Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 25, 2025

Administrator
Jones Harrison Residence
3700 CEDAR LAKE AVENUE
MINNEAPOLIS, MN 55416

RE: CCN: 245460
Cycle Start Date: July 9, 2025

Dear Administrator:

On August 19, 2025, we notified you a remedy was imposed. On September 25, 2025 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of September 5, 2025.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective October 9, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of August 19, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 9, 2025 due to denial of payment for new admissions. Since your facility attained substantial compliance on September 5, 2025, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

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July 24, 2025

Administrator
Jones Harrison Residence

3700 CEDAR LAKE AVENUE
MINNEAPOLIS, MN 55416

RE: CCN: 245460
Cycle Start Date: July 9, 2025

Dear Administrator:

On July 9, 2025, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted 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:

**Annette Winters, Regional Operations Supervisor, Rapid Response**
**Health Regulation Division**
**Minnesota Department of Health**
**625 Robert Street N**
**P.O. Box 64975**
**Saint Paul, Minnesota 55164-0975**
**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 October 9, 2025 (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 January 9, 2026 (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)**

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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:  https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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. A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

**INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)**

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:  https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst

Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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July 24, 2025

Administrator
Jones Harrison Residence

3700 CEDAR LAKE AVENUE
MINNEAPOLIS, MN 55416

Re: Event ID: RSCP11

Dear Administrator:

The above facility survey was completed on July 9, 2025 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, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245460 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 07/09/2025 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Jones Harrison Residence | 3700 CEDAR LAKE AVENUE , MINNEAPOLIS, Minnesota, 55416 |

| (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 |
|---|---|---|---|---|
| F0000 | INITIAL COMMENTS<br><br>On 7/3/25 through 7/9/25, a standard abbreviated survey was conducted at your facility. Your facility was<br><br>NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long<br><br>Term Care Facilities.<br><br>The following complaints were reviewed.<br><br>H54608508C(MN114285), H54608527C(MN114299), with a deficiency issued at F656.<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the<br><br>Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the<br><br>bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be<br><br>used as verification of compliance.<br><br>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted<br><br>to validate that substantial compliance with the regulations has been attained. | F0000 | | 07/30/2025 |
| F0656<br>SS = D | Develop/Implement Comprehensive Care Plan<br><br>CFR(s): 483.21(b)(1)(3)<br><br>§483.21(b) Comprehensive Care Plans<br><br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - | F0656 | F0656 – Develop/Implement Comprehensive Care Plan<br><br>Corrective Action: Resident 1 discharged on 06/25/25. Resident 2 had a care plan review and revisal on 7/30/25.<br><br>Corrective Action as it Applies to Other Residents: Care plan policy was reviewed and revised. Staff will be trained on policy updates, notifying provider of refusals, and creation of person-centered care plans. All care plans will be reviewed and made current by date certain.<br><br>Date of Completion: 08/15/2025 | 08/15/2025 |

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 reverse for further 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.

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245460 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 07/09/2025 |
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| F0656 SS = D | Continued from page 1<br><br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br><br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br><br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br><br>(iv)In consultation with the resident and the resident's representative(s)-<br><br>(A) The resident's goals for admission and desired outcomes.<br><br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br><br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br><br>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br><br>(iii) Be culturally-competent and trauma-informed.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on interview and document review the facility failed to identify a resident's highest level of wellbeing, develop individualized care plan interventions, involve the medical provider to review rejection of care, and develop new goals and treatment choices, for 2 out of 3 residents (R1 and R2) when both residents refused hygiene (washing face and hands, brushing hair and teeth), peri care (washing rectum and vaginal areas after incontinence), weekly bed baths, and reducing risk for developing pressure ulcers. In addition, R1 refused to let staff check her blood | F0656 | Continued from page 1<br><br>Recurrence will be prevented by: Random audits of resident care plans will be conducted weekly for four weeks. Results of the audits will be brought to the QAPI committee for review and further recommendations.<br><br>The Correction will be monitored by: Director of Nursing or Designee | |

