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

Electronically delivered
July 13, 2023

Administrator
Lakewood Care Center
600 Main Avenue South
Baudette, MN  56623

RE: CCN: 245580
Cycle Start Date: May 24, 2023

Dear Administrator:

On June 6, 2023, we notified you a remedy was imposed. On July 7, 2023 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 June 20, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective June 21, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of June 6, 2023, 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 is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 24, 2023. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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

Electronically Submitted
June 6, 2023

Administrator
Lakewood Care Center
600 Main Avenue South
Baudette, MN  56623

RE: CCN: 245580
Cycle Start Date: May 24, 2023

Dear Administrator:

On May 24, 2023, 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety.  This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

## REMOVAL OF IMMEDIATE JEOPARDY

On May 20, 2023, the situation of immediate jeopardy to potential health and safety cited at F389, past non-compliance was removed.

## REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective June 21, 2023.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective June 21, 2023 (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 21, 2023 (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,995; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective May 24, 2023. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

If you have not achieved substantial compliance by June 21, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Lakewood Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 21, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care,

483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Lakewood Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective May 24, 2023. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

## ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" and/ or "E" tag), i.e., the plan of correction should be directed to:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 24, 2023 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an

administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

## 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 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
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245580 | A. BUILDING _____ B. WING _____ | C 05/24/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LAKEWOOD CARE CENTER | 600 MAIN AVENUE SOUTH BAUDETTE, MN 56623 |

| (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 |
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| F 000 | INITIAL COMMENTS<br><br>On 5/22/23 to 5/24/23, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was NOT in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities.<br><br>The following complaints were reviewed:<br><br>H55802293C (MN00093640) deficiency was issued at F689 at PAST NON-COMPLIANCE<br>H55802344C (MN00090458)<br>H55808962C (MN00089761)<br><br>As a result of the investigation a deficiency was cited at F610.<br><br>The immediate jeopardy began on 5/15/23, at 9:02 p.m., when R1 cut off his wander guard, left the facility unsupervised, in the evening. It was not identified until 5/16/23, at 7:45 a.m. that R1 was missing. At approximately 8:30 a.m. four blocks away from the facility R1 was located, despite being care planned for hourly checks. The administrator, co-director of nursing (CDON)-A, CDON-B, and licensed social worker (LSW) were notified of the immediate jeopardy on 5/24/23, at 1:45 p.m. The facility immediately implemented corrective action and was corrected on 5/20/23, prior to the survey and was issued at past oncompliance.<br><br>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 | F 000 | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 06/14/2023 |

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 000 | Continued From page 1<br>form. Your electronic submission of the POC will be used as verification of compliance.<br><br>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 610 SS=D | Investigate/Prevent/Correct Alleged Violation<br>CFR(s): 483.12(c)(2)-(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.<br><br>§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review the facility failed to thoroughly investigation an allegation of staff to resident abuse for 1 of 2 (R2) allegations reviewed when other residents who would have worked with the alleged staff member were not formally interviewed as part of the investigation process. | F 610 | F 610 – Investigative / Prevent / Corrective Alleged Violation: Lakewood Care Center does acknowledge that during the survey, based on observation, interview and document review, the facility investigation did not include interview of other residents who may have been impacted by deficient practice of staff to | 6/20/23 |

