Electronically delivered
April 2, 2021

Administrator
Sylvan Court
112 St Olaf Avenue South
Canby, MN 56220

RE: CCN: 245433
Cycle Start Date: March 17, 2021

Dear Administrator:

On March 17, 2021, 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" tag), i.e., the plan of correction should be directed to:

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, MN 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

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 June 17, 2021 (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 September 17, 2021 (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,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245433	A. BUILDING _____ B. WING _____	C 03/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYLVAN COURT	**112 ST OLAF AVENUE SOUTH CANBY, MN 56220**

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F 000	INITIAL COMMENTS On 3/16/21 through 3/17/21, a standard abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found NOT in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5433007C (MN70863) and H5433009C (MN66353) with a deficiency cited at F600. The following complaints were found to be UNSUBSTANTIATED: H5433008C (MN70263), and H5433010C (MN68061). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation 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 includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to	F 600		4/21/21

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

Electronically Signed | 04/11/2021

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 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 observation, interview, and document review, the facility failed identify potential interventions to prevent resident-to-resident altercations between 4 of 4 residents (R1, R2, R3, and R4) with known physical behaviors. Findings include: Review of the 3/10/21, report to the State Agency (SA) identified R1 and R4 were having a conversation when R4 became angry and slapped R1 on the left side of her face. Staff immediately intervened. No injuries were noted and staff continued to monitor. R1's 1/7/21, Minimum Data Set assessment (MDS) dated identified severe cognitive impairment, Alzheimer's disease with behavioral disturbance, depression, anxiety, and history of chronic pain. R1 was independent with activities of daily living (ADLs) for all but dressing which required limited assistance. R1 wandered on a daily basis and was exit-seeking at times. Observation and interview on 3/16/21 at 2:15 p.m., with R1 in her room identified she was seated in her recliner. R1 denied any abuse concerns or problems with staff or residents and stated every one was really nice. R1 then leaned back in her chair, closed her eyes and went to	F 600	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. 1.Resident care plans were modified on 3/12/21 to state to keep R1 and R4 away from each other when irritation is noted by either party. There are times when R1 and R4 get along well with one another, in this case, staff supervision is to occur. R1 and R4 care plans and resident daily grid review occurred on 3/17/21 to focus on identification and interventions to use with residents with known behaviors. R1 and R4 care plans were modified on 3/19/21 to add additional interventions/strategies of how staff can prevent behaviors with	

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F 600	Continued From page 2 sleep. There were no observable signs of abuse noted. R1's current, undated care plan identified behaviors of dementia and a tendency to "develop crushes on males, both residents and staff". Staff were to provide redirection to divert R1's attention from focusing her conversations primarily toward male staff or residents. R1 was to be monitored due to issues with sun-downing (behavioral problems that occur in the evening or while the sun is setting), agitation, and anger. R1 identified herself as a caregiver, due to a history of working as a nursing assistant (NA). R1 had a history of attempting to interfere with care provided for other residents by staff, and would enter their room in an attempt to provide her assistance. When staff would attempt to redirect R1 from the room she became vocal and argumentative. There were no interventions to identify how staff were to prevent behaviors that would affect other residents. Interview on 3/16/21 at 2:30 p.m., with LPN-A identified R1 was confused most of time, but usually responded to attempts of redirection but R1 was not able to determine herself, when other residents did not want to be bothered. R1 was "bossy" toward other residents due to wanting to direct their activity or provide care and answer call lights. R1 was difficult to redirect from her attempts of assistance and didn't accept staff telling her "no" and would become argumentative. LPN-A was not aware of any previous incidents between R1 and R4 but both residents were kept safe by staff monitoring and providing intervention to prevent close contact. Interview on 3/16/21 at 2:51 p.m., with nursing	F 600	residents including distraction, re-direction, and assurance. Treatment interventions monitoring for signs of escalating behavior and mood changes of R1 and R4 was implemented on 3/17/21 and continues as an intervention and reviewed for continuation monthly. Consultant pharmacists completed additional medication reviews on 4/7/21. R4 had recent psychiatry appointment on 2/22/21 with follow up scheduled in 3 months. Communication occurred to R4's psychiatric provider on 4/8/21 to determine if any additional recommendations would be considered in regards to recent resident to resident altercation that occurred on 3/11/21. Consultant Pharmacist completed medication review for R1 and recommended medication adjustment. This was then ordered by attending physician on 3/25/21. Behavior management incident was discussed at team meeting on 3/15/21. At the time of the submission of this document, no additional altercations between R1 and R4 have occurred since incident on 3/11/21 and R1 and R4 have not had any altercations with other residents in the unit. _____ On 10/16/20, increased observation from nursing staff was immediately implemented between R2 and R3. Staff communication for monitoring between the two residents from shift to shift occurred to nursing staff and via shift	

