Electronically delivered
November 15, 2021

Administrator
Shakopee Friendship Manor
1340 Third Avenue West
Shakopee, MN 55379

RE: CCN: 245445
Cycle Start Date: October 19, 2021

Dear Administrator:

On October 19, 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:

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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 January 19, 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 April 19, 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,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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	245445	A. BUILDING _____ B. WING _____	C 10/19/2021

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SHAKOPEE FRIENDSHIP MANOR	**1340 THIRD AVENUE WEST SHAKOPEE, MN 55379**

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F 000	INITIAL COMMENTS On 10/18/21 and 10/19/21, 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 complaints were found to be SUBSTANTIATED: H5445033C (MN77096) with a deficiency cited at F609 and F600. The following complaints were found to be SUBSTANTIATED: however no deficiencies were cited. H5445035C (MN73871) H5445034C (MN73225) The following complaint was found UNSUBSTANTIATED: H5445032C (MN68334) 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,	F 600		11/29/21

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

Electronically Signed | 11/18/2021

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F 600	Continued From page 1 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 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 document review and interview the facility failed to prevent abuse for 1 of 3 residents (R1) whom reviewed for abuse. Findings include: R1's Face Sheet dated 5/10/21, indicated mild cognitive impairment, bilateral secondary osteoarthritis of the knee, muscle weakness, difficulty in walking, chronic pain, idiopathic peripheral autonomic neuropathy, hearing loss, constipation, spinal stenosis of lumbar region, end stage renal disease, dependent on machines and devices. R1's quarterly Minimum Data Set dated 8/15/21, indicated intact cognition. R1 required extensive assistance of two for bed mobility, transfers, locomotion, and toilet use. R1 felt bad about self-several days and was at minimal risk for depression. R1's care plan dated 8/17/21, indicated R1 was vulnerable related to reduced physical function and confusion. R1 had potential to be verbally	F 600	R1 has no ill effects from the incident on 9/26/21. His Care Plan continues to state that if resident's behaviors start to escalate and he becomes agitated, staff are to re-approach at a later time. All residents will be monitored for interventions that would decrease potential incidences of abuse. Nursing assistants will document all behaviors and report to the nurses. Interventions are implemented to ensure safety and security of all residents. Added to the Vulnerable Adult Policy, all new admissions will be screened for staff capability to care for them, including behaviors, and amount of care required to meet resident's needs. All staff have been educated via Power Point titled, Vulnerable Adults, along with a quiz on the following: 1. Vulnerable Adult Abuse policy, which	

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F 600	Continued From page 2 aggressive. Staff were directed to analyze circumstances, triggers and what deescalates behavior. Staff were to allow time for R1 to express self and feeling towards the situation. Staff were to engage calmly in conversation and if response was aggressive staff were to walk away calmly and reproach. R1's progress note dated 9/26/21, at 12:59 p.m. indicated R1 was upset. LPN-A entered and found R1 red in the face screaming at NA-A and NA-B. LPN-A had to raise her voice in an attempt for resident to hear her. The facility Witness Statement Form dated 9/27/21, indicated an incident on 9/26/21, in R1's bathroom. R1 put his all light on after lunch to use the bathroom. NA-A and NA-B went to toilet R1. R1 became angry, aggressive, and yelled load. LPN-A came to help and tried to explain to R1 that he always needed sling on him during transfers. R1 began to yell and got aggressive. LPN-A started to scream and get in R1's face and scream over R1's voice. LPN-A pushed R1 very aggressively back on his toilet chair and pulled the EZ stand very hard back while R1's legs were still attached. NA-A unhooked R1's legs from the EZ stand. LPN-A grabbed the arms of the toilet chair and slammed it very hard on the toilet again. LPN-A began to scream at R1 and shake the arms of the chair. LPN-A continued to yell at R1. About 15 minutes later R1 was not as angry but was shook up from the incident. R1 was not in pain. R1's progress note dated 9/29/21, at 12:10 p.m. indicated resident coordinator (RC) met with R1 regarding the incident on 9/26/21. RC asked R1 what was wrong that day for him to become	F 600	was updated to include the 2 hour timeframe for reporting alleged abuse and or serious injury to the OHFC. If the incident is not a serious injury and not abuse, the report must be submitted within 24 hours of the alleged incident. This policy is posted in the staff breakroom. 2. Elder Justice Act 3. Resident Bill of Rights 4. Reporting definitions of different types of abuse 5. Information for staff on open communication with their supervisors to help manage stress, occupational burnout, how to handle angry outbursts and dealing with difficult/uncooperative behaviors. Quarterly and 'as needed' monitoring of all staff through pulse surveys (texting of staff) to get feedback on how they are dealing and/or coping with the challenges in healthcare. Staff are encouraged to voice concerns to the Administrative Team and are welcomed to do so at any time. In addition, an ACP flyer is posted in the breakroom offering free services with a professional psychologist to help deal with occupational stressors.	

