Electronically delivered
March 11, 2021

Administrator
St Clare Living Community Of Mora
110 North 7th Street
Mora, MN 55051

RE: CCN: 245291
Cycle Start Date: February 18, 2021

Dear Administrator:

On February 18, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be 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" tag), i.e., the plan of correction should be directed to:

Susie Haben, Unit Supervisor
St. Cloud B District Office
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 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 May 18, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by August 18, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

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	245291	A. BUILDING _____ B. WING _____	C 02/18/2021

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F 000	INITIAL COMMENTS On 2/17/21 - 2/18/21, an abbreviated survey was completed at your facility to conduct complaint investigations. Your facility was found to be NOT in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5291025C (MN00069987) with a deficiency issued at F610 H5291026C (MN00058770) with no deficiencies issued The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Upon receipt of an acceptable electronic POC, a revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the	F 610		3/26/21

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

Electronically Signed | 03/21/2021

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F 610	Continued From page 1 investigation is in progress. §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. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure post-injury interventions were implemented to prevent further potential resident injury and failed to ensure a thorough investigation was completed upon injury identification for 1 of 3 (R1) residents reviewed for accidents and hazards. Findings include: R1's quarterly Minimum Data Set (MDS), dated 1/5/21, identified R1 had moderate cognitive impairment with a diagnosis of Alzheimer's dementia and chronic pain; however, R1 had been able to communicate her needs without concerns. The MDS indicated R1 required extensive physical assist for bed mobility and had been totally dependent on staff for transfers. In addition, the MDS identified R1 had been free of behaviors and had been free of arm and leg movement limitations. R1's care plan, dated 1/5/21, identified R1 had poor safety awareness, severely impaired decision making, was usually understood when she communicated, and would often wait for staff to approach her before she expressed her needs. The care plan identified R1 had impaired mobility	F 610	It is the policy of St. Clare Living Community of Mora to prevent and protect all residents from abuse, neglect, financial exploitation, and misappropriation of property. St Clare Living Community failed to ensure post-injury interventions were implemented to prevent further potential resident injury and failed to ensure thorough investigation was completed upon injury identification for accidents and hazards. R1's bed was moved 1 foot away from heater on the morning of 2/12/2021. R1's care plan was reviewed and updated on 2/27/2021 and on 3/2/2021. An audit of all residents rooms was conducted on 2/12/2021. All like residents who are affected by this practice beds/sleep surface were moved 12 inches/1 foot away from wall heater. St. Clare Living Community Abuse Prevention Plan reviewed and revised on 2/17/2021 to include immediate notification of responsible party and attending physician/provider. Licensed nursing staff re-educated on Abuse Prevention Policy with emphasis on immediate implementation of post injury interventions including safety measures for all other like	

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F 610	Continued From page 2 related to Alzheimer's dementia, arthritis, weakness, chronic pain, and adult failure to thrive which required physical assist of staff for all mobility and a full body mechanical lift for transfers. In addition, the care plan identified R1 liked to spend the good portion of her day in bed. R1's skin care plan identified a goal that her skin would remain clean, dry and intact thru her next review; however, identified a burn to her right lower leg, dated 2/12/21. A progress note, dated 2/11/21 at 1:41 a.m. identified, "When NAR [nursing assistant] was doing rounds, she noted resident's RLE [right lower extremity] was wedged between her bed and the heater on the wall. Writer [licensed practical nurse] immediately assessed and found a superficial burn to R [right] lateral calf. Entire reddened area measures 23 cm [centimeters] in length and 7.5 cm at it's widest point. At center of reddened area, there is a 7 cm x 6.2 cm area where skin had started to peel. Area cleansed w [with]/ NS [normal saline], bacitracin [antibiotic ointment] applied and covered w/ non-adherent pad and coversite [sic]. New orders in place. Will report to AM [day] staff to update family d/t [due to] TOD [time of day]." The progress note failed to indicate communication with facility management or a medial provider. Additionally, the progress note failed to indicate immediate interventions implemented to prevent further injury to the resident. A completed State Agency (SA) initial report, submitted 2/11/21, at 11:19 a.m. indicated a NAR had been doing rounds and found R1's RLE wedged between her bed and the heater on the wall. The nurse had immediately assessed the area and identified a superficial burn. The nurse	F 610	residents if warranted. Immediate notification to resident□s responsible party, attending physician/provider, and facility managers such as Administrator, Director of Nursing, Licensed Social Worker and/or RN Clinical Manager on 2/18/2021. Facility created and adopted Sleep Surface Distance from Radiator policy on 2/11/2021. All Nursing, Wellness, Housekeeping/Laundry, and Maintenance staff were educated on this policy. Sleep Surface Distance from Radiator policy was distributed to each of the above staff members on 2/11/2021 for review and employee signature. Abuse prevention education will continue to be provided to all new employees, through orientation and annual training programs. These programs include but are not limited to formal in-service presented by licensed staff, online education, written education with post test to ensure competency, and review of policies. The boiler temperatures will be monitored and recorded in a logbook located in the boiler room by employees possessing a boiler□s license no less than every 24 hours and no more than every 72 hours. The facility□s contract services will be used as a reference in order to maintain consistent boiler temperatures during the heating season as required. Facility will conduct sleep surface distance from heat source and temperature of heaters audits. These audits will be conducted weekly for four weeks, bi-weekly for four weeks, monthly for three months and randomly thereafter. Increase or decrease in these audits will be determined by cold weather	

