DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
July 13, 2022

Administrator
Good Samaritan Society - Battle Lake
105 Glenhaven Drive
Battle Lake, MN 56515

RE: CCN: 245403
Cycle Start Date: June 3, 2022

Dear Administrator:

On July 6, 2022, the Minnesota Department(s) 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.

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
	245403	A. BUILDING _____ B. WING _____	C 06/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BATTLE LAKE	105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515

(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 6/2/22 through 6/3/22, 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 UNSUBSTANTIATED: H54032048C (MN83885) AND The following complaint was found to be SUBSTANTIATED: H54032049C (MN83936), however NO deficiencies were cited. As a result of the investigation, additional deficiencies were cited at F609 and F610. 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 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 609		6/30/22

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

Electronically Signed | 06/23/2022

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 609	Continued From page 1 §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to report an injury of unknown origin to the State Agency (SA), within two hours, as required for 1 of 3 residents (R1) who were reviewed for abuse. Findings include: R1's quarterly Minimal Data Set (MDS) dated 3/30/22, indicated R1 had diagnoses which included Parkinson's Disease and dementia and had moderate cognitive impairment.	F 609	F609: 1) Injury of unknown origin was reported to state agency 5.5 hours after being noted. 2) All current and future residents have the potential to be affected by this deficient practice. 3) Current RN’s on call and all floor RN/LPN’s will be educated on what needs to be reported to the state agency and the timeframes in which each incident needs	

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F 609	Continued From page 2 R1's incident report dated 5/30/22, indicated R1's bruise on left breast was from the nipple to her left side and measured approximately 11 centimeters wide by 7 centimeters long. Another bruise was noted on the top of the left breast measuring approximately 5 centimeters long by 3 centimeters wide. Both bruises were noted to be dark reddish-purple with some green on the breast. Review of facility report to the SA dated 5/30/22, at 1:07 p.m. indicated R1 had a skin check completed on 5/30/22, at 7:40 a.m. and was noted to have a "very large" bruise on her left breast and was dark in color. R1 was unaware of how the bruise occurred. On 6/2/22, at 1:41 p.m. during interview with R1, she stated she was not sure how the bruise occurred and denied any abuse. On 6/2/22, at 1:56 p.m. registered nurse (RN)-A stated facility policy for injuries of unknown origin were to be reported to the SA within a "short time-frame" but for sure less than 24-hours. RN-A stated she was notified of the bruise when nursing assistant (NA)-A reported to RN-A during R1's bath on 5/30/22. RN-A was unsure what time R1 had received her bath but stated before 9:30 a.m. RN-A could not determine the cause of the bruise or rule out abuse at the time of identification. RN-A stated she reported the new bruise to the director of nursing (DON) and Administrator who indicated a report to the SA needed to be completed. RN-A stated she began the report shortly after, however was unable to complete the report due to being needed on the floor. RN-A confirmed she did not report the injury of unknown origin to the SA within the two-hour	F 609	to be reported. A workflow process will be updated and available in each charting room for reference for any current/future nurses. 4) Audits of all incident reports will be completed by DNS or designee daily x30 days to ensure any reporting requirements are followed. All audit findings will be taken to the Quality Assurance committee for review and further recommendations.	

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F 609	Continued From page 3 timeframe and stated the importance of reporting timely was to begin the investigation. On 6/3/22, at 9:38 a.m. case manager (CM)-A stated facility policy for injury of unknown origin were to be reported to the SA within two hours. Further, CM-A stated R1's bruise was identified on 5/30/22, in the morning during her bath and was reported to the SA "sometime in the afternoon". CM-A confirmed RN-A did not submit the report to the SA within the two-hour time frame as expected and was not aware of the late report until surveyor interviewed RN-A on 6/2/22. In addition, CM-A stated reporting to the SA timely was important due to the possibility of abuse due to the unknown nature of the bruise and to ensure R1 is safe and not subject to further potential harm. On 6/3/22, at 11:12 a.m. administrator stated the facility policy for injuries of unknown origin were to be reported to the SA within two-hours which was important to prevent any potential harm to the resident and ensure safety. In addition, administrator stated he was unaware R1's bruise was not report timely to the SA until surveyor interviewed RN-A. On 6/3/22, at 11:30 a.m. DON stated facility policy for reporting injuries of unknown to the SA was within two hours, however occasionally it has been a little more than two hours but the more serious injury the facility would try to be quicker. Further, DON stated she was not aware R1's bruise was not reported to the SA timely until 6/3/22, and indicated staff need more education on reporting as soon as staff are aware. In addition, DON stated reporting to the SA timely was important due to the possibility of abuse and	F 609		