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| F 610 | Continued From page 2<br>Findings include:<br><br>R2's quarterly Minimum Data Set (MDS) dated 4/20/23, identified R2 had impaired cognition, no behaviors, total dependence of two staff needed for bed mobility, transfers, dressing, personal hygiene, and toilet use. R2's upper extremity function limitation in range of motion (ROM) impairment on one side, lower extremity function limitation in ROM impairment on both sides and used wheelchair. R2's diagnoses included stroke, seizure disorder, and depression.<br><br>R2's care plan dated 4/20/23, identified at risk for abuse due to cerebral vascular accident (stroke), limited use of upper and lower extremities, impaired cognitive function, dementia, impaired thought process, and confusion. Staff were directed to report signs and symptoms of abuse to administrator immediately.<br><br>Review of Facility Investigation Report dated 1/27/23, at 4:14 p.m. indicated R2's care plan was reviewed, and co-director of nursing (CDON)-A met with R2 to discuss incident. The investigation report indicated R2 was asked if anyone had touched him inappropriately or in a way he did not want to or feel comfortable and R2 stated not that he knew of. CDON along with nursing assistant (NA)-D present completed an inspection of the peri-area with no abnormalities or redness found. Interviews were then completed with the alleged perpetrator (AP) (NA-E), witness (NA-F), R2's wife, and deputy sheriff were all interviewed. The report did not identify additional residents were interviewed. The NA-E was suspended from work at the facility on 1/24/23, and then terminated from employment. | F 610 | resident abuse for 1 of 2 residents (R2).<br>1. Regarding Resident (R2), an RN Care Coordinator completed the immediate interview and physical assessment, no harm was found. Family has changed the camera in the room to record at all times. Residents' care plan has been reviewed and revised. The facility suspended then terminated the alleged staff. The facility has educated staff on the Sexual Abuse in Nursing Homes and reviewed policy on Vulnerable Adults. Completed 6/13/23.<br>2. Regarding all other residents. All residents that have the same or similar identifiers have been interviewed and responses recorded. Of this sample an additional 7 residents have been interviewed. No Concerns have been identified. Completed 6/13/23.<br>3. To assure this deficient practice does not occur in the future for the facility, the Vulnerable Adult Policy has been updated effective 1/23. An updated VA Investigation Checklist has been developed so that the Interdisciplinary Team can ensure that a thorough investigation is completed on each new reported VA. Updated Vulnerable Adult Policy was reviewed and revised with the IDT team. Education on the new process for the Social Worker and DON(s) to be completed by 6/20/23.<br>4. To assure this practice enhancement is sustainable and hardwired, leadership (Director(s) of Nursing or Social Worker) shall complete audits as follows:<br>a. DON(s) or Social Worker to audit all VA Reporting's as they occur in the next 6 months. | |

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| F 610 | Continued From page 3<br>During an interview on 5/24/23, at 4:45 p.m. LSW stated he had been notified of the incident on 1/24/23, immediately and interviewed the AP, witness, and five other staff, notified the police department and family. LSW stated the AP was immediately placed on a five-day suspension then terminated. LSW verified R2 had a camera in his room but was not set to record on 1/24/23. LSW indicated there were times when one staff completed cares but usually required assistance of two staff. LSW stated no additional residents were interviewed in the facility and indicated it was not relevant at the time. LSW stated he talked with the facility residents daily and asked them if they had concerns while out in the dining room, activities, and outside.<br><br>Facility policy titled Vulnerable Adult/Elder Justice Act reviewed last 1/2023, indicated this policy/plan was established to protect all adults dependent upon this facility for their health care services and for providing a safe environment to which to live. Neglect is defined in this policy as the failure or omission by a caregiver to supply a care or services, including but not limited to, food, clothing, shelter, healthcare, or supervision. To protect and ensure residents are safe, staff may be directed to take steps to ensure the resident is safe from further harm and to protect other vulnerable adults. Steps may include but not limited to, staff investigatory leave, suspension, monitoring, discharge from facility, and law enforcement intervention. Staff will document all information during the investigation. | F 610 | b. These audit results will be reviewed at QAPI meetings for the next 6 months, ending 1/1/2024. | |
| F 689 SS=J | Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents. | F 689 | | |