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F 600	Continued From page 3 assistant (NA)-D identified he had noticed R1 had previously irritated other residents by attempting to provide cares, such as attempts to help them transfer, push their wheelchairs, or making comments to them about what they could or could not do. R1 had also become upset with staff for their attempts at redirection or speaking with other residents about something she had "over-heard and didn't agree with. R1 wandered through out the unit and had attempted to enter other resident spaces and would attempt to answer call lights and provide assistance to them. R4's 2/25/21, quarterly, MDS identified he had severe cognitive impairment with diagnoses of alcohol dependence with alcohol-induced dementia, anxiety disorder, and panic disorder. He required limited assist with personal hygiene, extensive assistance for dressing and toileting, and was independent in other areas. R4 displayed behaviors of wandering on a daily basis with frequent exit-seeking attempts and agitation at staff attempts of redirection. R4's current, undated care plan identified he had behaviors of wandering into private spaces, rummaging in other's belongings, exit-seeking, refusal of care and medication, and lack of safety awareness. He was know to hit at staff, swear, grumble under his breath and had resistance to attempts at redirection. Staff were to redirect as able and provide a calm environment. There were no interventions to identify how staff were to prevent behaviors that would affect other residents. Interview on 3/16/21 at 2:30 p.m., with LPN-A identified she was notified of the incident by NA-E and attempted to interview R4 who replied, he	F 600	reporting. On 10/16/20, reviewed resident care plans and were appropriate for interventions to their behaviors. Upon further review, additions to R2 and R3 care plans and daily grids occurred on 4/8/21 to identify additional intervention to aide in prevention of behaviors with other resident such as various activities, 1 to 1 interactions, re-direction, assurance, and distraction. Consultant pharmacists completed additional medication review for R2 and R3. Pharmacy recommendations for R2 were reviewed and additional pharmacological interventions were not recommended at this time. R3 has been followed by psychiatry and follow up appointment is scheduled on 4/14/21. Consulting Pharmacy medication review for R3 indicated possible dose reduction and this is to be addressed at appointment on 4/14/21 so no medication adjustments made as of date of this report. At the time of the submission of this document, no substantiated additional altercations between R2 and R3 have occurred since 10/16/20 and R2 and R3 have not had any altercations with other residents in the unit. Treatment interventions monitoring for signs of escalating behavior and mood changes of R2 and R3 was implemented on 2/21/21 and continues as an intervention and reviewed for continuation monthly.	

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F 600	Continued From page 4 was tired of R1's [expletive]. "I slapped her". R4 continued to wander in the hall and no further incidents were noted. R4 had a history of becoming angry at staff and had refused of medications and cares. LPN-A was not aware of any incidents directed toward other residents. R4 wandered and would attempt to exit facility outer doors or get on the elevator. He would become agitated when the alarm sounded and the door didn't open. She described R4 as having an angry facial expression, and leaning his upper body toward staff in a threatening manner when they attempted to redirect him. Interview on 3/16/21 at 2:51 p.m. with NA-D identified R4 was upset and more irritable at times, and R1 was not able to differentiate between R4's moods or recognize when he does not want to be bothered. R4 was exit-seeking and wandered. He would be looking for family members or believed he needed to care for farm animals. R4's behaviors included wandering into resident rooms and rummaging through belongings, becoming angry with staff who attempted redirection, and refusal of care and medications. NA-D identified the frequency of his behavior can vary, but he was frequently exit seeking and became angry when the door wouldn't open and the alarm sounded.. Interview on 3/17/21 at 3:26 p.m. with NA- E identified she was walking with R1 on 3/10/21 at 9:47 p.m. when R4 asked what they were doing. R1 responded and R4 became angry and began swearing. R1 became upset that R4 was swearing at her. R4 came closer, leaned toward R1, grabbed her arms and shook them, then raised his hand and slapped her on her left cheek. NA-E immediately stepped between R1	F 600	2.All residents were reviewed in regards to determine abuse and neglect and ensured care plans reflect interventions resident to resident altercations, nothing identified with the exception of the residents that were identified in this survey. 3.Staff education to nursing and ancillary staff members that interact with residents at Sylvan Court will be completed by 4/20/21 with focus on vulnerable adult prevention of abuse and neglect. Will review with staff where they find information indicating resident has past history of abuse towards other residents and the specific interventions to use when they see any conflict begin to occur between residents. 4.A random audit of 10 observations per month will occur during various shifts to determine if R1 and R4 and R2 and R3 are together and unsupervised with or without signs of increasing conflict. This monitor will be done for a duration of 3 months and then reassessed for continuation. Results of audit will be communicated at monthly QAPI meeting for further recommendations and communicated directly to staff members if residents are not following the recommendations of the resident care plan.	

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F 600	Continued From page 5	F 600		

and R4 and was able to redirect R1 and R4. R1 did not have any redness or injury to her cheek. NA-E ensured R1 was safe and reported the incident to LPN-A. Later that same evening R1 and R4 were attempting to converse and had no recollection of the earlier incident. Staff remained in attendance to ensure neither resident was within arms length of the other. NA-E was not aware of any previous incidents between R1 and R4. R4 had behaviors toward staff persons at times, but she was not aware of any physical behavior directed at other residents prior to the incident.