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F 609	Continued From page 4 to investigation to ensure no further abuse and neglect occurs. Review of facility policy titled Abuse and Neglect policy revised 3/31/22, indicated the purpose of the policy was to ensure that all identified incidents of alleged or suspected abuse/neglect, including injuries of unknown origin, are promptly reported, and investigated. Further review of policy directed if there is an allegation of abuse, neglect, exploitation of mistreatment, including injuries of unknown source, then it will be reported immediately but not later than two hours after the allegation is made.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 610	F610:	6/30/22

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F 610	Continued From page 5 facility failed to thoroughly investigate allegations of injury of unknown origin for 1 of 3 residents (R1) reviewed for allegations of abuse. Findings include: R1's quarterly Minimal Data Set (MDS) dated 3/30/22, indicated R1 had diagnoses which included Parkinson's Disease and dementia and had moderate cognitive impairment. Further, R1's MDS indicated R1 required extensive assistance with two staff for activities of daily living (ADLs) such as bed mobility, transfers and toileting and required assistance with one staff for dressing and grooming. R1's incident report dated 5/30/22, indicated R1's bruise on left breast was from the nipple to her left side and measured approximately 11 centimeters wide by 7 centimeters long. Another bruise was noted on the top of the left breast measuring approximately 5 centimeters long by 3 centimeters wide. Both bruises were noted to be dark reddish-purple with some green on the breast. Review of facility report to the State Agency (SA) dated 5/30/22, at 1:07 p.m. indicated R1 had a skin check completed on 5/30/22, at 7:40 a.m. and was noted to have a "very large" bruise on her left breast and was dark in color. R1 was unaware of how the bruise occurred due to cognitive level. Review of facility's 5-day investigation to the SA dated 6/1/22, indicated staff were interviewed who worked with R1 in the past 24-hours with no report of bruising noted prior to skin check on the morning of 5/30/22. Further review of	F 610	1) Interviewed 10 random cognitive residents on their care perceptions in relation to rough care. Completion of sit-stand-walk assessment in complaint resident's chart to show safety and appropriateness of continued use of mechanical lift and sling. All other current resident's will have review of sit stand walk assessments to ensure accuracy of last assessment in relation to current mechanical use status. 2) All current and future residents have the potential to be affected by this deficient practice. 3) Education for RN case managers regarding proper investigation following c/o or suspected abuse/neglect including assessments, documentation and interviews. Education to all licensed nurses on completion of appropriate sit stand walk assessment with resident changes and mechanical lift use. Education to all current nursing staff on proper use of mechanical lifts and resident perceptions of rough care. 4) Audits of all incident reports and investigations will be completed by DNS or designee daily x30 days to ensure accuracy of investigations. Random audits for proper use of mechanical lift transfers will be completed by QAPI coordinator or designee every shift x 7 days, then daily x2weeks, then 3x/week x1 week. Random interviews with cognitive residents will be completed 3x weekly x2 weeks and once weekly x2 weeks to ensure no further c/o	

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F 610	Continued From page 6 investigation indicated R1 requires the use of the mechanical standing lift and R1's bruising lines up with harness and "question if this may have been placed improperly leading to bruising". Additionally the report indicated that R1 had reported to family that staff were "too rough" with her at times as reported by family to the facility on 5/31/22. Interventions implemented to prevent reoccurrence were physical therapy evaluation to ensure ongoing safety with current transfers, placing a sheep skin pad under left side under harness to prevent discomfort, and staff education related to using caution with ADLs and transfers per facility's safe resident handling protocols and update licensed staff if staff are feeling they need any further training or if staff had concerns with transferring any resident. In addition, facility's 5-day investigation lacked evidence of interventions implemented to address and protect R1 and other residents following the allegation of "rough" care, as well as interventions to protect R1 and other residents who utilize the standing mechanical lift when the root cause of the bruise was determined to be improper use of the harness. On 6/3/22, at 9:38 a.m. case manager (CM)-A stated she completed the facility's 5-day investigation for R1's bruise. CM-A stated her investigation included reviewing R1's incident report, interviews with staff that worked with R1 within the past 24-hours of 5/30/22, interviewed R1 and R1's family. Further, CM-A stated she reviewed R1's medications and hemoglobin levels with no concerns noted with those two things. CM-A determined R1 utilizes the mechanical standing lift for transfers and the bruise was in line with the harness used for the mechanical lift so a sheep skin pad with implemented as a	F 610	rough care. All audit findings will be taken to the Quality Assurance committee for review and further recommendations.	

