DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 23, 2026

Administrator
MN VETERANS HOME - LUVERNE
1300 NORTH KNISS AVENUE
LUVERNE, MN 56156

RE: CCN:245631
Cycle Start Date: July 1, 2026

Dear Administrator:

On July 1, 2026, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.

  What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility’s Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Alex Warren, Regional Operations Supervisor
Duluth District Office
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082
Email: Alex.Warren@state.mn.us
Office: 218-302-6186 Mobile: 651-279-5375

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or
Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by October 1, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by January 1, 2027 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)
In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are

disputing those deficiencies, to:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

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Re: Event ID: 25C480-H1

Dear Administrator:

The above facility survey was completed on July 1, 2026 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
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us

Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245631	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME - LUVERNE	1300 NORTH KNISS AVENUE , LUVERNE, Minnesota, 56156

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS On 7/1/26, an abbreviated survey was completed by surveyors from the Minnesota Department of Health (MDH) to conduct a complaint investigation. Your facility was found NOT in compliance with the requirements of 42 CFR 483, Subpart B, the Requirements for Long Term Care Facilities. The following complaint was reviewed: H56313123C (3063755, 3063776); with non-compliance cited at F684. 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.	F0000		
F0684 SS = D	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 care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure a change of condition was identified and assessed by a nurse to determine what, if any, additional intervention maybe needed for 1 of 2 residents (R1) reviewed. R1 developed audible “gurgling” and potential respiratory impairment on 6/26/26 in the mid-afternoon which was not	F0684		

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

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

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F0684 SS = D	Continued from page 1 comprehensively assessed by a nurse until several hours later. Findings include: On 7/1/26 at 11:46 a.m., an interview was held with emergency medical technician (EMT)-E who stated they were on a crew that responded to the care center for R1 on 6/26/26, with reported respiratory distress. They arrived and found R1 lying in bed and “very clearly in respiratory distress.” The staff members present reported R1’s condition onset “about 2:00 p.m.,” which EMT-E then questioned aloud, “Why did it take eight hours [to call]!?” R1 had just had oxygen placed via cannula at 2 liters per minute (LPM) as EMT arrived and R1’s oxygen saturations were poor when they checked them. EMT-E stated R1 was then transported to the hospital where she was found to have a “very intense pneumonia in her lungs.” R1’s Physician Orders for Life Sustaining Treatment (POLST), dated 1/2024, identified R1 had wishes for “selective treatment” marked but was agreeable to limited interventions such as IV/IM antibiotics or a defined trial of artificial nutrition. R1’s quarterly Minimum Data Set (MDS), dated 4/12/26, identified R1 had both long and short-term memory impairment and a history of previous stroke. R1 did not have a history of respiratory failure recorded. R1’s care plan, last reviewed 4/15/26, identified R1 had an activity of daily living (ADL) self-care deficit and was dependent on staff for most care. The care plan lacked evidence R1 had any current respiratory issues or concerns such as wet-sounding voice or ‘gurgling’ with spoken word R1’s Respiration / Pulse / O2 Sat Summaries, printed 7/1/26, identified the recorded vital signs for R1 over the previous 90-day period. These vitals were recorded: 6/16/26 – 18 respirations per minute (RPM), 53 beats per minute (BPM), and 92% on room air (RA). 6/23/26 - 18 RPM, 62 BPM, and 93% on RA. R1’s progress note, dated 6/26/26 at 10:19 a.m., identified R1 was seen by medical doctor (MD)-D and no new orders were written. R1’s corresponding Family Medicine Progress Note, dated 6/26/26, identified R1 was seen for a routine 60-day examination. MD-D recorded himself as having a	F0684		

