DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 8, 2021

Administrator
Good Samaritan Society - Arlington
411 Seventh Avenue Northwest
Arlington, MN 55307

RE: CCN: 245598
Cycle Start Date: May 18, 2021

Dear Administrator:

On June 9, 2021, we notified you a remedy was imposed. On July 1, 2021 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 3, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective June 24, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of June 9, 2021, 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 June 24, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on June 3, 2021, 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 Therefore, the NATCEP prohibition is rescinded.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 Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

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

Electronically delivered
June 9, 2021

Administrator
Good Samaritan Society - Arlington
411 Seventh Avenue Northwest
Arlington, MN 55307

RE: CCN: 245598
Cycle Start Date: May 18, 2021

Dear Administrator:

On May 18, 2021, 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 actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

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(ies) 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 24, 2021.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective June 24, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 24, 2021.

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.

This Department is also recommending that CMS impose:

• 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.

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 $11,160; 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.

If you have not achieved substantial compliance by June 24, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Good Samaritan Society - Arlington will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 24, 2021. 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.

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

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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 - Health Regulation Division 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 18, 2021 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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

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:

Tamika.Brown@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 Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	C 05/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARLINGTON	**411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307**

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F 000	INITIAL COMMENTS On 5/14/21, 5/17/21, and 5/18/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5598013C (MN72573), and H5598014C (MN72619), with a deficiency cited at (F684). The following complaints were fond to be UNSUBSTANTIATED: H5598015C (MN60284). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered	F 684		6/3/21

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

Electronically Signed | 06/16/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 684	Continued From page 1 care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify, assess, monitor, provide maintenance care, and dressing changes for a central venous catheter (CVC) for 1 of 3 residents (R1) reviewed for quality of care. This deficient practice resulted in actual harm for R1 who required hospitalization and antibiotic therapy for CVC infection. Findings include: R1's admission face sheet dated 12/15/20, identified the following diagnoses: end stage renal disease, stage 4 (severe), arm grafts (vascular access for dialysis), and dependence on renal dialysis. R1's quarterly Minimum Data Set (MDS) assessment dated 3/2/21, Brief Interview for Mental Status and Resident Mood Interview (PHQ-9) indicated R1 was unable to complete the interviews and scored 99. R1's MDS Section O indicated R1 was not receiving intravenous medications or that a CVC line was in place. R1's Emergency Department discharge summary dated 2/5/21, documented a central venous catheter in the left groin due to the severity of the patient's condition that required intravenous access. R1's regional hospital discharge summary dated 2/9/21, documented 3-Lumen CVC is located in the left femoral vein. No physician discharge orders for CVC catheter management were found.	F 684	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. F684 1. R#1's central venous catheter was removed at the hospital on 5-4-21. 2. All residents were reviewed, and none identified as having the potential to be affected. 3. Re-education was provided to all licensed nurses by the DNS on 5-6-21 regarding head-to-toe assessment for all admissions and re-admissions to identify, assess, monitor, document, and provide appropriate care based on the assessment. Licensed nurses were also provided re-education regarding GSS policy and procedure for weekly skin observation, following up with clarification from provider if there is a CVC present that does not have appropriate orders for care. Admission nurses were provided with re-education on reviewing all hospital	

