <p>Review of R1's progress note dated 4/22/24 at 2:12 a.m..., licensed practical nurse (LPN)-A documented "At 1:15 a.m. was summoned to rm [room] by CNA [nursing assistant (NA)] and said to bring a stethoscope. Upon entering rm [room] could see res [resident] had no color other that [sic] yellowish blue. Listened for heart rate, heard</p>	F 678		

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

PRINTED: 05/13/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/02/2024
NAME OF PROVIDER OR SUPPLIER avera granite falls care center		STREET ADDRESS, CITY, STATE, ZIP CODE 250 JORDAN DRIVE GRANITE FALLS, MN 56241		
(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 678	<p>Continued From page 2</p> <p>very rapid light heart rate. Ran to call RAT [rapid assessment team] and grabbed AED [automated external defibrillator]. Returned to rm [room] and found no HR [hear rate] and was already cyanotic [bluish gray]. Ambulance crew here in minutes, entered rm [room] and they started CPR and tried to revive him. They worked on him for 40 min [minutes]. They then called [name of doctor] for further instruction and he called time of death at 0152 [1:52 a.m.]"</p> <p>Review of R1's ambulance report dated 4/22/24, indicated ambulance was dispatched on 4/22/24 at 1:13 a.m., arrived at patient at 1:26 a.m. was met by LPN-A at nurses station, who stated "He is gone". They asked for clarification and LPN-A restated "he is gone". Confirmed that R1 was a full code. Ambulance crew continued to room to evaluate R1. R1 was found laying in bed, without oxygen on, no signs of rigormortis, no pulse, warm to touch and cyanotic dusky color in face, no effort in breathing, no palatable carotid pulse. LPN-A at bedside and stated around 1:10 a.m., NA-A was in room, came out of room and found her to get the stethoscope, LPN-A came to room and listened to R1's heart, she thought she heard a rapid heart beat but was unsure of what to do other than call 911. No attempt of compressions or ventilation until ambulance arrival. R1 moved from bed to ambulance cot and CPR initiated. Ambulance crew performed CPR until call placed to on call physician at 1:52 a.m. when R1 was pronounced deceased.</p> <p>During an interview on 5/2/24 at 1:50 p.m., NA-A stated she had checked on R1 during her water pass at about 1:15 a.m. and noticed R1 was breathing but then at 1:30 a.m. when she went back noticed R1 was not breathing. NA-A called</p>	F 678		

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

PRINTED: 05/13/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/02/2024
NAME OF PROVIDER OR SUPPLIER avera granite falls care center		STREET ADDRESS, CITY, STATE, ZIP CODE 250 JORDAN DRIVE GRANITE FALLS, MN 56241		
(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 678	<p>Continued From page 3</p> <p>for LPN-A to bring a stethoscope to R1's room over the radio and heard no response so stepped out in the hallway and called for LPN-A. LPN-A came into R1's room and listened for heartbeat. LPN-A told NA-A R1 heart rate was rapid and then LPN-A left the room to call 911 and get the AED. NA-A explained, LPN-A returned to R1's room about 5 minutes later and sat the AED on R1's bed. LPN-A did not apply the AED or start CPR, instead told NA-A that R1 "was gone". LPN-A had NA-A return the AED to the storage place. NA-A stated the ambulance crew arrived and NA-A heard LPN-A tell them R1 was a full code and ambulance crew asked if they started CPR and LPN-A stated no she did not. The Ambulance crew started CPR and were not able to revive R1.</p> <p>During an interview on 5/2/24 at 1:10 p.m., LPN-A stated the evening of 4/21/24, R1 had been anxious and used her call light frequently. LPN-A had checked on R1 at approximately 10:00 p.m. and had appeared to be at baseline. LPN-A had medicated R1 with Tramadol (pain medication used to relieve moderate to severe pain) around 11:15 p.m. LPN-A continued to monitor R1 until she was called to his room around 1:15 a.m. on 4/22/24 and found R1 with a rapid heart rate and not breathing. LPN-A left the room and went to call a RAT/ 911. She then grabbed the AED and returned to R1's room but upon entrance she had noticed R1 had passed away. LPN-A stated R1 was a full code and CPR should have been started, but it was not. LPN-A stated this was her first "code" and she did not know why she did not start CPR.</p> <p>During an interview on 5/2/24 at 11:45 a.m., director of nursing (DON) stated she had not</p>	F 678		

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

PRINTED: 05/13/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/02/2024
NAME OF PROVIDER OR SUPPLIER avera granite falls care center		STREET ADDRESS, CITY, STATE, ZIP CODE 250 JORDAN DRIVE GRANITE FALLS, MN 56241		
(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 678	<p>Continued From page 4</p> <p>been aware CPR had not been initiated by staff on the night shift of 4/22/24, until it was reported to by a quality assurance nurse on 4/24/24. DON stated she then interviewed LPN-A who confirmed CPR had not been initiated by facility staff. DON reviewed R1's record and confirmed R1 was a full code according to physician orders however a signed POLST could not be located in the record. DON stated CPR should have been initiated per physician orders. DON was unable to find the POLST in R1's record.</p> <p>Review of facility's policy titled, LTC- Emergency Response, CPR, section emergency guidelines:</p> <ol style="list-style-type: none"> 1. in the event staff come upon a resident without obvious signs of clinical death, staff will start CPR and send someone to check code status. 2. initiation of CPR- prior to the arrival of emergency medical services (EMS), nursing homes must provide basic life support, including initiating CPR, to a resident who experiences cardiac arrest in accordance with that resident's advanced directives or in the absence of advanced directives or a Do Not Resuscitate (DNR) order. <p>The past non-compliance IJ began on 4/22/23. The IJ was removed, and the deficient practice corrected on 4/30/24 when it was verified the facility had implemented corrective action that included:</p> <ul style="list-style-type: none"> -Reviewed their policy and systems and made the following changes: <ul style="list-style-type: none"> A) Implemented full code residents have a red heart at the foot of their bed. B) Implemented the unit group sheets were all revised to identify full code status. -NA-A received education on 4/24/24, LPN-A was put on administrative leave on 4/24/24. 	F 678		

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

PRINTED: 05/13/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245243	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/02/2024
NAME OF PROVIDER OR SUPPLIER avera granite falls care center		STREET ADDRESS, CITY, STATE, ZIP CODE 250 JORDAN DRIVE GRANITE FALLS, MN 56241		
(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 678	Continued From page 5 -All nursing staff participated in mock code with local ambulance service on 4/30/24. -All staff received education on implementation of POLST orders/CPR on 4/30/24 and participated in a mock code drill with local ambulance. They were reeducated again on 5/2/24.	F 678		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 13, 2024

Administrator
Avera Granite Falls Care Center
250 Jordan Drive
Granite Falls, MN 56241

Re: Event ID: RBXT11

Dear Administrator:

The above facility survey was completed on May 2, 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, appearing to read 'Melissa Poepping'.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
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: 00725	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/02/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER avera granite falls care center	STREET ADDRESS, CITY, STATE, ZIP CODE 250 JORDAN DRIVE GRANITE FALLS, MN 56241
--	--

(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	<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 5/2/24, 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 complaints were reviewed: H52433434C (MN00102827). NO licensing</p>	2 000		
-------	--	-------	--	--

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE
---	-------	-----------

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00725	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/02/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER AVERA GRANITE FALLS CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 250 JORDAN DRIVE GRANITE FALLS, MN 56241
--	--

(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	Continued From page 1 orders 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		