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F0684 SS = D	Continued from page 2 hard time understanding R1's speech but R1 had been eating okay. The note identified R1 had a previous choking episode but the congestion "… seems to be better at this time." The note recorded R1 had no cardiopulmonary symptoms present and a physical exam was done which recorded R1's vital signs as 110/62 (BP), 62 BPM, and 16 breaths per minute. R1's lung sounds were listed as clear and R1 was in no acute distress. However, R1's subsequent progress note, dated 6/25/26 at 9:45 p.m., identified the staff had noticed R1 "sounded gurgle [sic]" when getting her up for the supper meal. R1 was alert and ate 25% of her supper meal. The note then recorded, "By the time she was assisted to bed. She started to cough more and sounded even more gurgle [sic]. She looked pale and was difficult to arouse. She said she was tired … was afebrile with 96.5 [F], P 67 and went up to 161, R 35 and irregular. O2Sat ranged from 75 to 80% [on] RA. After administering O2 [oxygen] per [cannula] it increased to 85% at 2 L [liters per min] … Family called to communicate resident's change of condition." EMS was then called and R1 was transported to the hospital at 10:18 p.m. Registered nurse (RN)-B authored the note, however, the note lacked what, if any, assessment had been completed of R1's respiratory system when the staff had initially identified the "gurgle" noise when getting her up from bed before the meal. When interviewed on 7/1/26 at 11:28 a.m., licensed practical nurse (LPN)-D stated they had worked with R1 prior to her hospitalization and recalled R1 as needing help to complete most cares. R1 was also talkative but often didn't "make sense" with the conversation flow. LPN-D stated they "[couldn't] say for certain" if R1 had a normal 'wet' voice or audible ongoing cough. R1 was on thickened fluids so at times people will hear that. LPN-D stated they felt R1 having audible 'gurgling' noises at rest would be "definitely different for her." If that was reported to the nurse, then the nurse should evaluate the lung sounds and check vital signs. That evaluation should then be recorded in the progress notes. LPN-D stated they were not sure what happened to R1 causing her hospitalization but added they were "quite shocked" when they came to work and heard R1 subsequently died at the hospital as R1 was not terminally ill or on hospice care. When interviewed on 7/1/26 at 12:32 p.m., nursing assistant (NA)-B stated they were assigned to help care for R1 on 6/26/26 for the evening (PM) shift. NA-B and NA-C got R1 up from bed around 3:30 p.m. and at that time noticed R1 was "a little gurgly"	F0684		

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F0684 SS = D	Continued from page 3 sounding. NA-B stated it caused them to wonder if “something was a little off” but the noise was not very prominent. R1 was taken to the commons area and NA-B stated they told the nurse, RN-B, about the noise R1 had been making. RN-B responded aloud, “OK,” and NA-B stated they were not sure what actions RN-B did after that with R1. NA-B stated there were no visible secretions on or around R1’s mouth when they noticed the noise. When supper time arrived, NA-B stated they helped R1 with eating and R1 then again seemed “more gurgly” sounding. This was again reported to RN-B who stated they “just wanted to watch her” and keep monitoring it. NA-B stated the gurgling noise R1 was making “was definitely new to me [hearing it].” Then, later in the evening, as they helped R1 to bed the audible gurgling noise was still present, so they raised the head-of-the-bed after R1 was laid down. NA-B stated they again notified the nurse who went into the room around 7:30 or 8:00 p.m. they thought. The nurse attempted to do vital signs but couldn’t locate the pulse oximeter right away which caused a delay adding, “That took a while.” Then around 9:30 p.m., the nurse finally got one and took vital signs, then “everything was low” and R1’s vitals were abnormal. NA-B recalled that R1’s family was then called and then she was sent to the hospital with EMS. NA-B stated R1 “didn’t look too good” when she left for the hospital. NA-B reiterated the main nurse helping with R1 that shift was RN-B. When interviewed on 7/1/26 at 12:53 p.m., NA-C stated they recalled working with R1 on 6/26/26 in the PM. R1 had “sounded like she was really gurgly” when they helped her up from bed in the afternoon and “felt a little warm” to touch. NA-C stated RN-B was told about these issues and responded to “keep an eye on her” and keep R1 upright in the chair for a while. NA-C stated they were unsure what actions RN-B took to evaluate R1 as they had other people to help care for and left the area. NA-C then helped NA-B put R1 to bed around 7:00 p.m., and R1 again sounded “gurgly” so the head-of-the-bed was raised up. RN-B was again told of R1 but NA-C was unsure what, if any, follow up was done as they went and helped other people. NA-C recalled that around 8:30 p.m. to 9:00 p.m., RN-B was in R1’s room and trying to get vital signs but they were having trouble getting the oxygen levels due to the oximeter being missing. When they finally got it, R1’s oxygen level was “like 80’s [%]” and the nurse was “super concerned.” The nurse then applied oxygen to R1 to help her, but this was “just before she left” with EMS. R1’s medical record was reviewed and lacked	F0684		

