Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 15, 2022

Administrator
Jensen Health LLC
2501 Rice Lake Road
Duluth, MN 55811

RE: CCN: 245366
Cycle Start Date: August 4, 2022

Dear Administrator:

On August 30, 2022, we notified you a remedy was imposed. On September 12, 2022 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of August 25, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective September 14, 2022 did not go into effect. (42 CFR 488.417 (b))

However, as we notified you in our letter of August 18, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 19, 2022. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed 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

Electronically delivered
August 18, 2022

Administrator
Jensen Health LLC
2501 Rice Lake Road
Duluth, MN 55811

RE: CCN: 245366
Cycle Start Date: August 4, 2022

Dear Administrator:

On August 4, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by November 4, 2022 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by February 4, 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.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 18, 2022

Administrator
Jensen Health LLC
2501 Rice Lake Road
Duluth, MN 55811

Re: Event ID: TZ2M11

Dear Administrator:

The above facility survey was completed on August 4, 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,

Sarah Lane

Sarah Lane, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245366	A. BUILDING _____ B. WING _____	C 08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JENSEN HEALTH LLC	2501 RICE LAKE ROAD DULUTH, MN 55811

(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 8/3/22 - 8/4/22, a standard abbreviated survey was conducted at your facility. Your facility was found NOT to be in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H53663630C (MN85611), with a deficiency cited at F600 H53663737C (MN85564), with a deficiency cited at F600. H53663777C (MN84203), with a deficiency cited at F600. H53663778C (MN84060), with a deficiency cited at F600. 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 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This	F 600		8/19/22

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

Electronically Signed | 08/24/2022

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 600	Continued From page 1 includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide ongoing protection of residents from abuse, failed to consistently implement interventions to prevent resident to resident abuse and failed to evaluate the effectiveness of interventions resulting in resident to resident abuse for 4 of 4 residents (R1, R2, R3, R4) reviewed for abuse. R2 has had ongoing altercations with other residents on the secured unit. Findings include: R1's admission Minimum Data Set (MDS) dated 7/22/22, indicated he was severely cognitively impaired and displayed no behaviors. R1's Care Area Assessment (CAA) dated 7/22/22, identified wandering behaviors and indicated cognitive loss and dementia. R1's care plan dated 7/19/22, identified a risk for mood and behavior problems. R2's quarterly MDS dated 7/21/22, indicated severe cognitive impairment and identified delusions and verbal behaviors directed toward others. The MDS indicated R2 ambulated independently. R2's CAA dated 11/9/21, identified physical/behavioral symptoms directed toward	F 600	F600 Freedom from Abuse and Neglect Alleged DOC: 8/19/2022 1. Corrective Action • Resident 1 continues to reside at the Facility. • Resident 1 care plan updated to include wandering behavior and interventions. • Resident 2 continues to reside at the Facility. • Resident 2 behavior care plan updated to include new interventions related to resident to resident altercations and behaviors. • Resident 2 has been referred to provider for medication review and follow up. • Resident 3 continues to reside in the Facility and has been transferred to another unit. Current care plans remain appropriate. • Resident 4 continues to reside at the Facility. Care plan updated to reflects activities of interest.	

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F 600	Continued From page 2 others, wandering and rejection of care behaviors. The CAA analysis indicated R2 received antidepressants and indicated "SW [social worker] continues to provide support and monitors behaviors/moods." The analysis did not identify causes and/or interventions nor an evaluation of the effectiveness of interventions. R2's care plan dated 7/28/22, identified mood and behavior and indicated a diagnosis of Korskoff's anxiety, amnesic disorder and dementia due to alcoholism. The care plan identified the use of psychotropic medications and identified the target behaviors to include aggressive behaviors towards others. The care plan indicated R2 displayed swearing at, hitting, pushing, screaming at staff, resistance to cares and wandering throughout the unit. The care plan directed staff to offer linens to fold and snacks for agitation. The care plan did not include interventions related to resident to resident altercations. R3's significant change MDS dated 5/28/22, indicated severe cognitive impairment and identified no behaviors. R3's CAA dated 5/28/22, identified cognitive loss due to diagnosis of dementia. The CAA indicated social worker continues to provide support and monitors mood/behaviors. R3's care plan dated 5/5/22, identified an area of vulnerability to include mental illness. The care plan directed staff to observe/suspect abuse and move resident away from aggressor to a safe location. R4's quarterly MDS dated 7/21/22, indicated moderately impaired cognition and indicated she displayed verbal behaviors directed toward others. R4's CAA dated 4/30/22, identified a psychiatric or mood disorder and indicated the	F 600	2. Identifying other residents • Director of Nursing/Designee/IDT conducted an audit of residents residing in the secured memory care unit to identify resident specific behaviors and updated care plans to include appropriate interventions. 3. Systemic Changes • DON/designee shall educate staff including agency personnel regarding behavior management. • DON/designee shall educate staff including agency personnel regarding Abuse policy. • DON/designee shall educate staff including agency personnel regarding Kardex. • DON/designee shall educate staff including agency on the behavioral monitoring policy. • Interdisciplinary team shall meet weekly to discuss behavioral residents to determine the appropriateness of current interventions. • Unit managers shall monitor behavior charting to ensure behaviors are care planned and interventions are in place. 4. Monitoring • DON/designee shall monitor behavior charting daily x 7 days then 5 times a week x 2 weeks then weekly x 4 weeks or until sustained compliance is achieved • DON/Unit managers shall audit behavior care plans to ensure appropriate interventions are in place daily x 7 days then 5 times a week x 2 weeks then weekly x 4 weeks or until sustained	

