Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 27, 2023

Administrator
Benedictine Health Center Innsbruck
1101 Black Oak Drive
New Brighton, MN 55112

RE: CCN: 245310
Cycle Start Date: January 31, 2023

Dear Administrator:

On March 22, 2023, 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.

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 10, 2023

Administrator
Benedictine Health Center Innsbruck
1101 Black Oak Drive
New Brighton, MN 55112

RE: CCN: 245310
Cycle Start Date: January 31, 2023

Dear Administrator:

On January 31, 2023, 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 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"and/or an "E" tag), i.e., the plan of correction should be directed to:

Pete Cole, RN Unit Supervisor
Metro Team C 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: peter.cole@state.mn.us
Office/Mobile: (651) 249-1724

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 May 1, 2023, (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 31, 2023, (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.

Please contact me with questions.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement | Licensing and Certification
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-mail: Lori.Hagen@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 10, 2023

Administrator
Benedictine Health Center Innsbruck
1101 Black Oak Drive
New Brighton, MN 55112

Re: Event ID: PY6L11

Dear Administrator:

The above facility survey was completed on January 31, 2023, 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 contact me with any questions.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement | Licensing and Certification
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-mail: Lori.Hagen@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245310	A. BUILDING _____ B. WING _____	C 01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE HEALTH CENTER INNSBRUCK	**1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112**

(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 1/31/23, 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 complaint was found to be substantiated: H53107964C (MN90525), with a deficiency cited at F684. and The following complaints were found to be unsubstantiated: H53108039C (MN90538) H53108044C (MN90406) 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 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that	F 684		3/21/23

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

Electronically Signed | 02/17/2023

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 684	Continued From page 1 applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were administered in a timely manner according to orders and professional standards for 2 of 2 residents (R1, R3) reviewed for medication administration. Findings include: R1's admission Minimum Data Set (MDS) dated 1/13/23, indicated R1 had mild cognitive deficits and a Patient Health Questionnaire (PHQ-9) score of 10, indicating moderate depression. R1 required total assistance for transfers and extensive assistance for all other activities of daily living (ADLs). The MDS indicated bed mobility did not occur during the assessment period. R1 had diagnoses that included a displaced fracture of the cervical spine (neck), Parkinson's disease, repeated falls, dementia without behavioral disturbance, psychotic and mood disturbance, anxiety, thoracic (low back) fractures, failure to thrive, acute pain due to trauma, high blood pressure, asthma, overactive bladder, depression, gastro-esophageal reflux disease (GERD), insomnia, muscle spasms, constipation, and chronic pain. R1's Care Area Assessment (CAA) dated 1/13/23, indicated R1 triggered for cognitive	F 684	1. How the corrective action will be accomplished for identified affected individuals? R1's pain assessment, medication regimen and overall plan of care has been evaluated for effectiveness by assigned hospice team and pharmacist. Changes in orders have been implemented. R3 passed away peacefully with family at bedside under the direction of a hospice provider. 2. How will other individuals with the potential to be affected or in similar situations be identified and protected? Residents are assessed for pain daily through their daily interactions with NARS and licensed nurses. A formal pain assessment is completed on admission, quarterly, and with significant change of condition. All changes of condition are shared with NP/MD as appropriate for coordination of care. 3. What systemic changes will ensure that the deficient practice will not recur?	