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F 684	Continued From page 2 R1's Nursing Admit Re-admit Data (NARA) collection form dated 2/9/21, at 12:35 p.m. by registered nurse (RN)-A documented R1 was admitted to the hospital for surgical repair of a ruptured right fistula and directed to provide surgical incision care with dressing changes. RN-A further documented skin integrity observations including care planning for skin issues and wounds. RN-A did not identify presence of left groin CVC line. Every Friday evening from 2/13/21, through 05/15/21, RN-B completed a weekly head-to-toe skin assessment and documented the results of the findings in the facility Skin Observation documentation tool. Every week RN-B documented R1 had a left inguinal (groin area) port. RN-B documented treatments for the port can be found in the treatment administration record (TAR). R1's 2/1/21 - 2/28/21 TAR identified physician orders to place a dressing to the right arm fistula (permanent abnormal passageway between two organs in the body or between an organ and the exterior of the body) and monitor for worsening or concerning symptoms) site right arm. The TAR did not identify any physician orders for CVC care and no care documentation was found for CVC assessments, monitoring, providing maintenance care, or dressing changes. R1's hospital discharge summary dated 5/7/21, included discharge diagnosis of sepsis (a serious condition resulting from the presence of harmful microorganisms in the blood) and the source appears to be multifactorial from cellulitis on the left foot, C. Difficile, and potential left femoral	F 684	discharge information to ensure identification of CVCs and ensuring appropriate orders are obtained prior to admission for the care of the CVC. In addition, all licensed nurses were re-trained with competency verification by the Clinical Learning and Development Specialist on the care of PICC lines, central lines, and peripheral lines on 6-3-21. 4. Audits to ensure accurate completion of head-to-toe assessments upon admission and re-admission and appropriate care delivery will be done by the DNS or designee X 3months. 3 Weekly skin observation UDAs will be audited on random residents every week X 4, then monthly X 2. Results will be taken to the Quality Committee for further recommendations each month. 5. Completion date 6-3-21	

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F 684	Continued From page 3	F 684		

central line catheter. Hospital emergency department assessment included the patient was found to have a left femoral central line. Patient does not know why he had this line in place and the line was removed in the emergency department. The line, most likely, is from a discharge from regional hospital months ago. The Plan of Care Assessment documents septic shock, likely due to staph aureus. Suspect R1 has a line infection or at least very high risk for a colonized central line. He has both a right IJ (internal jugular vein in the neck) tunneled dialysis catheter and presented with a left femoral central line. Femoral line has been removed.

R1's regional hospital After Discharge Orders and Summary dated 5/13/21, included: Specific recommendations to be addressed at the follow up visit - admitted with coagulase negative staphylococci sepsis/bacteremia due to infection of retained lines. Femoral and right IJ lines removed this admission; femoral catheter tip culture also positive for coagulase negative staphylococci, likely source of Infection. He has chronic foot wounds as well-vascular, and podiatry assessed. Regarding treatment of his line associated bacteremia, Infectious Diseases recommended seven days of IV (intravenous) vancomycin (antibiotic) after line removal (5/4/21).

R1's care plan from admission dated 12/15/20, indicated R1 received dialysis three times per week related to renal failure. The care plan did not identify documentation for CVC assessments, monitoring, or provide maintenance care, or dressing changes.

The facility's investigation regarding the lack of

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F 684	Continued From page 4	F 684		

care for R1's CVC titled, Investigation - R1, documentation, dated 5/5/21, completed by director of nursing (DON) included: RN-A was not aware R1 had a CVC in his left groin and did not provide CVC care; licensed practical nurse (LPN)-A did not provide CVC care and indicated dialysis was caring for the CVC line; LPN-B knew the CVC line was in place, did not provide CVC care, and the line was for dialysis; RN-B did not provide CVC care and assumed the CVC line was for dialysis; RN-E indicated not knowing the CVC line was placed and did not provided CVC care; LPN-C indicated not knowing the CVC line was placed and did not provided CVC care; RN-C stated, "no, I had no idea" there was a CVC line and did not provide CVC care; and DON was not informed R1 had a CVC line.

Review of physician orders printed on 5/25/21, did not include orders to assess, monitor, provide maintenance care, and dressing changes for CVC.