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F 600	Continued From page 3 use of antipsychotics and antidepressants. R4's care plan dated 4/13/22, identified an area of vulnerability to include mental illness. The care plan directed staff to observe/suspect abuse and move resident away from aggressor to a safe location. A report to the state agency (SA) dated 6/5/22, indicated R2 and R3 both resided on the secured unit of the facility. The report indicated a family member reported to the nurse on the unit R2 had struck R3 on the left upper arm earlier when he asked for her cookie. A correlating Progress Note created 6/7/22, indicated R3's family member (FM) approached the nurses desk to report R3 had been struck by another resident because he wanted her cookie. A report to the SA dated 6/10/22, indicated R2 and R4 both resided on the secured unit of the facility. The report indicated R2 and R4 were in the dining room when staff heard "let go." Staff rounded the corner and found R2 grasping R4's clothing protector. R2 let go of the clothing protector and made contact with the top of R4's head with an open hand. A report to the SA dated 7/28/22, indicated R3 and R2 both resided on the secured memory care unit. R2 was witnessed making contact with an open hand to R3's shoulder. R2 was also heard using vulgar language. Residents immediately separated, skin and pain assessment completed. Family and physician updated. Full investigation to follow. A correlating Progress Note dated 7/28/22, indicated R2 was shouting at R3 as he was trying	F 600	compliance is achieved • Audit results shall be submitted to QAPI to be addressed as appropriate	

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F 600	Continued From page 4 to take her cookie from her. R2 called R3 a "bitch" then pushed her on her right shoulder. The Progress Note indicated R3 was upset and stated, "I need to get outta here." A report to the SA dated 7/31/22, indicated R2 was witnessed cleaning the dining room per his usual routine when he approached R1 who had a visitor. R2 attempted to take an item from R1. Staff witnessed the incident but was unable to intervene prior to R2 making contact with R1's shoulder with an open hand. A correlating Progress Note dated 7/31/22, indicated R2 approached R1 and "open handed" slapped R1 on the right shoulder. R1 said R2 was going through his stuff and was asked to stop then R2 slapped him on the shoulder. During interview on 8/4/22, at 9:44 a.m. nursing assistant (NA)-A stated R2 stayed in his room a lot but when he came out he was loud. NA-A stated some of the residents tell him to be quiet and he will get upset and yell back. NA-A stated she had not been present during the incidents when R2 hit other residents but stated she had seen R2 and R3 yell at each other. NA-A stated staff usually redirected R2 with food. On 8/4/22, at 11:14 a.m. R3's family member (FM)-A stated R3 had been moved off the secured unit after the recent incident with R2. FM-A stated R3 had complained about R2 before and said R2 would grab her Coke and had stolen other things from R3. FM-A stated although he understood R2 did not know what he was doing, "you still don't want your [family member] pushed around." FM-A stated he thought R2 scared R3 and said R3 would tell him she would wake up in	F 600		

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F 600	Continued From page 5 the middle of the night and find R2 standing in her room. On 8/4/22, at 11:19 a.m. FM-B stated there had been more than one altercation between R3 and R2 and stated R2 had hit R3 and stole pop out of her hand. FM-B said R2 did it to everybody and said they should have moved R3 a long time ago. FM-B stated the nurse was usually in the area passing medications but R2 moved quickly and if the nurse was in and out of rooms passing medications could not always intervene. During interview on 8/4/22, at 11:49 a.m. NA-B stated she was working the day the incident occurred between R2 and R1 but she had not seen the incident. NA-B stated she heard R2 went to R1's table and wanted his clothing protector. NA-B stated all the staff were in the dining room but no one had seen what happened. NA-B further stated it had happened a few times. NA-B stated R2 was placed on 15 minutes checks and said she felt like R2 was always being placed on safety checks. Untitled facility monitoring sheets dated 7/31/22 - 8/3/22, indicated staff were observing R2's whereabouts and signing off every 15 minutes. On 8/4/22, at 11:54 p.m. registered nurse (RN)-A stated R2 had days where he walked around wanting to clean things and got in other peoples way. RN-A stated wen R2 was like that he tried to keep an eye on him. RN-A stated he was working when the incident between R2 and R3 occurred in June but did not remember what happened. RN-A stated the previous weekend he had been working when the incident between R2 and R1 occurred. RN-A stated he was seated at the	F 600		