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| F0656 SS = D | Continued from page 2<br>pressure (BP) required prior to giving medication, and monitoring R2's weight weekly as ordered.<br><br>Findings include:<br><br>R1's care plan dated 11/20/24, indicated she needed two staff to change her incontinent pad when soiled and transfer out of bed with a mechanical lift. Staff would do a sponge bath when unable to do a full bath or shower. She needed one staff member to turn from side to side in bed, dress, hygiene, and oral care. No indication she refused care.<br><br>R1's care plan dated 11/22/25, indicated she would decline being weighed due to pain. The intervention was not updated since.<br><br>R1's care plan dated 1/23/25, indicated only one reference to refusal of care associated with taking antidepressant medication and risk for refusal to eat.<br><br>R1's nursing progress notes dated 3/7/25 through 7/9/25, indicated she refused: being weighed 28 times, incontinent care five times, blood pressure (BP) checked leading to missing Midodrine (medication to elevate BP) dose nine times, and weekly bed bath three times.<br><br>R1's care plan dated 3/31/25, indicated she was bed bound and required the assistance of two staff members to bathe, incontinent care, turn in bed, dress, and transfer using a mechanical lift. She required the assistance from one staff member to perform daily hygiene and eating assistance. She had impaired hearing, and difficulty communicating her needs to staff. The care plan did not address any rejection of cares and there were no individualized interventions to minimize the refusals of care.<br><br>R1's Minimum Data Set (MDS) dated 4/19/25, indicated she had intact cognition, neuromuscular neuropathies (a disease effecting her nerves and muscles), inability to stand or walk, malnutrition, hearing loss, inability to urinate, difficulty swallowing and the history of alcohol abuse. Care Area Assessments (CAA) triggered inability to care for herself, move in bed, had a Foley catheter, impaired vision, inability to communicate, risk for falling, poor nutrition, risk for developing a | F0656 | | |

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| F0656 SS = D | Continued from page 3<br>pressure ulcer, use of anti-psychotropic medication to treat depression, anxiety, and Oxycodone (opioid) for chronic pain.<br><br>R1's nursing assistants (NA) Kardex dated 7/8/25, indicated staff would identify risks related to refusing care, and re approach later. After 2 refusals they would notify the nurse.<br><br>On 7/8/25 at 12:12 p.m., nurse manager registered nurse (RN)-A stated R1 had a history of refusing care. Staff would re-approach at a different time. If staff were unable to check her blood pressure before giving Midodrine, the dose would be held. She would expect the staff after a couple of refusals to update the medical provider for further guidance.<br><br>On 7/8/25 at 1:00 p.m., director of nursing (DON) stated she expected her staff to notify the medical provider for any missed doses of medication, refusing weights, incontinent care, hygiene, medication, lab draws, and food, along with increased or decreased weights. Staff did not identify the root cause for rejection of care, including a risk benefit analysis. She also agreed R2's care plan did not identify refusal of care and lacked individualized care plan interventions.<br><br>On 7/9/25 at 10:27 a.m., nurse practitioner (NP) stated staff updated her about R1 refusing BP checked prior to receiving Midodrine nine times on 7/8/25. She had been trying to adjust the Midodrine dose several times, because her blood pressure remained low. Had she known she could have educated R1 to gain compliance. She expected the staff would have contacted her in March when the behavior started not four months later. In addition, regarding activities of daily living (ADLS) refusals, she would have encouraged compliance by discussing the risk for developing pressure ulcers and infection.<br><br>R2's medical record from 11/20/24 through 6/26/25, indicated in 38 weeks the facility weighed her eight times.<br><br>R2's risk for altered nutrition care plan dated 11/22/25, indicated she would decline weights related to pain. No further interventions identified in the | F0656 | | |

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| F0656 SS = D | Continued from page 4<br>care plan to minimize the number of times she refused.<br><br>R2's medical record dated 12-1-24 through 12-31-24, indicated staff would document her weight in two places. Weighing her was documented on the treatment administration record (TAR) and the actual weight under the results tab in point click care (PCC) electronic medical record. PCC documentation indicated staff weighed her, but there were no weights recorded under the result tab.<br><br>R2's MD-A visit note dated 12/31/25, indicated her last weight was 203 lbs.<br><br>R2's TAR dated 1-1-24 through 1-31-24, indicated staff weighed her every week, but only one weight was documented on 1/1/25. No indication the NP was notified.<br><br>R2's TAR dated 2-1-24 through 2-28-24, indicated staff weighed her every week, but only one weight was entered on 2/21/25 with a gain of 37.8 lbs. from her previous weight. No indication the NP was notified.<br><br>R2's Nurse Practitioner (NP)-A note dated 2/15/25, first indicated a weight gain from 202 lbs. to 240 lbs. in six weeks. During her assessment she observed edema (swelling of the feet related to fluid buildup in the tissue.) R2 told her that was not normal for her.<br><br>R2's TAR dated 3-1-24 through 3-31-24, indicated staff weighed her weekly, staff documented three weights on 3/5/25, 3/12/25, and 3/26/25, resulted in weight gain of 10 lbs. since 2/19/25. No indication the NP was notified.<br><br>R2's nursing note dated 3/5/25 at 11:00 a.m., indicated her weight was 250 lbs. and she developed worsening edema. NP-B was updated and would visit R2.<br><br>R2's NP-B note dated 3/10/25, stated she developed edema in her lower extremities since February 2025. Review of weights showed she gained 50 lbs. since admission four months ago. Staff told her she drank a lot of fluid throughout the day. She started a diuretic (medication to pull fluid out of the tissue) on 3/6/25 | F0656 | | |

