Electronically Delivered via Email
January 4, 2021

Administrator
The North Shore Estates Llc
7700 Grand Avenue
Duluth, MN 55807

RE: CCN: 245483
Cycle Start Date: November 20, 2020

Dear Administrator:

On January 4, 2021, the Minnesota Department of Health, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

*P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s*

Electronically delivered
December 9, 2020

Administrator
The North Shore Estates Llc
7700 Grand Avenue
Duluth, MN 55807

RE: CCN: 245483
Cycle Start Date: November 20, 2020

Dear Administrator:

On November 20, 2020, 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), 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) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Teresa Ament, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Phone: (218) 302-6151

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 February 20, 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 May 20, 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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245483 | A. BUILDING ______ B. WING ______ | C 11/20/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **THE NORTH SHORE ESTATES LLC** | **7700 GRAND AVENUE** **DULUTH, MN 55807** |

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| E 000 | Initial Comments<br><br>A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 11/18/20, through 11/20/20. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>A COVID-19 Focused Infection Control survey was conducted on 11/18/20, through 11/20/20, at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was determined not to be in compliance. In addition, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.<br><br>The following complaint was found to be substantiated: H5483046C<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance.<br>Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form.<br><br>Upon receipt of an acceptable electronic POC, a revisit of your facility will be conducted to validate substantial compliance with the regulations has been attained in accordance with your verification. | F 000 | | |
| F 600 SS=D | Free from Abuse and Neglect<br>CFR(s): 483.12(a)(1)<br><br>§483.12 Freedom from Abuse, Neglect, and | F 600 | | 12/16/20 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 12/16/2020

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<br>Exploitation<br>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 treat the resident's medical symptoms.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure 1 of 3 residents (R4) was free from allegations of sexual behaviors from another resident (R5).<br><br>Findings include:<br><br>R4's Transfer/Discharge Report printed on 11/20/20, indicated R4's diagnoses included hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body) following cerebral infarction (stroke) affecting left non-dominant side, and rheumatoid arthritis (a chronic progressive disease causing inflammation in the joints and results in painful deformity and immobility).<br><br>R4's 5 day admission Minimum Data Set (MDS) dated 8/14/20, indicated R4 was cognitively intact, and required assistance with activities of daily living (ADLs). R4 was independent with wheel chair mobility. | F 600 | Immediate Corrective Action<br>Administrator met with resident and they spoke about the behavior and why it needs to be done in private, resident denied it occurred. Administrator asked if he needed any materials, such as magazines so that he can control his urges privately in his room, resident declined. Physician was asked to meet with resident to see if a medication change could help reduce urges/this behavior. Physician added medication Flomax and Proscar to improve urination and to shrink enlarged prostate. The IDT requested that the physician also give orders for counseling, physician declined. Room change was offered to the resident that was flashed, resident declined. Social Services was scheduled to visit resident twice weekly for the next two weeks, then weekly for four weeks to do PHQ9, BIMS, and meet with resident about his mood and behaviors. The resident that was | |

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F 600

Continued From page 2

R4's care plan initiated 8/18/20, indicated R4 was at risk for increased depression and anxiety, alteration in mood and behavior, noted to make false statements when she is upset. R4's care plan directed staff to utilize resident advocacy program to assure daily visits are being completed, be alert to mood and behavioral changes, and offer resident assistance every two hours and as needed.

R5's Transfer/Discharge Report printed on 11/20/20, indicated R5's diagnoses included chronic obstructive pulmonary disease.

R5's quarterly MDS dated 9/17/20, indicated R5 had moderately intact cognition, and was independent with ADLs.

R5's care plan initiated on 9/5/18, indicated R5 was at risk for sitting in his doorway and touching himself inappropriately, and exposing himself to other residents. R5's care plan directed staff to ask resident to close his door when he feels the urge to touch himself, and to report concerns or changes mood/behavior to his medical doctor. R5 was moved to the other hallway that was primarily males near him for less temptation of inappropriate touching in his doorway, a sign was placed on his door alerting other residents to not disturb him when the door was closed.

R5's care guide (NA care sheets) printed on 11/20/20, directed nursing assistants if resident has any inappropriate touching in doorway, ask resident to go into his room and close the door.

On 11/19/20, at 1:01 p.m. R4 was interviewed. R4 stated one of the residents down the hallway (R5) "flashed" her on her birthday (11/15/20). R4

F 600

flashed also stated she would not go down to that part of the hallway.

Corrective Action as it applies to others:
All residents with similar behaviors were reviewed. Any residents that have similar care plans would have their care plans updated.

Recurrence will be prevented by:
Social services visits will continue visits as previously put in place. Resident still enjoys sitting in his doorway but no behaviors have been noted since interventions have been put in place. Behaviors will continue to be monitored by nursing staff. Audits of R5s behaviors and all residents with like behaviors will be reviewed by documentation/staff interview will be conducted 3x/week for 4 weeks. 2x/week for 4 weeks, and then weekly for 4 weeks. The results will be shared with facility QAPI committee for input on the need to increase, decrease or discontinue the audits.