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F 600	Continued From page 3	F 600		

upset. R1 stated, "that was nothing, I forgot all about it." R1's wife was present.

Relias Certificate of Completed dated 9/29/21, indicated LPN-A successfully completed 2.5 hours of Challenging Behaviors in Dementia care.

R1's Psychology progress note dated 9/28/21, indicated R1 was seen to discuss his coping strategies and anger.

The Facility Incident Report dated 10/1/21, indicated the facility spoke to staff who worked on the station at the time of the incident. R1 didn't remember having and issues with staff, LPN-A was taken off the schedule during investigation and had to complete re-education before she was able to return to work. LPN-A was re-educated on caring for residents with challenging behaviors, LPN-A watched a video titled Delivering Excellent Customer Service in the LTC Environment and completed Relias Module: Challenging Behaviors in Dementia care.

During an interview on 10/18/21, at 9:08 a.m. R1's wife stated the facility tried very hard to deal with R1's behaviors. R1's wife stated R1 struggled as he was mentally doing alright and was a retired physician but needed to physically be in a nursing home. R1's wife stated it was "extremely hard" for R1 to be in long term care. R1's wife stated the staff do a great job with him when he lashes out and got upset. R1's wife further stated it wouldn't surprise her if staff got upset with R1 as she has before. R1's wife further stated she learned that it was just best to listen when he got upset with her as when she spoke back it made thing worse. R1's wife stated she had no concerns with the care her husband

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F 600	Continued From page 4	F 600		

received.

During an interview on 10/18/21, at 9:39 a.m. NA-A stated on 9/26/21, around 12:00 p.m. NA-A and NAB went to assist R1 to the bathroom. NA-A stated she went to get LPN-A intervene when R1 got upset, agitated, and swung his arms back and forth. NA-A stated LPN-A yelled and screamed into R1's face. NA-A further stated LPN-A told R1 they did not need to cater to him, that R1 was here for a reason and aggressively pushed the EZ stand while R1 was still connected to it. NA-A stated she said "stop!" and NA-A unhooked R1's legs from EZ stand. NA-A further stated R1 made a "gasp noise" when LPN-A rammed his body into the toilet. NA-A stated she left the room as she felt uncomfortable when LPN-A and R1 continued to yell at each other. NA-A stated LPN-A used degrading words and yelled so load at R1 she started to cough. NA-A stated LPN-A was very rude and was "bloody murder, screaming at him." NA-A stated she informed RN-A of the incident the following day.

During an interview on 10/18/21, at 10:00 a.m. NA-B stated around 12:00 p.m. she went to assist R1 with NA-A. NA-B stated they connected R1 to the EZ stand with straps around his chest, behind his legs, arms and a sling that hung under him. NA-B staid R1 demanded to get unhooked when he was mid air. R1 started to shout while he clenched his right fist hit his knee and bang his right arm on the side by bar the sink. NA-B and NA-A pulled the shower chair under R1 immediately and lowered him to sit while he was still hooked up. LPN-A came to help. NA-B stated LPN-A looked and acted like she was irritated. NA-B further stated LPN-A stated to shout, yell at R1. NA-B stated LPN-A aggressively pushed R1

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F 600	Continued From page 5	F 600		

whom was in the shower chair over the toilet and "aggressively shook" R1 out of anger. NA-B stated she went to get R1 his newspaper to read while he used the bathroom, but LPN-A stated, "he doesn't deserve to read on the toilet." NA-B stated LPN-A was not appropriate and felt bad for R1 since he was vulnerable, and it was his home. NA-B stated LPN-A knew she was wrong after the incident, and it appeared she tried to justify herself after.

During an interview on 10/18/21, at 12:11 p.m. R1 stated he felt respected by staff. R1 further stated he has no concerns with staff or the recent incident and understood he got upset often.