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F 610	Continued From page 7 preventative measure as well as ordering a physical therapy evaluation to ensure R1 was safe to use the mechanical stand for transfers. CM-A stated she typed up an education sheet on ensuring staff are careful with cares due to "this complaint" and bruising and staff were to sign and acknowledge they understood. When asked what prevention measures were implemented to protect R1 and other resident's residing on the unit following the allegation of "rough" care, CM-A stated the education she typed for the staff that direct staff to be careful during cares. CM-A confirmed no additional residents on the unit were interviewed to determine if there were additional concerns related to "rough" care because there had been no additional complaints reported by other residents regarding "rough "care and no additional skin concerns had been noted on the other resident's weekly skin check. In addition, CM-A stated interviewing other residents would be important if there were a concern for abuse, however CM-A stated she personally did not have any concerns about abuse but indicated she was not on the floor with staff observing everything the staff are doing. CM-A confirmed she did not observe any staff transferring residents using the mechanical standing lift or provide education on the proper use of the lift following the determination of the root cause of R1's bruising to be improper placement of the harness. On 6/3/22, at 11:12 a.m. administrator stated R1's family reported the allegation of "rough care" to the administrator who then reported the additional concern to CM-A to add into the investigation for R1. Administrator stated staff were expected to interview the resident when an allegation of rough care is made, however if the resident is cognitively impaired staff were expected to	F 610		

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F 610	Continued From page 8 interview other cognitive residents on the unit and other staff to determine if there are any trends or a widespread issue. On 6/3/22, at 11:30 a.m. director of nursing (DON) stated rough care allegations were expected to be investigated by completing staff interview and other resident interviews to see if there are additional concerns or trends or if the allegation can be narrowed down to a specific staff member. Further, DON stated she was not aware of R1's allegation of rough care until 6/3/22. In addition, DON stated CM-A deemed the cause of the bruise occurred potentially from the lift harness which DON stated she would expect CM-A to re-evaluate the use of the mechanical lift and complete a facility assessment titled Sit, Stand, Walk to ensure resident is appropriate for the lift and no changes need to be made. DON confirmed CM-A did not complete a new Sit, Stand, Walk assessment and R1 had not had one completed since 3/22 for her quarterly assessment and there was no further education provided to staff related to safe transfers with mechanical lifts following the incident. Review of facility policy titled Abuse and Neglect policy revised 3/31/22, indicated the investigation team will review all incidents no later than the next working day following the incident. The investigation team will determine whether further investigation is needed. Further, the policy indicated the investigation may include interviewing employees, residents, or other witnesses to the incident.	F 610		

Electronically delivered

Administrator
Good Samaritan Society - Battle Lake
105 Glenhaven Drive
Battle Lake, MN 56515

RE: CCN: 245403
Cycle Start Date: June 15, 2022

Dear Administrator:

On June 3, 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 September 3, 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 December 3, 2022 (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,

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 15, 2022

Administrator
Good Samaritan Society - Battle Lake
105 Glenhaven Drive
Battle Lake, MN 56515

Re: Event ID: OP4011

Dear Administrator:

The above facility survey was completed on June 3, 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
	00146	A. BUILDING: _____ B. WING _____	06/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BATTLE LAKE	105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	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 6/2/22 through 6/3/22, 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	2 000		

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2 000	Continued From page 1 UNSUBSTANTIATED: H54032048C (MN83885) AND The following complaint was found to be SUBSTANTIATED: H54032049C (MN83936), 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		