Corrections will be monitored by: DON, Social Services Director, and or their designees

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| F 600 | Continued From page 3 | F 600 | | |

stated he was wearing a hospital gown and showed her his penis, and was masturbating in front of her. R4 stated he was also blowing kisses and waving at her. R4 stated it made her feel "uncomfortable." R4 stated she will no longer walk down that part of the hallway to the elevator to go to the therapy gym. R4 stated R5 had a nursing assistant (NA)-A give her a small Christmas tree on the day he exposed himself. R4 pointed to the waste can, and said she threw it away.

On 11/19/20, at 3:52 p.m. NA-A was interviewed. NA-A stated R5 was in his doorway and called her over on 11/15/20, and asked her to bring a small Christmas tree to "the lady in the doorway [R4]." NA-A stated she brought the tree to R4 who said thank you. NA-A stated she had not seen R5 waving at any female residents, or expose or touch his genitals while seated in his doorway.

On 11/20/20, at approximately 9:30 a.m. R4 was overheard telling therapy staff she did not want to go down the hallway toward the back elevator (passing R5's room) to go to the therapy gym.

R4's progress notes were reviewed, and lacked documentation about the incident or about the impact it had on R4's emotional well-being.

On 11/16/20, a communication form from the nurse to the physician regarding R5's reported behavior on the weekend indicated resident (R5) had been noted on several occasions to be touching and exposing himself to female residents. We have previously spoken with resident regarding these behaviors, that it was inappropriate to do this in the hallway and requested that when he feels the urge to touch

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| F 600 | Continued From page 4 | F 600 | | |

himself to do so in his room with the door closed, offered resident magazines, and also changed his room so that he was in a predominately male area. R5 was reported to have exposed himself to another female resident this weekend. Resident was willing to try medicinal intervention as well as counseling at this time. The facility requested the MD order Prozac, and order counseling. The response to both requests from the physician was no to the medication, and not right now to counseling. Orders were given to start Flomax (used to improve urination in men) 0.4 milligram (mg) each morning and Proscar (used to shrink an enlarged prostate [a gland surrounding the neck of the bladder] in men) 5 mg each morning.

On 11/17/20, at 2:01 p.m. a nursing note was written in regards to R5's physician visit. R5 was evaluated by in regards to recent behaviors described in the nurse to physician communication. R5 declined Prozac or counseling. The physician thought R5's behaviors might be stress related, but could also be sleep disturbance from nocturia (increased urination at night). Two new medications were started, one to increase urine flow and one for nocturia.

On 11/19/20, at 9:16 a.m. a progress note indicated R5's behavior had been appropriate and that he enjoyed sitting in his doorway and people watch.

On 11/19/20, at 4:00 p.m. a progress note indicated R4 was offered a room change, but she declined to move. On 11/20/20, at 9:33 a.m. a progress note indicated R4 was re-approached about changing rooms. R4 declined, stating the resident who was calling her names had stopped the behavior.

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| F 600 | Continued From page 5 | F 600 | | |

On 11/19/20, at 4:28 p.m. R5 was seated in his doorway wearing a hospital gown, no pants or pajama bottoms.

A report to the State Agency (SA) on 11/16/20, at 11:04 a.m. indicated R4 reported the incident to nursing staff. The administrator spoke to R5 who denied the incident. R4 stated she would not go down that hallway because she didn't want to see that again, and R5 doesn't leave his room. The facility report to the SA on 11/18/20, at 5:28 p.m. indicated the behavior likely occurred, a room change should be offered, and an evaluation by R5's physician occurred. The report further indicated social services was going to meet with R5 twice weekly for the next two weeks, then weekly for four weeks, and R5 would not leave his room except for appointments.

On 11/20/20, at approximately 10:00 a.m. R5 was interviewed. R5 recalled giving R4 the Christmas tree, stated he did not know her name, and he did not expose himself to her. R5 stated he didn't do that anymore.

-at approximately 10:30 a.m. the director of nursing (DON) was interviewed. The DON stated she was not aware that R5 was still waving and blowing kisses at R4. The DON verified the plan as reported in the 5 day investigation report summary.

-at 12:24 p.m. the administrator was interviewed and provided documentation R5 had agreed to psychological services. A referral to a psychological service was made on 11/19/20, for depression/sadness, anxiety, and non-compliance.

