Electronically delivered
September 8, 2022

Administrator
Mother Of Mercy Senior Living
230 Church Avenue, Box 676
Albany, MN 56307

RE: CCN: 245339
Cycle Start Date: August 31, 2022

Dear Administrator:

On August 31, 2022, 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), as evidenced by the electronically delivered CMS-2567, whereby corrections are not required.

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 August 26, 2022, the situation of immediate jeopardy to potential health and safety cited at F760 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 listed below to the CMS Region V Office forimposition: You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

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

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 $11,292; 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 effectiveAugust 31, 2022. 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 Region V Office 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, Mother Of Mercy Senior Living is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective NO DATA. 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:

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Rd., Suite 300
Fergus Falls, Mn. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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:

Tamika.Brown@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) 565-9462

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 Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@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://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,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 08/31/2022

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MOTHER OF MERCY SENIOR LIVING	230 CHURCH AVENUE, BOX 676 ALBANY, MN 56307

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F 000	INITIAL COMMENTS On 8/30/22, to 8/31/22, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance. The survey resulted in an Immediate Jeopardy (IJ) at F760 when the facility failed to ensure residents were free of significant medication errors. The IJ began on 8/15/22, and the immediacy was removed on 8/26/22, prior to the start of the survey and was therefore issued at past non-compliance. The following complaint H53394393C (MN86271) was: SUBSTANTIATED at F760. Although the provider had implemented corrective action prior to survey, immediate jeopardy was sustained prior to the correction. NO plan of correction is required for a finding of past non-compliance. The facility is still required to acknowledge receipt of the electronic documents. The above findings constituted substandard quality of care, and an extended survey was conducted on 8/31/22.	F 000		
F 760 SS=J	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 interview and document review, the	F 760	Past noncompliance: no plan of	

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.

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F 760	Continued From page 1 facility failed to ensure residents were free of significant medication errors for 1 of 3 residents (R1) who did not receive his anticoagulation medication. This deficient practice resulted in an immediate jeopardy situation (IJ) for R1 who suffered a cerebral vascular accident (CVA) and subsequent death as a result of the medication errors. The immediate jeopardy began on 8/15/22, when R1 did not receive his scheduled dose of Xarelto (an anticoagulant medication, prescribed to prevent blood clots). In addition, R1 had not received his scheduled Xarelto on 8/16/22, 8/17/22, 8/18/22, for a total of four days. On 8/19/22, R1 was found to have right sided flaccidity, was difficult to arouse, was sent to the hospital by ambulance and admitted with a diagnosis of CVA due to embolism (obstruction of an artery), was placed on palliative care and died four days later. The IJ was identified on 8/30/22. The facility administrator and interim director of nursing (DON) were notified of the IJ on 8/30/22, at 3:07 p.m. The facility had identified the significant medication error, implemented corrective action to prevent recurrence by re-educating the staff involved and other licensed staff to ensure they understood the proper procedure for medication administration. In addition, the facility implemented a system to ensure medications were available for administration. The immediate jeopardy and the deficient practice was removed on 8/26/22, prior to the start of the survey, therefore, was issued at past noncompliance. Findings include:	F 760	correction required.	

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F 760	Continued From page 2 Review of R1's admission Minimum Data Set (MDS) dated 6/13/22, identified R1 had diagnoses which included atrial fibrillation (an irregular and often very rapid heart rhythm (arrhythmia) that can lead to blood clots in the heart, increased the risk of stroke, heart failure and other heart-related complications), hemiparesis (one sided weakness) and dementia. Review of R1's admission Care Area Assessment (CAA) dated 6/13/22, indicated R1 was admitted to the facility from home related to advanced dementia. The CAA revealed R1 had altered cognition, had a previous stroke with hemiparesis and required assistance with ADL's. The CAA identified R1 received Xarelto, had chronic atrial fibrillation and had indicated he had right sided hemiparesis. Review of R1's physician orders identified an order dated 6/24/22, for Xarelto 20 milligrams (mg) by mouth (po) daily for chronic atrial fibrillation. Review of R1's Medication Administration Record (MAR) for August 2022, identified R1 had not received his scheduled Xarelto on 8/15/22, through 8/18/22, a total of four (4) days. The MAR identified under the reason/comments section R1's Xarelto was unavailable on 8/15/22, 8/16/22, 8/17/22 and 8/18/22. Review of R1's Emergency Room (ER) note dated 8/19/22, identified the following: -emergency room history and physical (H&P) identified R1 presented to the emergency department with acute neurological deficit. Reports from emergency medical services (EMS)	F 760		