During an interview on 10/18/21, at 1:46 p.m. LPN-A stated an aide came to the door to ask for help as R1 was screaming. LPN-A stated R1 shook the EZ stand and swung his arm and told use we were incompetent and that he was the customer and had to do what he said. LPN-A sated she told R1 you will not talk to us like that and that they will not help him if he acted that way. LPN-A stated he screamed and then LPN-A screamed and helped him to the toilet. LPN-A stated she yelled at him when he yelled at her. LPN-A stated she received education, was taken off the schedule and had to watch various videos before she could work again. LPN-A stated she was embarrassed on how she reacted and that this had never happened before. LPN-A stated she screamed at R1 when R1 was swearing at her, NA-B and NA-A. LPN-A stated R1 always acted this way but she was upset about an issue that had been going on at work. LPN-A stated looking back she should have just left the room when she felt she was getting upset.

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F 600	Continued From page 6 During an interview on 10/19/21, at 11:24 a.m. the director of nursing (DON) and resident coordinator (RC) stated LPN-A was not herself that day due to an administrative issue which was taken care of. The director of nursing (DON) and resident coordinator (RC) stated they have been working with R1 and his behaviors and to the reason to why he got upset. The DON and RC verified the nurse was verbally and physically inappropriate and there were no physical or lasting affects from the incident. The facility Vulnerable Adult Policy and Procedure plan dated 4/21, indicated abuse included verbal, physical, and mental abused Instance of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. Relias Certificate of Completed dated 9/29/21, indicated LPN-A successfully completed 2.5 hours of Challenging Behaviors in Dementia care.	F 600		
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: §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	F 609		11/29/21

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F 609	Continued From page 7 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 documents review the facility failed to immediately report an allegation of abuse to the State Agency for 1 of 3 residents (R1) who were reviewed for abuse. Findings include: R1's Face Sheet dated 5/10/21, indicated mild cognitive impairment, bilateral secondary osteoarthritis of the knee, muscle weakness, difficulty in walking, chronic pain, idiopathic peripheral autonomic neuropathy, hearing loss, constipation, spinal stenosis of lumbar region, end stage renal disease, dependent on machines and devices. R1's quarterly Minimum Data Set dated 8/15/21, indicated intact cognition. R1 required extensive assistance of two for bed mobility, transfers, locomotion, and toilet use. R1 felt bad about self-several days and was at minimal risk for depression.	F 609	R1 has no ill effects from the incident on 9/26/21. His Care Plan continues to state that if resident's behaviors start to escalate and he becomes agitated, staff are to re-approach at a later time. All residents will be monitored for interventions that would decrease potential incidences of abuse. Nursing assistants will document all behaviors and report to the nurses. Interventions are implemented to ensure safety and security of all residents. Added to the Vulnerable Adult Policy, all new admissions will be screened for staff capability to care for them, including behaviors, and amount of care required to meet resident's needs. All staff have been educated via Power Point titled, Vulnerable Adults, along with	

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F 609	Continued From page 8 R1's care plan dated 8/17/21, indicated R1 was vulnerable related to reduced physical function and confusion. R1 had potential to be verbally aggressive. Staff were directed to analyze circumstances, triggers and what deescalates behavior. Staff were to allow time for R1 to express self and feeling towards the situation. Staff were to engage calmly in conversation and if response was aggressive staff were to walk away calmly and reproach. R1's progress note dated 9/26/21, at 12:59 p.m. indicated R1 was upset. LPN-A entered and found R1 red in the face screaming at NA-A and NA-B. LPN-A had to raise her voice in an attempt for resident to hear her. The facility Witness Statement Form dated 9/27/21, indicated an incident on 9/26/21, in R1's bathroom. R1 put his all light on after lunch to use the bathroom. NA-A and NA-B went to toilet R1. R1 became angry, aggressive, and yelled load. LPN-A came to help and tried to explain to R1 that he always needed sling on him during transfers. R1 began to yell and got aggressive. LPN-A started to scream and get in R1's face and scream over R1's voice. LPN-A pushed R1 very aggressively back on his toilet chair and pulled the EZ stand very hard back while R1's legs were still attached. NA-A unhooked R1's legs from the EZ stand. LPN-A grabbed the arms of the toilet chair and slammed it very hard on the toilet again. LPN-A began to scream at R1 and shake the arms of the chair. LPN-A continued to yell at R1. About 15 minutes later R1 was not as angry but was shook up from the incident. R1 was not in pain.	F 609	a quiz on the following: 1. Vulnerable Adult Abuse policy, which was updated to include the 2 hour timeframe for reporting alleged abuse and or serious injury to the OHFC. If the incident is not a serious injury and not abuse, the report must be submitted within 24 hours of the alleged incident. This policy is posted in the staff breakroom. 2. Elder Justice Act 3. Resident Bill of Rights 4. Reporting definitions of different types of abuse 5. Information for staff on open communication with their supervisors to help manage stress, occupational burnout, how to handle angry outbursts and dealing with difficult/uncooperative behaviors. Quarterly and 'as needed' monitoring of all staff through pulse surveys (texting of staff) to get feedback on how they are dealing and/or coping with the challenges in healthcare. Staff are encouraged to voice concerns to the Administrative Team and are welcomed to do so at any time. In addition, an ACP flyer is posted in the breakroom offering free services with a professional psychologist to help deal with occupational stressors.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245445	A. BUILDING _____ B. WING _____	C 10/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 609	Continued From page 9	F 609		