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| F 689 | Continued From page 4<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to provide adequate supervision to prevent an elopement for 1 of 3 resident (R1) who was identified as at risk for elopement and left the facility with out staff knowledge for 10 hours and 45 minutes before it was discovered he was gone. This was an immediate jeopardy for R1.<br><br>The immediate jeopardy began on 5/15/23, at 9:02 p.m., when R1 cut off his wander guard, left the facility unsupervised, in the evening. It was not identified until 5/16/23, at 7:45 a.m. that R1 was missing. At approximately 8:30 a.m. four blocks away from the facility R1 was located, despite being care planned for hourly checks. The administrator, co-director of nursing (CDON)-A, CDON-B, and licensed social worker (LSW) were notified of the immediate jeopardy on 5/24/23, at 1:45 p.m. The facility immediately implemented corrective action and was corrected on 5/20/23, prior to the survey and was issued at past noncompliance.<br><br>Findings include:<br><br>R1's face sheet indicated R1 was admitted to the facility from the hospital on 1/12/23, with diagnosis of Alzheimer's disease, cognitive communication deficit, and muscle weakness. | F 689 | Past noncompliance: no plan of correction required. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 689 | Continued From page 5<br>R1's quarterly Minimum Data Set (MDS) assessment dated 4/13/23, indicated R1 had Brief Interview of Mental Status (BIMS) of a three (severe impaired cognition) including disorganized thinking, difficulty focusing attention, adequate vision and hearing, clear speech, and sometimes understood others. R1 required supervision with bathing, independent with all other cares and ambulation. R1 required the use of a wander/elopement alarm.<br><br>R1's admission care plan dated 1/20/23, indicated R1 had Alzheimer's disease, cognitive deficits that hindered in making good decisions regarding his safety, and required simple directive sentences. R1 also required assistance of one staff for locomotion on/off unit and during transfer between surfaces due to unsteady gait, weakness, and fall prior to admission. R1 required verbal cues, use of bed alarm, intervals of hourly safety rounding, and use of wander guard for risk of elopement.<br><br>R1's elopement risk assessments upon admission dated 1/12/23, identified disoriented, unsafe decision making, does not understand surroundings, displayed Sundowner (late day confusion that can affect memory, thinking, personality, reasoning, behavior, and mood), history of wandering from home or other facilities, no attempts to exit the facility, Alzheimer's dementia, and high risk for elopement. After the elopement incident on 5/15/23, an elopement risk assessment was completed again and indicated R1 additionally had a forgetful/short attention span, not agreeable to living arrangements, packed belongings, wanders aimlessly, and indicated R1 wanted to leave and go back to his apartment again, which placed R1 at high risk for | F 689 | | |

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| F 689 | Continued From page 6<br>elopement.<br><br>R1's fall risk assessment dated 4/11/23, indicated one to two falls in the past six months and placed R1 at a moderate fall risk.<br><br>R1's treatment administration record (TAR) indicated R1's wander guard was to be checked each shift for placement to the left ankle from 5/9/23, through 5/16/23. Facility staff signed off R1's TAR a total of 24 times, 4 times with a check mark and 20 times with the number nine (which indicated see progress notes). R1's progress notes revealed from 5/9/23, through 5/16/23, nine out of 24 times no progress notes were noted in R1's medical record to correlate to the TAR. It was unclear as to what the check mark indicated as R1 progress notes indicated he had cut off the wander guard and not allowed it to be replaced from 5/9/23, through 5/16/23.<br><br>Review of facility's Nursing Home Initial Report identified facility staff entered R1's room at 7:45 a.m. on 5/16/23 and R1 was not located. Facility staff assumed R1 was at breakfast; upon discovery, R1 was also not in dining room. Staff did a quick check of other areas and notified other staff to assist in search including Administrator and Social Worker. Report identified Law Enforcement was contacted when R1 was not found and because R1 had been talking about returning to his apartment, facility staff went to his apartment approximately 4 blocks away where he was located at 8:30 a.m. R1 was escorted to the hospital for evaluation with no signs of injury or trauma.<br><br>R1's Emergency Room (ER) visit document dated 5/16/23, at 9:05 a.m. identified R1 had left the | F 689 | | |