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F 760	Continued From page 3 and the nursing home staff, at approximately 1:00 p.m. that day, R1 had a right sided facial droop, began to lean to the right and was not able to converse. The H&P revealed a stroke neurologist specialist was consulted regarding R1's condition. -emergency room medical decision making (MDM) note identified R1 presented with acute catastrophic neurological deficits and had severe right sided neglect. The MDM note revealed R1 had advanced imaging which revealed significant left-sided MCA (left middle cerebral artery) stroke. The note identified R1 was not a candidate for treatment, was placed on palliative care and admitted to the hospital. -emergency room diagnosis identified R1 had a CVA due to an embolism of left middle cerebral artery. Review of R1's Cerebrovascular Diseases/Neurology progress note dated 8/23/22, identified R1's history of present illness (HPI) indicated R1 had atrial fibrillation, had been off his anticoagulation medication and had a history of a prior CVA with chronic right hemiplegia who presented to the hospital emergency department with acute onset of right facial droop and unresponsiveness. The note revealed the hospital had been notified R1 had missed several doses of his Xarelto, with his last possible dose on 8/14/22. -assessment and plan identified R1 had an acute ischemic stroke, LMCA with cerebral edema, left MCA thrombus (blood clot), ICA occlusion (internal carotid artery blockage) and left vertebral artery occlusion with presumed etiology (cause): atrial fibrillation with recent missed doses of	F 760		

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F 760	Continued From page 4 Xarelto. Review of R1's State Agency (SA) report dated 8/25/22, identified R1 was sent to the hospital on 8/19/22, due to a change in condition. The report revealed R1's medical record identified he had not received his anticoagulation medication from 8/14/22, to 8/18/22. The report identified facility staff directly involved with the incident had reported R1's anticoagulant medication had not been available. The report revealed facility staff indicated they had re-ordered the medication from the pharmacy and it had not been received. The SA report facility staff were educated on the following steps: updating the pharmacy, updating the provider, internal communication, and documentation. The report revealed an internal investigation was ongoing. Review of R1's progress note dated 8/19/22, identified R1 was drowsy, leaning to the right and could not be aroused. The note revealed R1 was sent to the emergency department by ambulance. -a note dated 8/23/22, revealed R1 passed away at the hospital with a primary diagnosis of a stroke. During an interview on 8/30/22, at 10:20 a.m. licensed practical nurse (LPN)-A stated she had received education by text via the facility's communication system within the last few days regarding the six rights to safe medication administration, ensuring residents received their medications, managing pharmacy orders/delivery and notification to providers with a post test. LPN-A indicated she had received the education as a result of a significant medication error where R1 had not received his anticoagulation medication for several days, had a stroke and	F 760		

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F 760	Continued From page 5 passed away. LPN-A stated she made sure she had all of the medications prescribed for the residents. She indicated when pharmacy delivered medications to the main level for the other floors, she would personally deliver the medications to the other units and placed in the medication cart with the residents' other medications. Further, LPN-A indicated if a medication was not available for the resident, she would contact the pharmacy and the provider for further instruction. During an interview on 8/30/22, at 10:41 a.m. registered nurse (RN)-A indicated she had recently received written education via text within the last few days regarding the six rights to safe medication administration, ensuring residents received their medications, managing pharmacy orders/delivery and notification to providers with a post test. RN-A indicated she had been working on 8/19/22, the day R1 was sent to the hospital with symptoms of an acute stroke. She stated R1 had a significant medication error as he had not received his Xarelto for four days, had a stroke and died in the hospital four days later. RN-A indicated she had received education and reminders to ensure resident medications were available. RN-A stated she was reminded of the steps to take when resident medications were not available, such as contacting the pharmacy and the resident's provider for further instructions. During an interview on 8/30/22, at 11:40 a.m. trained medication aid (TMA)-A stated she had recently received written education via text within the last few days regarding the six rights to safe medication administration, and notification to providers and licensed nursing staff of any missed medications. TMA-A stated a licensed	F 760		

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F 760	Continued From page 6 nurse was required to receive medications from any of the pharmacies the facility used. TMA-A indicated she was provided education as a result of R1's significant medication error. She indicated R1 had not received his anticoagulation medication for several days, was hospitalized with a stroke and died. TMA-A indicated she had received skills assessment/competency for medication administration upon hire and on-line education annually. During a telephone interview on 8/30/22, at 11:57 a.m. the pharmacist identified the pharmacy received a fax request on 8/15/22, to refill R1's Xarelto from the nursing home R1 resided in. The pharmacist identified R1's Xarelto was sent to the facility on 8/16/22, at 8:00 p.m. The pharmacist indicated he had been unaware R1 was completely out of Xarelto, or had missed any doses. He identified Xarelto had a half -life (the time it takes for a drug's active substance in your body to reduce by half) of 12-24 hours. The pharmacist identified, after missing a day's dose, R1 would have no longer been considered anticoagulated and would have placed him at an increased risk for a stroke. The pharmacist stated the missed doses of an anticoagulant would be considered a significant medication error with almost certain harmful consequences. During an interview on 8/30/22, at 12:33 p.m. the DON indicated R1 was sent to the hospital on 8/19/22, for symptoms of acute stroke. The DON stated she had reviewed R1's medical record and noted a significant medication error in which R1 had not received his scheduled Xarelto for four days prior to his stroke symptoms. The DON stated R1 had been admitted to the hospital on 8/19/22, and died on 8/23/22. She stated upon	F 760		