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F 684	Continued From page 2 loss/dementia, communication, ADLs, psychosocial well-being, mood, urinary incontinence, falls, psychotropic drug use, and pain. R1's care plan dated 1/11/23, indicated R1 was at risk for complications due to psychotropic drug use. Interventions included observing for side effects, proper dosing and continued need of medication. R1 had potential for pain related to end stage Parkinson's, spinal fractures, dementia, depression, anxiety, and asthma. Interventions included administering pain medications and treatments per hospice orders, observing non-verbal cues of pain and reporting signs of pain or discomfort. Staff were also to offer pain medications as ordered, monitor their use and effectiveness, and provide a calm and quiet environment. R1 was also at risk for nutrition due to diagnoses and disease process and was on hospice. Interventions included administering medications as ordered. R1's physician orders indicated to "Ask resident if having pain and offer pain medication." The orders indicated the morning (AM) medication administration (Med Pass) time was 7:00 a.m. to 10:00 a.m., the evening (PM) Med Pass time was 3:00 p.m. to 6:00 p.m. and the night Med Pass (HS) was 7:00 p.m. to 10:00 p.m. The orders also indicated R1 received the following medications: -albuterol sulfate solution for nebulizer three times a day (AM, PM, HS) for shortness of breath. -carbidopa-levidopa extended release 25-250 milligrams (mg) four times a day (8:00 a.m., 11:30 a.m., 2:00 p.m., 5:00 p.m.) for Parkinson's disease.	F 684	Policy of medication administration was reviewed by community leadership with no revisions needed. All associates who administer medications will be educated on the 6 R's of medication administration that includes the "right time" and "right documentation." 4. How will the facility monitor its corrective actions/performance? DON/Designee will audit medication administration to ensure 6 R's are followed for 4 resident's med pass per week for the first four weeks. Results of audit will be reviewed by the Quality Council and Medical Director with follow up decision made by Quality Council. When will corrective action be accomplished? This will be corrected March 21st, 2023.	

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F 684	Continued From page 3 -Cymbalta (duloxetine) delayed release 60 mg (AM) for depression and anxiety. -lidocaine patch 4% twice a day (8:00 a.m., 8:00 p.m.) a 24-hour application for pain. -methadone (a narcotic) 2.5 mg three times a day (8:00 a.m., 2:00 p.m., 10:00 p.m.) for pain. -methocarbamol 250 mg twice a day (AM, PM) for muscle spasms. -omeprazole delayed release 20 mg (AM) for GERD. -oxycodone 5 mg sublingual as needed every hour for pain. -rivastigmine patch twice a day (8:00 a.m., 8:00 p.m.) for dementia associated with Parkinson's. -acetaminophen (Tylenol Extra Strength) 1000 mg three times a day (AM, PM, HS) for pain. During an interview and observation on 1/31/23, at 9:58 a.m. R1 was lying flat on her back in bed. R1's arms were on her abdomen and her whole body was shaking. R1 was staring at the ceiling and was slow to respond to questions. R1 stated she had not received any medications that morning. R1 stated she was having pain in her shoulders, neck, and abdomen (pointing to her epigastrium). R1 stated her pain was a 10/10. During an interview on 1/31/23, at 10:06 a.m. trained medical assistant (TMA)-A stated she had not given R1 any medications yet and did not know if the nurse had given R1 any of her hourly PRN oxycodone medications that morning. TMA-A verified R1's electronic medical record (EMR) indicated R1 had not been offered or given any PRN oxycodone medication that morning for pain. During an interview on 1/31/23, at 10:09 a.m. registered nurse (RN)-A stated she asked R1 if	F 684		

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F 684	Continued From page 4 she wanted pain medication at 8:30 a.m. but R1 refused. RN-A did not return to R1's room after 8:30 a.m. because she "knew" TMA-A would be giving R1 her scheduled pain medication during the AM Med Pass. RN-A stated she did not document assessing R1's pain or R1's refusal of the PRN oxycodone at 8:30 a.m. yet and would do that "later." RN-A also confirmed because she had not documented R1's pain assessment or refusal of her PRN pain medication, TMA-A would not know if R1 had received her PRN oxycodone. During a continuous observation and interview on 1/31/23, from 10:19 a.m. to 10:50 a.m. hospice nursing assistant (HNA)-A was in R1's room giving her a bed bath when RN-A entered and gave R1 2.5 mg of methadone for her pain. RN-A did not ask R1 if she was having pain or ask R1 to rate her pain. RN-A then left R1's room. RN-A stated she did not ask R1 if she was having pain because R1 was unable to verbalize or rate her pain. At 10:27 a.m., RN-A administered the rest of R1's AM oral medications. At 10:43 a.m. RN-A entered R1's room to apply R1's medication patches. RN-A rolled R1 onto her right side and lifted the back of R1's shirt. RN-A applied the lidocaine patch, for pain, to the middle of R1's back and the rivastigmine patch, for dementia and depression, to R1's left shoulder blade. There were no previously applied medication patches observed on R1's back. RN-A lowered R1's shirt, rolled her onto her back and left the room. At the medication cart, RN-A stated R1's medication patches were removed before she went to bed and therefore there would not be previously applied patches on R1's skin. At 10:50 a.m. RN-A verified R1's medication patches were to be applied for 24 hours and returned to R1's room. After inspection of R1's skin a rivastigmine	F 684		