During an interview on 5/17/21, at 9:30 a.m. DON stated there is a NARA readmission assessment completed on every resident that returns to the facility or when the resident is first admitted. The assessment requires a head-to-toe visualization of all R1's skin, but the admitting nurse did not look in R1's brief to see the CVC line. DON stated we have never requested hospital discharge summary's when a resident goes from one hospital to another. We would just get the last hospital discharge summary. DON stated we will now always get all the paperwork from all providers, so we have the information. DON stated if the facility would have had Ridgeview Medical Center's discharge summary, they would have seen R1 has a CVC, and something should

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F 684	Continued From page 5	F 684		

be done with it. DON stated the facility could have sent resident next door to Ridgeview Arlington (hospital) campus and had the CVC line pulled. DON stated during the investigation it was discovered staff had mistakenly identified the CVC line as a dialysis access port.

During an interview on 5/17/21, at 12:58 p.m. RN-A stated she did not see the CVC line during her NARA on 2/9/21, at 12:35 p.m. because it was under the brief and she did not look inside the brief. On 2/13/21, RN-B completed a weekly skin check and found the CVC line. RN-B indicated the line was for dialysis. RN-A stated she had not worked with central lines before and is not trained in CVC line management. RN-A further stated if she observed it during the NARA, she would have looked for physician orders, looked for dressing change instructions, and the purpose of the CVC line. RN-A further stated physician order information would be added to the medical administration record (MAR) and TAR.

During an interview on 5/17/21, at 1:25 p.m. certified nurse practitioner (CNP)-A stated the first time she heard about the CVC was last week and had no idea it was there. No one informed her or asked her about the CVC. CNP-A stated not knowing the medical decision making of why the CVC was placed. CNP-A stated, if the CVC is not being used, R1 could have gone next door to local hosptial and have it pulled; easy as that.

During an interview on 5/18/21, at 10:05 a.m. R1 was reluctant to be interviewed and stated, "get to the point." R1 angrily stated he has no concerns with care and staff are helpful. R1 would not continue with the interview.

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F 684	Continued From page 6 During an interview on 5/18/21, at 10:30 a.m. DON stated she completed reeducation of staff on skin assessment that included visualization all of the skin from head to toe and to identify all wounds and intravenous (IV) or CVC lines. All IV or CVC lines have to be identified and matched to the physician order. The physician order would direct why the IV or CVC line was placed and care management. The skin assessment directed any device on the skin has to be addressed and care planned. DON further stated, there were no CVC dressing changes since R1 returned to the facility on 2/09/21. Staff thought dialysis was doing dressing changes. When the CVC line was discovered on 2/13/21, unknown nursing staff concluded the CVC was for dialysis and to leave it alone. DON further stated staff are not good about reading the whole hospital discharge summary and that will change going forward. During an interview on 5/18/21, at 11:14 a.m. licensed independent clinical social worker (LICSW)-A stated the local emergency department physician contacted the social services department with concerns of R1 having a CVC line in for months, R1 as a poor historian and unable to speak for himself, and concerns of a possible CVC infection. The facility's Central Venous Catheter: Maintenance and Dressing policy dated 5/2020, directed only nurses competent in dialysis central venous catheters (CVC) may provide catheter care and to flush the catheter daily. The facility Skin Assessment policy dated 4/21/21, directed that a licensed nurse will complete a comprehensive skin assessment upon readmission to the facility.	F 684		

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GOOD SAMARITAN SOCIETY - ARLINGTON	**411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307**

(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 684	Continued From page 7 The facility Care Plan policy dated 10/16/20, directed that residents will receive and be provided the necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment.	F 684		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 9, 2021

Administrator
Good Samaritan Society - Arlington
411 Seventh Avenue Northwest
Arlington, MN 55307

Re: Event ID: VWWJ11

Dear Administrator:

The above facility survey was completed on May 18, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

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

Please feel free to call me with any questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00617	A. BUILDING: _____ B. WING _____	C 05/18/2021

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/14/21, 5/17/21, and 5/18/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaints were found to be	2 000		

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2 000	Continued From page 1 SUBSTANTIATED: H5598013C (MN72573) and H5598014C (MN72619) , however NO licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		