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| F 689 | Continued From page 7<br>facility building sometime during the night and walked back to his apartment. R1 was found by law enforcement and brought him back. The ER visit document indicated R1 stated he would continue to go home. R1 was identified as confused with dementia. OT completed cognitive testing Montreal Cognitive Assessment (MoCA) (screens for cognition impairment and Alzheimer's) R1 scored 7/30 which indicated severe cognitive decline. R1 was identified as an obvious risk to self and a 72-hour hold was signed to help with staffing and law enforcement assistance. ER visit document indicated OT (Occupation Therapy) assessment determined, even though R1 was able to find his way back to his apartment OT believed independent living would be unsafe.<br><br>R1's emergency hold order dated 5/16/23, completed by hospital physician assistant (PA) identified R1 had serve cognitive decline. R1 left the long-term care facility during the night and was found this morning at his apartment. R1 talked also about going to the river. R1 indicated he would keep leaving because he wants to go home. R1 was determined to be at risk of injury/harm to himself.<br><br>R1's progress notes from 5/12/23, through 5/21/23 identified:<br><br>-5/12/23, at 4:37 p.m. R1 told staff he would probably leave tomorrow, jump the fence, and go to his apartment.<br><br>-5/12/23, at 9:28 p.m. R1 removed wander guard from left ankle.<br><br>-5/13/23, at 12:56 p.m. R1 cut off wander guard. | F 689 | | |

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| F 689 | Continued From page 8<br><br>-5/13/23, at 1:23 p.m., 5/14/23, at 10:20 a.m. 5/14/23, at 1:37 p.m., 5/15/23, at 9:37 a.m. R1 did not have wander guard on left ankle, cut off and had not allowed back on.<br><br>-5/15/23, at 1:44 p.m. R1 wanted to leave building, asked staff how to get out, only inquired did not attempt to exit facility.<br><br>-5/15/23, at 9:45 p.m. R1's left ankle had been checked for placement of the wander guard and did not have one on. (R1 was not physically in the building at time of check, video footage showed R1 had left the building at 9:05 p.m.)<br><br>-5/16/23, at 2:44 a.m. R1's left ankle had been checked for placement of the wander guard and not wearing it, R1 had cut it off and refused to have another one on. (R1 was not physically in the building at time of check, video footage showed R1 had left the building at 9:05 p.m.)<br><br>-5/16/23, at 9:38 a.m. writer found R1's wander guard next to the recliner on the floor with evidence it had been cut off along with fingernail clipper and cuticle clipper on R1's table. All were removed.<br><br>-5/16/23, at 11:04 a.m. facility licensed social worker (LSW) met with R1 at his neighborhood apartment after the elopement. R1 stated he did not want to return to facility and planned on leaving again. One to one initiated with R1 at that time. LSW contacted R1's son and discussed placement elsewhere. R1 scored 7/30 on a MoCA completed by occupational therapy (OT) indicated severe cognitive impairment. | F 689 | | |

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| F 689 | Continued From page 9<br>-5/16/23, at 12:21 p.m. R1 refused to have wander guard placed back on his ankle.<br><br>-5/16/23, at 12:34 p.m. R1 had been very agitated and expressed negative emotions about being at the facility after he returned from elopement.<br><br>-5/17/23, at 7:46 a.m. R1 refused to leave wander guard on has been one on one supervision all shift.<br><br>-5/17/23, at 1:16 p.m. R1 agitated with being at the facility.<br><br>-5/17/23, at 1:47 p.m. R1 set the alarm off at the front doors of the facility. R1 informed nurse he would be leaving again tonight, just like the other night. Informed Registered nurse (RN).<br><br>-5/17/23, at 3:14 p.m. LSW actively and currently seeking alternative placement for R1 in a secure unit. R1 is currently on one-on-one watch from a distance in order to reduce anxiety.<br><br>-5/18/23, and 5/19/23, R1 one on one watch continues.<br><br>-5/21/23, at 1:13 p.m. R1 made comments about jumping the fence again tonight. R1 was reminded that if he leaves the facility that the police will be called. R1 stated he does not care and will run from them and tell them to "F**K off."<br><br>During an interview on 5/23/23 at 11:15 a.m. TMA-C stated R1 had asked many times why he needed to be there and indicated he wanted to leave the facility. TMA-C stated she worked the day shift on 5/16/23, at 8:00 a.m. could not find R1 and looked for him but was unable to find | F 689 | | |