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| F0656 SS = D | Continued from page 5<br>had not improved the edema. Her left thigh graft (healthy skin transplanted on a wound to promote healing) currently reopened draining fluid. Likely cause was the edema in her leg.<br><br>R2's TAR dated 4-1-25 through 4-30-25, indicated staff weighed her weekly, but no weight was documented for the month. No indication the NP was notified.<br><br>R2's medical doctor (MD) note dated 4/14/25, indicated the edema was related to low albumin (protein cells) and taking Gabapentin (medication for nerve pain). The left leg wound infection resolved.<br><br>R2's medication and treatment documented dated 4/19/25, indicated an order for daily weights and update the provider for a weight gain more than 2 lbs. in one day or five lbs. in one week.<br><br>R2's administration note dated 5/21/25, indicated she needed an MDS weight on 5/22/25, since her last weight was on 3/26/25. She refused to be weighed.<br><br>R2's MDS dated 5/22/25, indicated she had normal cognition, risk for skin breakdown, heart disease, diabetes, high blood pressure, obesity, depression, left thigh skin graft after motor vehicle incident, chronic pain, and depression. She currently took anti-depression medication along with opioid narcotics. She was incontinent of bowel and bladder.<br><br>R2's result note dated 6/26/25, indicated she was weighed one time for 264.4 lbs. She gained an additional 14.4 lbs. No indication the NP was notified.<br><br>On 7/8/25 at 9:20 a.m., registered dietician (D)-A stated if a residence weight increased by two lbs. in one day or five lbs. in one week, she would notify the nurse manager who would update the provider.<br><br>R2 often refused to be weight related to increased pain when using the mechanical lift.<br><br>On 7/8/25 at 11:00 am., NP-B stated she was not aware R2 refused to be weighed as ordered when the facility | F0656 | | |

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|---|---|---|---|---|
| F0656 SS = D | Continued from page 6<br>contacted her on 7/7/25. She now realized the lack of weights failed to identify her significant weight gain and diagnosing fluid buildup, edema and why her leg failed to heal. Had she known about the refusals, and weight gain she would have addressed the situation with the resident and developed different methods to monitor fluid buildup without having a current weight such as measuring the diameter of her legs and checking for shortness of breath when lying flat.<br><br>On 7/8/25 at 1:00 p.m., director of nursing (DON) stated she expected her staff to notify the medical provider for any missed doses of medication, refusing weights, incontinent care, hygiene, medication, lab draws, and food, along with increased or decreased weights. Staff did not identify the root cause for rejection of care, including a risk benefit analysis. She also agreed R2s care plan did not identify refusal of care and lacked individualized care plan interventions.<br><br>The facility policy Individualized Care Plan dated 1/22/25, indicated, staff would develop a comprehensive care plan after using a comprehensive assessment. Resident's needs and functional capacity would be identified on the individualized plan of care. All physician orders are included in the care plan. Interventions would be updated in the residence Kardex. Any care plan alterations would be initiated by the staff member who identified the problem. | F0656 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING | (X3) DATE SURVEY COMPLETED<br>**07/09/2025** |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **Jones Harrison Residence** | **3700 CEDAR LAKE AVENUE , MINNEAPOLIS, Minnesota, 55416** |

| (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 |
|---|---|---|---|---|
| 20000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>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.<br><br>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.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>On 7/3/25 through 7/9/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure<br><br>The following complaints were reviewed during the survey: H54608508C(MN114285), H54608527C(MN114299)<br><br>Minnesota Department of Health is documenting the State | 20000 | | 07/30/2025 |



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

Minnesota State Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING | (X3) DATE SURVEY COMPLETED<br>**07/09/2025** |
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|---|---|---|---|---|
| 20000 | Continued from page 1<br>Licensing Correction Orders using Federal software.<br><br>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. | 20000 | | |