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F 610	Continued From page 3 provided treatment to the burn. R1's RLE had been rechecked at 8:30 a.m. and showed a reddened area that measured 5.7 cm x 6 cm with surrounding skin to be "pink and clear, dry and intact." The report indicated R1 had been able to move her feet in bed and that R1 had swung her leg out from under her blankets. In addition, the report indicated R1's bed had been moved away from the wall and heater, ice packs and first aid applied, family updated, and nursing treatment orders had been initiated while waiting for order changes from the NP. A Resident Incident Response report, dated 2/16/21, indicated the interdisciplinary team (IDT) had met that day to review R1's burn sustained on 2/12/21. The report identified RN-A and the charge nurse had reassessed the burn "later in the morning" on 2/12/21 and determined it had appeared as a "2nd degree burn." At the time of the IDT review, the remaining site of injury measured a total area of 6 cm x 5.5 cm, had been red in color, and appeared as if the "first layer(s) of skin peeling." Within the area there had been a darker area of redness that measured 3.6 cm x 4 cm and the surrounding skin had been without concern. R1 had received pain management approaches due to report of pain when the area was cleansed. The report indicated R1's bed had been removed from the heating unit on the wall and a vulnerable adult (VA) report had been filed on 2/12/21. Further, R1's daughter and the facility NP had also been updated by RN-A on 2/12/21. R1 had been documented to have the ability to move her legs independently while she had been in bed and nursing staff felt that R1's RLE had been wedged between her bed, the wall, and her blankets created difficulty for her to move her leg	F 610	season when facility heating system is operating. Sleep surface distance from radiator audits will continue during non-heating months to ensure compliance and consistency for staff. Results of these audits will be reported to the QA/QI Committee for review and further recommendation. Further system revisions and staff education will be provided if indicated by audits. The Director of Nursing or designee will be responsible for compliance.	

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independently. In addition, the report indicated the IDT had ruled out abuse, neglect, or maltreatment directed at R1. The IDT's root cause analysis identified they felt that R1's RLE rested too close to the heating unit on the wall. The report failed to identify 2/11/12 as the correct date of the burn and facility investigative follow-up.

A progress note, dated 2/16/21 at 6:50 p.m. identified R1's RLE burn had been examined during facility wound rounds. The old dressing had been stuck to the wound bed; however, once removed, the wound bed had been "dark maroon" with "some yellowing at edges" and "pink tissue" approximately 0.5 cm surrounding the "dark tissue." Further, the progress note indicated R1 moved her legs around in bed "a lot" and staff had a harder time keeping the dressing in place.

A completed SA submitted follow-up investigation report, dated 2/17/21, at 10:38 a.m. the facility had developed a policy on 2/11/21, regarding resident bed placement in relation to room radiator locations, all resident rooms were audited for safety, and staff were trained on new policy. In addition, the report indicated the facility Vulnerable Adult/Abuse Prevention policy had been followed. The report failed to identify the facility's acknowledgement or response to LPN-A's failure to immediately report the incident to management and failure to implement an intervention to protect R1 from potential future injury.

On 2/17/21 during observation and interview, at 11:15 a.m. R1 had been observed laying in bed with her bed positioned approximately two feet parallel to a full wall length boiler heated register

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unit. The top part of the register unit indicated the unit had been heating R1's room; however, the surveyor had been able to only touch the top part of the heater for approximately 10 seconds before having to remove her hand in response to the heated temperature. During the observation, R1 had been able to move her legs under the bed covers independently when instructed to do so. R1 stated her leg had been "stuck" and she had "burned it" on the register. R1 explained she had tried to move it from the register; however, had been unable to, but could not remember why.