During an interview on 10/18/21, at 9:39 a.m. NA-A stated on 9/26/21, around 12:00 p.m. NA-A and NA-B went to assist R1 to the bathroom. NA-A stated she went to get LPN-A intervene when R1 got upset, agitated and swung his arms back and forth. NA-A stated LPN-A yelled and screamed into R1's face. NA-A further stated LPN-A told R1 they did not need to cater to him, that R1 was here for a reason and aggressively pushed the EZ stand while R1 was still connected to it. NA-A stated she said "stop!" and NA-A unhooked R1's legs from EZ stand. NA-A further stated R1 made a "gasp noise" when LPN-A rammed his body into the toilet. NA-A stated she left the room as she felt uncomfortable when LPN-A and R1 continued to yell at each other. NA-A stated LPN-A used degrading words and yelled so load at R1 she started to cough. NA-A stated LPN-A was very rude and was "bloody murder, screaming at him." NA-A stated she informed RN-A of the incident the following day.

During an interview on 10/18/21, at 10:00 a.m. NA-B stated around 12:00 p.m. she went to assist R1 with NA-A. NA-B stated they connected R1 to the EZ stand with straps around his chest, behind his legs, arms and a sling that hung under him. NA-B stated R1 demanded to get unhooked when he was mid air. R1 started to shout while he clenched his right fist hit his knee and bang his right arm on the side by bar the sink. NA-B and NA-A pulled the shower chair under R1 immediately and lowered him to sit while he was still hooked up. LPN-A came to help. NA-B stated LPN-A looked and acted like she was irritated. NA-B further stated LPN-A stated to shout, yell at R1. NA-B stated LPN-A aggressively pushed R1 whom was in the shower chair over the toilet and "aggressively shook" R1 out of anger. NA-B

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F 609	Continued From page 10 stated she went to get R1 his newspaper to read while he used the bathroom, but LPN-A stated, "he doesn't deserve to read on the toilet." NA-B stated LPN-A was not appropriate and felt bad for R1 since he was vulnerable, and it was his home. NA-B stated LPN-A knew she was wrong after the incident, and it appeared she tried to justify herself after. During an interview on 10/19/21, at 12:19 a.m. resident coordinator (RC) and director of nursing (DON) stated the facility informed the state agency (SA) on 9/27/21, at 6:24 p.m.The RC and DON verified the allegation was not reported to the state agency within 2 hours. RC and DON stated they were not aware they needed to report allegation of abuse within the 2-hour time frame. The facility policy Vulnerable Adult Policy and Procedure Plan dated 4/21/21, indicated the administrative staff will submit an initial report when reasonable suspicion of resident abuse, or neglect had ben determined. There was no indication of a timeframe of when to report.	F 609		

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	00820	A. BUILDING: _____ B. WING _____	C 10/19/2021

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2 000	Initial Comments	2 000		

*****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 10/18/21 to 10/19/21, 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 complaint was found to be

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2 000	Continued From page 1 SUBSTANTIATED: H5445033C (MN77096), H5445035C (MN73871), H5445034C (MN73225); however NO licensing orders were issued. The following complaint was found UNSUBSTANTIATED: H5445032C (MN68334) 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		