Review of the 10/16/20, report filed to the SA report identified R3 was seated in his wheelchair in front of the nursing desk laughing and joking with staff. R2 was standing next to him when R3 suddenly yelled "move...move!". R3 struck R2 2 times in the stomach with a closed fist, causing her to bend forward and grab her stomach. LPN-B immediately separated R2 and R3 and assessed R2 for injury. R2 had a 2 centimeter (cm) reddened area located above her belly button area. R2 denied discomfort or distress and continued to wander in the halls while being monitored. R3 returned to his room without further incident..

R2's 10/12/20, MDS identified R2 had diagnosis of dementia with behavioral disturbance, stroke with signs and symptoms of decreased cognitive function and awareness, and impaired bilateral peripheral vision which reduced her mobility. R2 had severe cognitive impairment but was independent with all ADL's except personal hygiene and dressing which required the limited assistance of 1 staff.

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F 600	Continued From page 6	F 600		

R2's current, undated care plan identified a bright an orange sign with R2's name was posted by her room door to assist her in finding her room. Staff were to redirect R2 when she was found in another resident's room. R2 had a history of past family abuse, exhibited paranoia, agitation and became easily upset. R2 would at times strike out at staff when they attempted redirection. There were no interventions to identify how staff were to prevent behaviors that would affect other residents.

Interview on 3/16/21 at 3:10 p.m., with NA-D identified R2 wandered in and out of her room frequently down both halls and would wander into other resident rooms. R2 became upset easily and at times would throw objects at staff when they attempted redirection.

R3's 10/22/20, quarterly MDS identified R3 had severe cognitive impairment with diagnoses of anxiety, major depression, traumatic brain injury, history of substance dependence, dementia with behavioral disturbance, and difficulty swallowing. R3 exhibited behaviors of hitting and kicking at staff with cares and yelling out. R3 required extensive assistance with all ADLs including eating.

R3's current, undated care plan identified staff were to monitor R3 to promote safety and prevent behavior directed toward other residents. He was to receive hourly checks from staff for safety and his room was across from nursing station. R3's would be easily frustrated, refused care or to get out of bed, and was combative at times toward staff. Following the 10/16/20 incident an additional entry was added to include R3 was to maintain a safe distance from R2. There were no

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F 600	Continued From page 7	F 600		

interventions to identify how staff were to prevent behaviors that would affect other residents.

R3's 10/16/20 at 3:55 p.m., progress note identified after the incident on 10/16/20, R3 showed no reaction and wheeled himself to his room. Staff noted R3's cognition had continued to decline following admission to the facility and he had exhibited inappropriate anger and impulsivity demonstrated by striking out at staff.

Interview on 3/16/21 at 3:10 p.m., with NA-D described R3 as easy going. He he had not displayed aggressive behavior toward other residents, only toward staff when they attempted to provide care or transfer him into his chair.

Interview on 3/16/21, at 3:46 p.m., with LPN-D identified R2 and R3 did have "occasional issues" due to R2 wanting to touch other residents. R2 had limited vision and liked to walk with her hand on the hand rail. This practice would have caused her to pass the area in which R3 liked to sit. LPN-D thought R2 had possibly touched R3 as she attempted to move past. Following the incident, staff were to keep R2 and R3 out of touching distance, but the two liked to visit at times and it wasn't not always easy to keep them apart. Staff were aware R3 was more irritable and likely to strike out following visits from his significant other.

Interview on 3/17/21 at 4:30 p.m., with the director of nursing (DON) identified the above mentioned incident between R2 and R3 occurred following a visit from R3's significant other. The DON was informed R3 was heading back to his room, and R2 was in his way. He became impatient and struck out. The DON identified R2

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F 600	Continued From page 8 and R3 had a history of sitting beside each other when in the lounge area, so if she was standing close to R3 it wouldn't have been an area of concern. R2 had decreased vision and cognition which could have been the reason she did not move out of R3's path as he began moving away from the area. The DON identified there was not adequate identification into potential interventions that should have been in place knowing R3 displaying irritability following visits from his significant other. Review of the 1/7/21,Vulnerable Adults Reporting Maltreatment policy identified the facility was to provide a physically and emotionally safe environment for all residents residing in the facility. Residents receiving services from the facility were to be protected from abuse from anyone, including but not limited to staff and other residents, family members, friends, or other individuals.	F 600		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 2, 2021

Administrator
Sylvan Court
112 St Olaf Avenue South
Canby, MN 56220

Re: Event ID: NIYW11

Dear Administrator:

The above facility survey was completed on March 17, 2021 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,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00722	A. BUILDING: _____ B. WING _____	C 03/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYLVAN COURT	112 ST OLAF AVENUE SOUTH CANBY, MN 56220

(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 3/16/21 and 3/17/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaints were found to be	2 000		

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2 000	Continued From page 1 UNSUBSTANTIATED: H5433008C (MN70263), and H5433010C (MN68061). The following complaints were found to be SUBSTANTIATED: H5433007C (MN70863) and H5433009C (MN66353), 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, the facility must acknowledge receipt of the electronic documents.	2 000		