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| F 689 | Continued From page 10<br>resident. TMA-C indicated the facility began the search for R1. Leadership and police were notified and someone from the facility went to R1's apartment to look for him there. TMA-C verified staff are expected to open the resident's door and visually see them during hourly rounds to keep residents safe.<br><br>During an interview on 5/23/23, at 11:33 a.m. licensed practical nurse (LPN)-C stated R1 removed his wander guard, wandered outside in the garden area and hallways, and remained on hourly rounding which meant staff were expected to visually see what he was doing to keep R1 safe. LPN-C indicated she had worked the morning of 5/16/23, and at 8:15 a.m. staff informed her R1 could not be found. LPN-C stated she offered to go to R1's apartment and left facility at 8:00 a.m. LPN-C stated she drove into R1's apartment complex parking lot and saw R1 who stood next to his truck, with his keys in his hand, and was attempting to open the door to the truck. LPN-C verified R1 wore jeans, a brownish sweater, hiking boots, and weather was "nice outside." LPN-C stated R1 had been gone from the facility almost 12 hours and that was concerning.<br><br>During an interview on 5/23/23, at 1:55 p.m. CDON-A stated R1 was admitted from acute care to the facility after he fell and hit his head. CDON-A indicated R1's cognition was poor and a wandering and elopement risk assessment had been completed upon admission and indicated R1 was high risk for elopement. CDON-A also stated a wander guard was placed on R1's left wrist upon admission on 1/12/32. CDON-A stated R1 had a tendency to remove or cut off his wander guard on 2/23/23, 5/7/23, 5/11/23, but | F 689 | | |

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| F 689 | Continued From page 11<br>unable to determine when it was placed back on, however found wander guard cut off in is room on 5/16/23. CDON-A indicated staff were expected to check placement of the wander guard once a shift. CDON-A stated it was difficult to interpret the documentation on the treatment administration record (TAR) the number nine indicated a progress note be written but there would not be a progress note documented every time staff entered nine on the TAR. CDON-A verified the courtyard door alarm was not turned on at the time of the elopement. CDON-A indicated nurse Aid (NA)-B was contacted on 5/16/23, regarding R1's elopement and admitted he did not look in R1's room from the time he arrived at the facility at 10:30 p.m. until 3:00 a.m. when he passed fresh water, and swore he saw R1 in bed at that time. CDON-A also stated NA-B admitted he trusted the previous shift that R1 was in his room and did not check on him prior to 3:00 a.m.<br><br>During a follow up observation and interview on 5/24/23, at 10:20 a.m. CDON-A provided a tour of the facility's courtyard and fence. When CDON-A exited the courtyard door, alarm went off immediately and verified the alarm was currently set and working. CDON-A and surveyor walked outside to the northwest corner of the building where the door to the 6-foot fence was chained and locked. CDON-A indicated the fence gate could only be opened with a key and was secure. CDON-A stated she was sure R1 climbed over the fence to exit the courtyard. At 10:30 a.m. the administrator came out to the courtyard and stated he was confident R1 climbed over the six-foot fence to exit this area then walked to his apartment. Administrator verified R1 was out of the field of camera when he exited the courtyard. | F 689 | | |