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F0684 SS = D	Continued from page 4 evidence what, if any, nursing assessment of R1's respiratory condition was completed around 3:30 p.m., when the NA staff members first identified a possible change in condition of R1's respiratory status. The record lacked any record vital signs or assessment until 9:45 p.m., then the progress note identified RN-B's actions and care provided. When interviewed on 7/1/26 at 1:04 p.m., RN-B stated they were not told any concerns about R1 in the verbal report from the previous shift on 6/26/26, but only R1 had been seen by the MD and there were no new orders. RN-B stated R1 had a history of aspiration and would "once in a while" have a cough they noted. RN-B verified the NA staff reported R1 as sounding "gurgly" when they got her up before supper. RN-B stated she did a visual look of R1 at that time and R1 appeared "at her baseline." RN-B stated they did not obtain vitals or listen to R1's lung sounds when first told as R1 appeared visually to be fine. If she had not looked fine, then RN-B would have done "a whole assessment." RN-B stated they did not recall the NA reporting anything concerning R1 at the supper meal. RN-B then explained they saw R1 again after she had been placed into bed. RN-B entered the room and R1 voiced feeling "tired", so RN-B turned on the room light. R1 looked pale and her respirations were irregular. RN-B stated it was at that time when they "did a whole assessment" of R1 and found her to have some faint expiratory wheezing and a "very high" pulse rate. R1 also had a "fluid in her throat" sound present. RN-B notified the other nurse working to help evaluate R1 and got a second opinion. The other nurse felt R1 didn't look good, and a decision was made to call the family and seek permission to send R1 to the ED. RN-B verified the first time they listened to R1's lung sounds was after the supper meal when R1 had been placed back into bed. RN-B also verified they did not update the MD about the "gurgling" noise prior to R1 being sent to the hospital. RN-B stated since this had happened, nobody from management had talked with them about it but reiterated it was not the first time R1 had a wet-sounding voice or noise with breathing adding, "It's not like it's never happened before." When interviewed on 7/1/26 at 1:54 p.m., the director of nursing (DON) stated they felt it would not have been "out of the ordinary" for R1 to have a wet-sounding voice or gurgle with her speech. R1 had a history of swallowing issues and RN-B did a visual look of R1 and didn't see anything concerning to warrant a full assessment "at that point" in the early afternoon on 6/26/26. DON verified this wet-sounding voice or breathing was	F0684		

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F0684 SS = D	Continued from page 5 not something care planned as normal for R1. DON stated their “expectation” would be to “take a look” at R1 and if the nurse felt something was amiss, to then do a full assessment and chart their findings in the record. DON reiterated they felt a visual assessment would be appropriate and going beyond that “depends on the nurse and their nursing judgement.” DON stated they had visited with some of the staff members working on 6/26/26 during the AM shift who felt R1 was her baseline self. DON acknowledged the charting by RN-B did not have “a nice timeline” of the actions or events and felt it could have been more thoroughly documented. When asked about the regulatory expectations for notification to the physician, DON stated that in that framing and hindsight, she wished RN-B had done a full assessment at 3:30 p.m. when first told of R1’s potential issue but reiterated the direct care staff know the residents and she had to rely on the nurses’ judgement in the situation. DON stated RN-B was a good nurse and it was concerning there was discrepancies between the NA and nurse about R1’s presentation on 6/26/26. DON stated they did not feel action sooner, such as a full assessment being done by the nurse at 3:30 p.m., would have changed R1’s outcome as R1 was “very compromised” in her overall condition. DON stated it was important to ensure actions taken with a potential change-of-condition were recorded in the medical record to ensure credit is provided with care given and “we want to be able to defend ourselves.” On 7/1/26 at 2:39 p.m., an interview with MD-D was attempted but they were out of the office. MD-F was present who had also been involved with R1’s care in the past. MD-F was interviewed at 3:23 p.m. and explained they were part of a team of physicians who round on patients many patients, including R1, who were at the care center. MD-F described R1 as being “complicated but stable” when they had last evaluated her at the care center. MD-F did not recall R1 as ever having a major respiratory illness, such as COPD or asthma, but stated from his memory that he could envision R1 as having a potential ‘wet-sounding’ voice at baseline just given her medical history. R1 had a history of stroke and could have a harder time clearing secretions in her throat as a result. When asked if earlier notification to the physician would have changed R1’s outcome, MD-F stated R1’s clinical picture seemed to change “so quickly” after MD-D’s visit that listening to the lungs and checking vital signs, such as oxygen levels, would have made sense. If those were fine, then notification to the provider was not likely needed right then. MD-F stated an update from the staff about R1 having sudden “gurgle” noises was	F0684		

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F0684 SS = D	Continued from page 6 also likely not needed, but reiterated that if such happened, then if or when the nurse evaluated R1 and found some “objective findings” which showed a decline (i.e., poor lung sounds, vital signs out of normal range) then an update would become more appropriate. MD-F stated R1 had a goal of care for more comfort-focused treatments and not super aggressive measures so perhaps a telephone call from the nurse to the family earlier on 6/26/26 with an update of any assessment findings would have maybe been more appropriate. From that, then the staff could update the provider team for further guidance depending on the family’s wishes for care. A facility Notification of Resident Changes policy, dated 12/2024, identified the expectations for when to notify the resident’s physician. This included when there was a significant change in resident health. However, it lacked guidance or direction on how nursing was expected to evaluate a potential change of condition or document their actions with such.	F0684		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN VETERANS HOME - LUVERNE	**1300 NORTH KNISS AVENUE , LUVERNE, Minnesota, 56156**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
20000	Initial Comments *****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 7/1/26, 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 reviewed: H56313123C (3063755, 3063776) 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	20000		

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **07/01/2026**

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20000	Continued from page 1 the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	20000		