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| F 600 | Continued From page 6<br><br>The facility policy titled Abuse Prohibition/Vulnerable Adult Plan revision date 7/5/19, indicated the purpose of the policy was to ensure that residents are not subjected to abuse by anyone, including, but not limited to facility staff, other residents... and to identify and remedy any abusive situations. The policy further directed immediately upon learning of the incident, staff will take necessary steps to protect residents from possible subsequent incidents of misconduct or injury while the matter is being investigated. In addition, the policy directed in areas of resident to resident abuse, the abused resident will be removed to a safe environment and all other resident's safety will be ensured. | F 600 | | |
| F 885 SS=E | Reporting-Residents,Representatives&Families CFR(s): 483.80(g)(3)(i)-(iii)<br><br>§483.80(g) COVID-19 reporting. The facility must—<br><br>§483.80(g)(3) Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must—<br><br>(i) Not include personally identifiable information;<br>(ii) Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and<br>(iii) Include any cumulative updates for residents, their representatives, and families at least weekly | F 885 | | 12/16/20 |

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| F 885 | Continued From page 7<br>or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to inform 4 of 5 residents (R6, R7, R8, and R9) of COVID-19 positive residents in the facility. The had the potential to affect all 68 residents in the facility due to not acknowledging their right to be informed.<br><br>Findings include:<br><br>R6's quarterly Minimum Data Set (MDS) dated 10/8/20, indicated R6 was cognitively intact.<br><br>On 11/18/20, at 11:48 a.m. R6 was interviewed. R6 stated the only way to get information about COVID-19 in the facility was to ask. He stated they (the residents) were not informed of COVID-19 positive results from the last testing. R6 stated he went to the administrator to get information about whether the facility had the COVID-19 virus.<br><br>R7's admission MDS dated 10/27/20, indicated R7 was cognitively intact.<br><br>On 11/18/20, at 12:10 p.m. R7 was interviewed. R7 stated someone came in "last week" to talk about the COVID-19 virus in the facility, but he stated he had not received an update this week.<br><br>R8's quarterly MDS dated 11/6/20, indicated R8 had moderately impaired cognition. | F 885 | Immediate Corrective Action<br>R6, R7, R8, and R9 received notification.<br><br>Corrective Action as it applies to others:<br>Process for notifying residents was immediately changed on 11/20/2020. Upon notification of a positive staff or resident a therapeutic recreation staff member would share that information with all residents. The therapeutic recreation director would be given the list of all residents notified once completed and make a note that the resident had been notified in PCC.<br><br>Recurrence will be prevented by:<br>Audits of 5 random residents will be conducted 3x/week for 4 weeks. 2x/week for 4 weeks, and then weekly for 4 weeks to assure that they have documentation that they were notified of positive facility staff and or resident COVID results. The results will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits.<br><br>Corrections will be monitored by: DON, Social Services Director, and or their designees | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 885 | Continued From page 8 | F 885 | | |

On 11/18/20, at 12:13 p.m. R8 was interviewed. R8 stated she was being tested weekly for COVID-19, but could not recall anyone from the facility giving her updates on positive COVID-19 results in the facility.

R9's quarterly MDS dated 10/19/20, indicated R9 had moderately impaired cognition.

On 11/18/20, at 1:40 p.m. R9 was interviewed. R9 stated someone came around this morning and told her about COVID-19 test results from last week, but could this had not happened before.

On 11/18/20, at 11:33 a.m. the director of therapeutic recreation (TR)-C was interviewed. TR-C stated she notified residents of positive COVID-19 results, but stated she did not notify any residents of COVID-19 positive results from testing on 11/9/20. TR-C stated she was unsure of when she last notified any residents. TR-C stated she did not notify any residents off positive COVID-19 results on 11/16/20.

On 11/19/20, at 9:08 a.m. the director of nursing (DON) was interviewed. She stated the administrator was informing residents about COVID-19 in the facility.

On 11/19/20, at 9:46 a.m. the administrator was interviewed. The administrator stated he never sent the email to TR-C to inform residents of COVID-19 positive results in the facility. The administrator stated he found the email in his draft folder. The administrator stated he informed residents on 11/13/20, but he did not have any documentation to support it being done.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **245483** | A. BUILDING ______ <br> B. WING ______ | C <br> **11/20/2020** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 885 | Continued From page 9 | F 885 | | |

The facility policy Coronavirus Disease (COVID-19) - Specimen Collection, Reporting and Documentation for COVID-19 Testing dated September 2020, directed staff to report new cases of COVID-19 in the facility to residents, family, and staff according to reporting and notification requirements.

Center for Medicare & Medicaid Services (CMS) Center for Clinical Standards and Quality, Safety, and Oversight Group (CMS QSO) memo 20-29 NH dated 5/6/20, directed nursing homes to inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more resident or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. The memo further directed facility's to provide cumulative updates at least weekly to residents, their representatives and families on any subsequent positive cases or respiratory illnesses.

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
December 9, 2020

Administrator
The North Shore Estates Llc
7700 Grand Avenue
Duluth, MN 55807

Re: Event ID: L7X211

Dear Administrator:

The above facility survey was completed on November 20, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **00593** | A. BUILDING: ______<br>B. WING ______ | C<br>**11/20/2020** |

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|---|---|---|---|---|
| 2 000 | 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>On 11/18/20, through 11/20/20, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be in compliance with the MN State Licensure.<br><br>The following complaint was found to be substantiated with no licensing orders issued: | 2 000 | | |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00593 | A. BUILDING: ______<br>B. WING ______ | C<br>**11/20/2020** |

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| 2 000 | Continued From page 1<br><br>H5483046C<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.<br>Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents. | 2 000 | | |