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| F 689 | Continued From page 12<br><br>R1's facility one on one supervision (within site) information document dated and implemented, 5/16/23 identified R1 has a history of elopement and has been attempting to leave the facility. R1 refused to wear a wander guard and was in need of one-on-one supervision for safety. R1 was severally cognitively impaired. R1 does have physical abilities to climb the fence in the back yard and pick up large items. The individual supervising him was to always have him in line of site. If R1 leaves long term care permitted area ask him to return, if he refuses, inform if he does not return, we will have to call law enforcement, and call nurse for help. Do not leave R1 alone, go with him.<br><br>During an interview on 5/22/23, at 2:00 p.m. R1 stated he wanted to get out of the facility. R1 verified he removed his wander guard from his ankle, and it remained off for quite a while. R1 stated he crawled over the fence outside and walked to his apartment approximately 4 blocks away. R1 indicated it was dark out, not sure of the time or how long he was gone, and in the morning brought back to the facility by 2 policemen. R1 also stated he knew he was going to do this, had planned it out, and told staff. R1 indicated he knew he should have not gone but left because he felt he was being held against his will.<br><br>During a telephone interview on 5/23/23, at 2:00 p.m. nursing assistant (NA)-B stated R1's care plan indicated he was to be checked on every hour during the night by staff. NA-B also stated the hourly rounds are documented on a sheet kept with the registered nurse. NA-B indicated staff are expected to document the call lights, | F 689 | | |

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| F 689 | Continued From page 13<br>alarms, awake, sleeping, bathroom, where they are located, and open the door of the room if closed to visually see the resident on every round. NA-B verified on May 15, 2023 he had arrived at facility at 10:30 p.m. until 7:00 a.m. to work the night shift on Windy Cove. NA-B stated R1's door was not opened to visually see him when the first round was made with the evening shift around 10:30 p.m. because he thought he was in his room. NA-B also stated at approximately 11:30 p.m. NA-B indicated R1 no longer had a night light, room was dark, and it was hard to see if R1 was in bed. NA-B indicated at 11:30 p.m. R1 was checked on and NA-B thought he was in bed, "swore he was in bed" but later that day told he was not. NA-B stated hourly checks were then completed on R1 at 12:30 a.m., 1:30 p.m., 2:30 p.m. During those hourly checks, NA-B indicated R1's door was slightly cracked open enough for his head to be in there and peaked in and "swore he was seen in bed." NA-B verified at 3:30 a.m. he entered R1's room, walked over to the table located next to the bed and switched water mugs so that R1 would have fresh water. NA-B stated he thought R1 was in sleeping and tried to be quiet because R1 got agitated and irritated when staff opened the door. NA-B stated at 4:30 a.m. an 5:30 a.m. he opened R1's door to his room only enough for his head and peaked in on R1 and swore he saw him in bed. NA-B indicated at 7:00 a.m. hourly rounds were not completed with the oncoming day shift NA-A on R1 because he had checked on him at 5:30 a.m. NA-B verified R1 had talked about leaving the facility numerous times and he was fully aware of that. NA-B worked the night shift the following day 5/16/23, and after completing this shift met with director of nursing (DON) regarding education on completing visual hourly | F 689 | | |

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| F 689 | Continued From page 14<br>checks and R1's care plan changes following his elopement.<br><br>During an interview on 5/24/23, at 3:00 p.m. NA-C stated R1's cognition had declined, seemed more confused and forgetful lately, and told staff he was going to leave facility to go to his apartment. NA-C stated she had worked the evening shift 2:30 p.m. to 11:30 p.m. on 5/15/23. NA-C indicated R1 was on every hour checks and staff were expected to check to see where he was at and visually see him. NA-C also stated the nurse in charge should have locked the back door to the courtyard garden area by 9:00 p.m. NA-C verified she visually checked R1 on 5/15/23, at 3:00 p.m., 4:00 p.m. took bath, 5:00 p.m. outside, 6:00 p.m. in dining room for supper, 7:00 p.m. opened door to his room and saw him, 8:00 p.m. opened door to his room but he was in and out of room, 9:00 p.m. was the last time he was seen in his room and did not see again as she, "got busy." NA-C stated she assumed R1 was in his room at 10:00 p.m. and 11:00 p.m. during the hourly checks but did not open the door to check.<br><br>During an interview on 5/25/23, at 10:30 a.m. LPN-B stated staff were expected to complete hourly rounds on R1 which meant visualize him and verify where he was at to make sure he was safe. LPN-B verified she had worked the overnight shift from 10:30 p.m. to 7:00 a.m. on May 15, 2023. LPN-B stated she was not sure hourly rounds were completed by the NA that night shift on May 15, 2023, however, it was expected and important to visually see R1 for safety reasons and make sure he remained in the building during the night. | F 689 | | |