During interview on 2/17/21, at 12:03 p.m. LPN-B stated R1 had the ability to move herself in bed and would "scoot up and down." LPN-B explained R1 preferred to spend most of her time in her bed and R1 had periods of restlessness when in bed. LPN-B stated R1 had poor safety awareness and R1 "would not have the strength to actually pull her leg back up if it had been wedged between the wall and the bed." LPN-B confirmed R1's bed had been "straight up against the wall" prior to the morning of 2/11/21. LPN-B explained on the morning of 2/11/12, day shift staff had moved R1's bed away from the heater wall. LPN-B stated "they went to every room with their rulers and moved all the beds that had been up against the radiators;" however, LPN-B had stated she had not known how many in total they moved "but there were some." LPN-B explained she had performed wound care to R1's leg that morning. The middle of the burn had "dots where you could see where the radiator was" and stated "slight yellowing drainage" had been visualized on R1's leg dressing.

When interviewed on 2/17/21, at 12:24 p.m. the director of maintenance (DOM) stated facility staff

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had contacted him on 2/11/21, via text message and updated him on R1's burn. The DOM explained he had not been at the facility on 2/11/21, and had not returned until 2/15/21; however, he had explained to facility staff on 2/11/21, where the boiler logs had been kept. The DOM confirmed the boiler temperatures had not been checked on 2/11/21, by maintenance staff after the burn occurred. In addition, the DOM confirmed residents should not get burned from the radiators; however, he explained R1's blanket had fallen over the heater which may have increased the heat intensity at that location. The DOM stated on 2/15/21, the facility had checked resident room heater temperatures with an infrared scanner and the highest temperature recorded had been 119 degrees. The DOM explained any resident room heater temperature over 120 degrees would prompt him "to take action." The DOM denied having documented resident room heater temperature check audits prior to 2/15/21.

During interview on 2/17/21, at 1:29 p.m. the infection preventionist registered nurse (RN)-B stated R1's burn incident had been reported to IDT on 2/11/21, around 8:30 a.m. during their morning meeting. RN-B stated this information immediately prompted facility day shift staff to first assess R1's room, and then all other resident rooms for bed and heater placement. RN-B stated they [IDT day shift staff] had moved R1's bed away from the heater, along with a few beds in "west" and "south" resident rooms. RN-B explained resident beds should not have been placed up against the heaters prior to R1's burn; however, RN-B stated she had "never thought to go around to look in the rooms." RN-B denied knowledge of a facility policy for this; however,

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RN-B explained she "just knew it" from her longevity in "the nursing home world." RN-B confirmed residents should not get burned from the heaters; however, she explained R1 had "compromised skin integrity" risk factors and "it [weather] had been colder which probably makes the registers want to work harder." RN-B stated R1 had been known to "fling her legs off the side of the bed." RN-B denied the IDT had reviewed the actions of LPN-A who had initially identified and assessed R1's burn on 2/11/21 regarding the lack of immediate reporting and failure to assess and implement immediate interventions to reduce further injury.

When interviewed on 2/17/21, at 2:09 p.m. LPN-A stated she had initially assessed R1's burn on 2/11/21 after the NA had informed her of R1's leg having been on the heater. LPN-A stated initially R1 had redness along the lateral calf with the center top layer of skin having had "started to peel off." LPN-A explained she had not removed R1's bed away from the heater immediately after she had initially assessed and treated the burn as her first thought had been R1 had received "poor positioning" and she had not felt R1 "could have moved her legs like that if she would have been positioned correctly," though further denied having followed up with other nursing staff in relation to R1's poor positioning. LPN-A stated she "would like to think that a radiator could not burn a resident but it clearly did." LPN-A denied having made any phone calls to the medical provider, family, and/or facility management directly after R1's burn. LPN-A explained she would only contact the medical provider or facility management if the injury had been "severe" and she had not contacted the family as she had not felt "comfortable" calling them. LPN-A stated she

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had left a message with RN-A in the morning" and "passed it [R1's burn] on in morning report." Further, LPN-A explained she had thought R1's having gotten burned had been "terrible" and had been "thankful" the NA had caught it when she did; however, LPN-A stated "if it would have been anything other than just the first layer of skin than I would have dealt with it right away instead of in the morning."