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F 760	Continued From page 7 review of R1's MAR, she identified four entries from three different staff, which identified R1's Xarelto was not available. The DON identified the following three staff: RN-B, LPN-B and TMA-B, had not administered R1's Xarelto as ordered, and all identified the medication was not available. The DON stated on 8/24/22, upon looking in the medication room of R1's unit, she had found R1's Xarelto, which had been delivered on 8/16/22. The DON confirmed she had provided education on safe medication administration, management of pharmacy deliveries, notification to providers of missed medications to the three identified staff, and to all other nursing staff who administered medications. The DON confirmed the education had been completed as of 8/26/22. Further, the DON identified a facility-wide audit had been completed of all residents' medication administration records to review for additional medication errors. During a telephone interview on 8/30/21, at 12:48 p.m. R1's primary medical doctor (MD)-A stated he had not been made aware R1 had missed any doses of Xarelto and indicated he would have wanted to be informed of any missed doses so another plan could have been made. MD-A indicated R1 had a CVA in the past, prior to his admission to the nursing home. He indicated R1 had been receiving anticoagulation medication for the past few years. MD-A stated if R1 hadn't received a dose of Xarelto after 24 hours from the prior dose, he would not have been considered anticoagulated and was at risk for a CVA. MD-A indicated R1 had a significant medication error with unfortunate catastrophic consequences. During a telephone interview on 8/30/22, at 2:22 p.m. LPN-B stated she had been unable to	F 760		

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F 760	Continued From page 8 administer R1's Xarelto on 8/16/22, and indicated the medication was not available. LPN-B confirmed she had not contacted R1's MD, nursing leadership or the pharmacy to notify them the medication was unavailable. LPN-B stated within the last few days, she received written and verbal education on the six rights of safe medication administration, dealing with pharmacy deliveries, and notification of any missing medications or medication errors. LPN-B indicated she was provided the education in response to R1's significant medication error in which he had suffered a stroke and had died. During a telephone interview on 8/30/22, at 2:32 p.m. RN-B stated she had noticed R1 was out of Xarelto on 8/15/22, and placed an order by fax to his pharmacy. RN-B confirmed R1 had not received his ordered Xarelto that day and confirmed she had not notified R1's MD he had not received the medication. RN-B stated within the last few days, she received written and verbal education on safe medication administration, management of pharmacy orders/deliveries and notification to residents' providers and families and communication with nursing team. RN-B stated she had completed post tests on the education and would be ensuring residents received their medications as prescribed. During a follow-up interview on 8/31/22, at 10:40 a.m. with the DON, she indicated she planned to meet with the three staff involved in the medication error to perform further education, skills assessment and would continue to perform audits of medication administration for all residents and nursing staff who passed medications. She stated she would also provide education on high-risk medication which had the	F 760		

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F 760	Continued From page 9 potential for serious consequences with errors. The interim DON indicated she reviewed several facility policies and would be meeting with the facility medical director within the next week and the quality assurance team to review the significant medication error, to complete a root cause and to develop and implement processes to ensure safe medication administration. Further, she indicated there were plans to review the facility's process with pharmacy deliveries and communication within the facility's nursing and leadership team. Review of a facility policy titled, Medication Error - Long Term Care effective 5/2022, identified it was the policy of the facility medication errors and good catches would have been reported and monitored. The policy revealed a detailed account of the incident would have been recorded and would include the following: date/time of the incident, medication, provider name, date, and time they were notified, notification to family/representative, any known or suspected contributing factors that led to the incident. In addition, the policy revealed any changes in the resident condition would have been immediately reported to the attending physician, DON, or RN on call. Review of a facility policy titled, Medication Guidelines - Long Term Care effective 11/2021, identified medication administration guidelines which included: process for the six rights of medication administration; right resident, drug, dose, route, right time, and documentation. Review of a facility policy titled, Accepting Delivery of Medications effective 10/21, revealed all staff should follow a consistent procedure in	F 760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245339	A. BUILDING _____ B. WING _____	C 08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 760	Continued From page 10 accepting medications. The policy identified any errors noted in receiving medications should have been brought to the attention of the Pharmacist and director of nursing services. The past noncompliance immediate jeopardy began on 8/15/22. The immediate jeopardy was removed, and the deficient practice was corrected on 8/26/22, after the facility implemented a systemic plan which included the following actions: -a facility wide audit of resident medication administration records was conducted for medication errors; two additional errors were found, and both were followed up on. -re-educated the employees directly involved with the significant medication error on the standards of practice for safe medication administration, management of pharmacy deliveries and orders, communication with providers and nursing team. -re-educated all facility licensed nursing staff and trained medication aids regarding standards of practice for safe medication administration, management of pharmacy deliveries and orders, communication with providers and nursing team. -implemented systemic changes to management of pharmacy deliveries to ensure receipt and accountability.	F 760		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 8, 2022

Administrator
Mother Of Mercy Senior Living
230 Church Avenue, Box 676
Albany, MN 56307

Re: Event ID: D7I811

Dear Administrator:

The above facility survey was completed on August 31, 2022 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,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00634	A. BUILDING: _____ B. WING _____	C 08/31/2022

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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 8/30/22, to 8/31/22, 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 found to be SUBSTANTIATED:	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 H53394393C (MN86271), 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		