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| F 689 | Continued From page 15<br>During a telephone interview on 5/25/23, at 8:00 a.m. environmental services manager (ESM) stated R1 hopped the approximately 6-foot fence, he had heard R1 say it, and was the only way he could have gotten out of the courtyard area. ESM indicated there was a ledge about six inches wide on the building by the end of the fence on the northwest side that goes up to about three feet. ESM stated R1 could have placed his foot on that ledge to get over the fence. ESM verified the fence doors were checked on the morning of May 16, 2023, and they were locked and secure. ESM also stated the outside cameras on the northwest side of the building reached all the way out to the street, motion censored, and does not pick up human activity unless they are about 200 feet of camera. ESM indicated because of the way the camera was positioned it had not picked up R1 in that area. ESM indicated the camera footage verified R1 had exited the building via courtyard door at 9:02 p.m. then re-entered the building shortly thereafter, and at 9:05 p.m. exited the building again from the same door carrying a bag with him. ESM indicated facility nursing staff were expected to turn the alarm on to that door in the evening and on that day (May 15, 2023) it did not get turned on, unfortunately.<br><br>Review of Facility Investigation Report Summary identified:<br>On 5/15/2023, at 9:05 p.m. R1 was seen on camera leaving the grounds outside the courtyard fence. At 7:45 a.m. the next morning staff reported that she thought R1 was at breakfast as usual when she was completing rounding in R1's room. Staff then indicated she went to the dining room and R1 was not there either. Staff made a quick check of the area looking for R1 and asked other staff to assist her. At 8:05 a.m. | F 689 | | |

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| F 689 | Continued From page 16<br>Administrator and social worker were notified that R1 was not in the care center. R1's son was immediately called and a message was left. Law enforcement was called and all staff page was given to have all available staff come to the care center. Pictures of R1 were distributed and staff stated that R1 had talked about going to his apartment. R1's WanderGuard was found cut off laying on the floor next to his recliner with a cuticle clipper and a fingernail clipper. Staff were dispatched with law enforcement to R1's apartment four blocks away where R1 was found at 8:30 a.m. LSW/DON and law enforcement discussed R1's options with him and R1 agreed to go to ER for evaluation. R1 was evaluated, physically and mentally. ER reports no injuries or bruising, physically healthy male. Mental assessment show R1 has severe cognitive impairment. R1 returned to the care center later in the morning on 5/16/2023, and stated he is just going to leave again. As of 5/19/2023, R1 has not attempted to leave but continues to state that he will. R1 had scaled a 6 foot fence without injury, all gates locked on security check on morning of 5/16/23. Neglect of the care plan is substantiated, and disciplinary action is recommended to HR and nursing relating to this investigation. Process improvement relating to resident checks with audits is also recommended. Report summary also identified corrective action was implemented such as, 1-1 initiated, attempting to find secure unit placement, courtyard door alarm turned on at all times and require manual turn off. Staff education initiated, auditing of alarm systems and wander Guard systems, audit of all resident with WanderGuard on and updating wandering and elopement evaluations to assess their risk, as well as Care plan reviews on all residents with WanderGuard. | F 689 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245580 | A. BUILDING _____ B. WING _____ | C 05/24/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LAKEWOOD CARE CENTER | 600 MAIN AVENUE SOUTH BAUDETTE, MN 56623 |