During interview on 2/17/21, at 3:54 p.m. clinical manager RN-A stated staff had updated her on R1's burn on 2/11/21, at approximately 8:00 a.m. in which she went and assessed R1. RN-A stated R1's bed had been against the heater wall when she initially went into R1's room that morning. RN-A explained R1's heater that morning had been "warm" but "not scorching hot:" however, she stated the heater had been "warm enough to cause the burn." In follow-up, RN-A stated she had not known wether or not the burn had been caused by the heat or the length of time R1's leg had been on the heater "but she [R1] had a burn on her leg." RN-A stated the only conversation she had with LPN-A after R1's burn had been to remind LPN-A to complete an event incident report in R1's electronic medical record. RN-A stated she would have expected staff to contact the medical provider, the family, and "someone" from the facility after the incident for further guidance. Further, RN-A stated she would have expected staff to provide "some sort of intervention to prevent it [burn] from potentially happening again." RN-A denied having conversations with LPN-A about the lack of immediate reporting and intervention implementation.

When interviewed on 2/17/21, at 4:26 p.m. the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245291	A. BUILDING _____ B. WING _____	C 02/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CLARE LIVING COMMUNITY OF MORA	**110 NORTH 7TH STREET MORA, MN 55051**

(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 610	Continued From page 9	F 610		

director of nursing (DON) stated facility staff had texted her cell phone on 2/11/21, around 9:45 a.m. as she had not been at the facility that day. The DON explained R1 would move her legs in bed often and felt R1 may have sustained the burn due to the blankets and covers having restricted her "weak" legs while also holding in more heat at that location. The DON stated she had not thought the heaters could burn someone. The DON explained her expectations would have been for R1's medical provider and family to be updated that night, with further expectations staff would have contacted either herself or one of the managers personally. In addition, the DON explained "at a minimum" R1's bed should have been pulled away from the wall heater after her burn had been identified and stated pulling the bed from the wall heater would have been part of the immediate intervention as the source of the injury had been known. The DON denied having conversations with LPN-A about the lack of immediate reporting of the incident to management and reasons the night staff had not removed R1's bed from the heater immediately after the burn had been identified in order to protect R1 from potential re-injury from the heater.

During interview on 2/17/21, at 5:16 p.m. the administrator stated her expectations would have been for the night staff to have pulled R1's bed from the wall heater, along with follow up with R1's medical provider, family, and facility management. The administrator denied having conversations with LPN-A about the lack of immediate reporting of the incident to management and reasons the night staff had not removed R1's bed from the heater immediately after the burn had been identified in order to

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	245291	A. BUILDING _____ B. WING _____	C 02/18/2021

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F 610	Continued From page 10	F 610		

protect R1 from potential re-injury from the heater.

When interviewed on 2/18/21, at 11:03 a.m. during a subsequent interview the DON confirmed the facility VA policy had not been followed. The DON stated she had not thought about nursing staffs lack of immediate actions and incident follow-up prior to her having completed the SA follow-up investigation report. The DON denied having had verbal conversations with LPN-A about the events surrounding R1's burn on 2/11/21 up to the time of the interview.

An Abuse Prevention Policy, dated 12/2020, identified it was a facility purpose to ensure that all residents of the facility would be free of physical, emotional, and neglectful treatment. The policy indicated neglect meant a failure of the facility and it's employees to provide services that were necessary to ensure resident safety, well-being, and to avoid physical harm, mental anguish, illness, or emotional distress. A section labeled "Prevention" identified in order to prevent neglect the facility would require staff to report concerns and incidents immediately to their supervisor and further directed any concerns or incidents would be promptly investigated and appropriate steps would be taken to minimize the likelihood of re-occurrence.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 11, 2021

Administrator
St Clare Living Community Of Mora
110 North 7th Street
Mora, MN 55051

Re: Event ID: JF9P11

Dear Administrator:

The above facility survey was completed on February 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,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00814	A. BUILDING: _____ B. WING _____	C 02/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 2/17/21 - 2/18/21 an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be IN compliance with the MN State Licensure. The following complaints were found to be SUBSTANTIATED:	2 000		

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

Electronically Signed | 03/21/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00814	A. BUILDING: _____ B. WING _____	C 02/18/2021

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2 000	Continued From page 1 H5291025C (MN00069987); H5291026C (MN00058770) NO licensing orders were issued 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		