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F 600	Continued From page 6 nurses station (the dining room is visible from the nurses station). RN-A stated R1 was sitting with a visitor drinking coffee and R2 was cleaning. RN-A stated he saw R1 move his stuff away from R2 then saw R2 "swipe his hand across" R1's shoulder. RN-A stated the hit was not with "full force," more like a slap but "not playful by any means either." RN-A added after meals staff tried to get things cleaned up as soon as possible because that was R2's target. RN-A stated R2 also paced the halls so they tried to close the other residents room doors. On 8/4/22, at 12:12 p.m. the director of nursing (DON) stated when completing an investigation following an incident of resident to resident abuse she asked staff if the residents were separated and asked what triggered the incident. The DON stated she completed a skin and pain assessment and following the incidents staff observed behaviors "for a while." In regard to R2, the DON stated they needed to focus on R2 and his behaviors. She stated sometimes R2 slept a lot and sometimes he was out cleaning so staff focused on getting the dining room cleared faster. The DON stated during the recent incident involving R1, R1 had a visitor but she was not aware who R1's visitor was. She stated the incident in June involving R3 was in the dining room and involved a cup of coffee. The DON stated R3 had been moved off the unit after the recent incident on 7/29/22. The DON said when R2 wanted something, he wanted it and he did use vulgar language but did not feel he intended to abuse anyone. She further stated R2 had probably had between 8-10 incidents where had made contact with another resident. When asked about protection of other residents, the DON said	F 600		

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F 600	Continued From page 7 staff needed education and that R2 should not be left alone in the dining room. The DON stated they had tried things like labeling a coffee cup for R2 and giving him a basket of clothing protectors to fold but said it did not keep him occupied. She said they had made a referral to a tele-heath psychiatric doctor but R2 had not been seen yet. DON added she had asked for a medication adjustment but stated the nurse practitioner was not in agreement. The DON said the root cause was when other residents were being assisted by the staff and no one was in the dining room. At 2:24 p.m. the DON stated they had identified a need for supervision and said "I think there is more supervision during meal times now." The DON said she was planning to have someone in the dining room during and after meals until things were cleaned up and said she planned on having the environmental services director involved in the education. During interview with the administrator and DON on 8/4/22, at 3:26 p.m. the administrator stated R2 was placed on 15 minute checks after the incident on 6/5/22, involving R3. The administrator stated the 15 minute checks were not ongoing indefinitely and said they were removed after they they determined what they thought was the cause of the altercations. The administrator stated she felt R2's obsession with cleaning was the cause of the most recent altercation and felt it was a newer behavior. The DON stated after the incident on 6/12/22, staff made more snacks available to R2 and started an increase in his medications. The DON stated R3 had been moved off the unit following the incident on 7/28/22 and after the 7/31/22, incident R2 was again placed on 15 minute checks and staff were ensuring more staff were in the dining room after	F 600		

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JENSEN HEALTH LLC	2501 RICE LAKE ROAD DULUTH, MN 55811

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F 600	Continued From page 8 meals. The DON and administrator described interventions attempted related to R2's behaviors but were unable to verbalize ongoing interventions to protect other residents on the unit from R2's aggressive behaviors. A facility policy Freedom from Abuse, Neglect, Exploitation dated May 2020, defined a resident to resident altercation as an incident involving a nursing home resident who willfully inflicts injury on another resident. The policy indicated "willful" means the resident must have acted deliberately. The policy indicated if the circumstances require it, staff removed the residents suspected of being the subject of an alleged violation to an environment where the residents safety can be protected then staff separate the residents so they do not have access to each other until the circumstances of the alleged incident can be determined.	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00598	A. BUILDING: _____ B. WING _____	C 08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JENSEN HEALTH LLC	2501 RICE LAKE ROAD DULUTH, MN 55811

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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 8/3/22 - 8/4/22, 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. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/24/22

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 The following complaints were found to be SUBSTANTIATED: H53663630C (MN85611), with no orders cited. H53663737C (MN85564), with no orders cited.. H53663777C (MN84203), with no orders cited. H53663778C (MN84060), with no orders cited. 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		