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F 684	Continued From page 5 patch dated 1/30/23, was found on R1's left upper arm and a rivastigmine patch dated 1/29/23, was found on R1's upper right arm. RN-A removed the old patches and stated all previously applied medication patches should be removed prior to applying new patches to avoid over-medicating a resident. During an interview on 1/31/23, at 1:54 p.m. R1 was supine in bed with minimal shaking observed. R1 was organizing her bedside table and stated she was feeling better since she received her medications. R1 stated her pain was 5/10 and tolerable. R3's admission MDS dated 11/29/22, indicated R3 had intact cognition and required total assistance with transfers and extensive assistance with all other ADLs. R3 had diagnoses that included bacterial pneumonia, malignant neoplasm of the bronchus or lung resulting in a lobectomy (cancer of the airway/lung resulting in the removal of part of the lung), chronic heart failure, (CHF, causing fluid build-up in the lungs), shortness of breath, atherosclerotic heart disease (causing plaque build-up in the arteries of the heart resulting in decreased blood flow), atrial fibrillation (afib, an irregular heartbeat resulting in increased formation of clots), oxygen dependence, diabetes, anxiety, pain, myocardial infarction (heart attack), pneumonia, chronic obstructive pulmonary disease (COPD, causing difficulty breathing), depression, GERD, constipation, osteoporosis (decreased bone density), and malnutrition. R3's CAA dated 11/29/22, indicated R3 triggered for communication, ADLs, urinary incontinence, falls, nutrition, dehydration, and pain.	F 684		

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F 684	Continued From page 6 R3's care plan dated 11/23/22, indicated R3 had the potential for pain related to cancer, CHF, high blood pressure, afib, an enlarged heart, pneumonia, anxiety, protein malnutrition, and hospice. Interventions included assessing R3 for signs of pain or discomfort. Staff were to reposition and align R3 for comfort and administer pain medications as ordered by the provider and monitor pain medication use and effectiveness. The care plan also indicated R3 was at risk for psychotropic drug use. Interventions included administering medications as ordered by hospice and offering non-pharmacological interventions. The care plan also indicated R3 was at risk for a nutritional deficit related to disease progress and hospice status. Interventions included administering medications as ordered. R3's physician orders indicated the morning (AM) medication administration (Med Pass) time was 7:00 a.m. to 10:00 a.m., the noon Med Pass was 11:30 a.m. to 2:00 p.m., the evening (PM) Med Pass time was 3:00 p.m. to 6:00 p.m. and the night Med Pass (HS) was 7:00 p.m. to 10:00 p.m. The orders indicated R3 received the following medications: -acetaminophen 1000 mg twice a day (AM, HS) for pain. -apixaban (Eliquis, an anticoagulant) 2.5 mg twice a day (7:30 a.m to 10:30 a.m. and 7:30 p.m. to 10:30 p.m. -ipratropium-albuterol solution for nebulizer/inhalation four times a day (AM, Noon, PM, HS) for shortness of breath. -metoprolol succinate extended release 24 hour; 25 mg (7:30 a.m. to 10:30 a.m.) for high blood	F 684		