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| F 689 | Continued From page 17<br><br>R1's care plan dated 5/16/23, indicated R1 was independent on unit for ambulation, transfers, and personal hygiene. R1 was identified high risk for elopement related to severe cognitive impairment. Wanderguard was placed in coat and duffle bag due to R1 cut off the wander guard located on himself. R1 continued to be at high risk for falls and required continued verbal cues, use of the wander guard, and one on one intervals of timed safety rounding, due to deficit in thought process for risk of elopement.<br><br>During an observation and interview on 5/22/23, at 1:45 p.m. dietary aide (DA)-A was observed sitting outside R1's room. DA-A stated during her shift assignment today she was to complete continuous one to one observation of R1. DA also stated she has always kept a visual eye of R1 when he exited his room, otherwise sat in chair in hallway, then every 30 minutes got up, and opened the door to his room to visually see him and what he is doing. DA-A indicated the one to one observation of R1 was needed to keep him safe and help prevent him from leaving the facility unattended. DA-A verified R1 had ventured over to the fence gait outside but had not tried to leave the grounds on her watch.<br><br>During an interview on 5/23/23, at 9:13 a.m. trained medication aide (TMA)-B stated staff were required to make hourly rounds on R1 prior to his elopement, which meant lay eyes on him and note location. TMA-B verified when R1 first arrived at facility he was pleasantly confused now he is paranoid and does not trust staff. TMA-B indicted R1 talked a lot about leaving here and going to his apartment down the road, a wander guard was applied, cut off by R1 then applied | F 689 | | |

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| F 689 | Continued From page 18<br>another one but R1 cut it off with a nail clipper in his room. TMA-B indicated on hourly rounds she opened his door, flipped the light on located by the door, and R1 seemed ok with that to ensure he was in his room safe. TMA-B indicated on 5/17/23, early morning she received her education along with many other staff regarding elopement and supervision for R1 and his safety to avoid another elopement.<br><br>Facility policy titled Resident Elopement, reviewed last on 5/2023, indicated the facility strived to follow a standardized plan to utilize available resources when a resident is presumed to be missing from the building or grounds. All residents will be evaluated for elopement risk upon admission and a plan devised for elopement prevention such as a wander guard placement, increased supervision or redirection plan as needed. Each staff person is accountable for the resident's location in the facility by being aware of the whereabouts of each resident.<br><br>Facility policy titled Wander Guard, reviewed on 5/2023, indicated the facility will ensure all at risk residents will be maintained in a safe and secure environment. Residents that display behaviors of wandering will be assessed for placement of the wander guard. Those residents that wander may be unaware of his or her physical safety needs. When a resident is deemed an elopement risk, initiate monitoring. Monitor the placement of bracelet every shift and documents placement in the electronic medial record (EMR). Check the wander guard on a weekly basis for functioning and expiration dates and document of the resident treatment sheet.<br><br>The past noncompliance immediate jeopardy | F 689 | | |

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| F 689 | Continued From page 19<br>began on 5/15/23. The immediate jeopardy was removed and the deficient practice corrected by 5/20/23, after the facility implemented a systemic plan that included the following actions: 1-1 initiated, attempting to find secure unit placement for R1, courtyard door alarm turned on at all times and require manual turn off, staff education initiated, auditing of alarm systems and wander Guard systems, audit of all resident with WanderGuard on and updating wandering and elopement evaluations to assess their risk, as well as Care plan reviews on all residents with WanderGuard. | F 689 | | |

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

Electronically delivered

June 6, 2023

Administrator
Lakewood Care Center
600 Main Avenue South
Baudette, MN  56623

Re:  Event ID:  U98H11

Dear Administrator:

The above facility survey was completed on May 24, 2023 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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00332 | A. BUILDING: _____ B. WING _____ | C 05/24/2023 |

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|---|---|
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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 5/22/23 to 5/24/23 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. | 2 000 | | |

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| 2 000 | Continued From page 1<br><br>H55802293C (MN00093640)<br>H55802344C (MN00090458)<br>H55808962C (MN00089761)<br><br>No licensing orders were issued.<br><br>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.<br><br>Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents. | 2 000 | | |