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F 684	Continued From page 7 pressure. -morphine (a narcotic pain medication) 10 mg four times a day (AM, Noon, PM, HS) for pain. -pantoprazole delayed release 40 mg (AM) for GERD. During an interview on 1/31/23, at 11:14 a.m. R3 was observed slid down in her bed in a reclined position with a nasal cannula applied and delivering oxygen through her nose. R3 was attempting to eat but stated she did not have an appetite and had "been better." R3 was grimacing and only able to speak three words at a time. R3 stated she was having shortness of breath and chest pain that went to her back. R3 stated she told the staff "a long time ago" but that they were very busy and it "came with the territory." R3 further stated she had received her AM medications around 11:00 a.m. although they were scheduled for 8:00 a.m. R3's multiple attempts to reposition herself to ease her discomfort were ineffective. A nebulizer machine was on but R3 did not have the nebulizer mask on her face. During an observation on 1/31/23, at 11:16 a.m. RN-A entered R3's room, turned off the nebulizer machine, and left. RN-A did not speak to R3 or assess her shortness of breath or pain. During an observation and interview on 1/31/23, at 11:44 a.m. R3 remained in a reclined position, low in her bed with a nasal cannula delivering oxygen. R3 stated she was still uncomfortable and only able to speak three words at a time. R3 further stated she received her medications late "almost every day." R3 had eaten only a few bites of her food and stated she got too tired to eat.	F 684		

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BENEDICTINE HEALTH CENTER INNSBRUCK	1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112

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F 684	Continued From page 8 During an interview on 1/31/23, at 12:00 p.m. RN-A and TMA-A reviewed both R1 and R3's EMR's and verified both residents received their medications at the time they were documented despite the documentation indicating the medications were administered on time and only "charted late." RN-A also verified she had charted under TMA-A's credentials for some of the medications. RN-A and TMA-A verified inaccurate documentation could result in residents receiving medications too close to their next dose causing them to be overmedicated. During an interview on 1/31/23, at 5:03 p.m. the interim director of nursing (DON) stated staff should be administering medications, including pain medications, as they are ordered. The DON also stated nurse managers were available to assist the nurses and TMAs if they were falling behind in administering medications to residents. The DON stated nursing staff should assess a resident's pain before and after giving the medication to determine its effectiveness. The DON further stated old medication patches should be removed prior to applying a new patch to avoid over-medicating a resident. During an interview on 2/1/23, at 10:57 a.m. the consulting pharmacist (PH) stated residents should be receiving their medications no more than one hour prior to or one hour after their scheduled time to maintain therapeutic effect and over or under-medicating a resident. The PH stated it was particularly important for residents to receive Parkinson's and pain medications at even intervals throughout the day to maintain their efficacy. The PH further stated medications should be documented as soon as they are given to avoid confusion and administering medications	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245310	A. BUILDING _____ B. WING _____	C 01/31/2023

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F 684	Continued From page 9 too close together. The facility Administering Medications policy dated 2020, indicated medications were to be administered in accordance with the provider orders and within their prescribed time. The policy also indicated medications were to be documented in the EMR at the time they were administered. The policy also indicated to document when a resident refused medications. The facility Pain Management policy dated 2022, indicated staff were to evaluate residents for verbal and nonverbal signs and symptoms of pain, and encourage the resident to tell the staff about their pain. Staff were also to reevaluate and document a resident's pain at regular intervals after pharmacological and nonpharmacological interventions.	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00940	A. BUILDING: _____ B. WING _____	C 01/31/2023

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2 000	Initial Comments *****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 1/31/23, a complaint survey was conducted at your facility by a surveyor from the Minnesota Department of Health (MDH). Your facility was found in compliance with the MN State Licensure. The following complaints were found to be unsubstantiated:	2 000		

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2 000	Continued From page 1 H53108039C (MN90538) H53108044C (MN90406) The following complaint was found to be substantiated: H53107964C (MN90525), however no licensing 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		