Electronically delivered

February 4, 2021

Administrator
Covenant Living Of Golden Valley Care & Rehab Ctr
5825 St Croix Avenue
Golden Valley, MN 55422

RE: CCN: 245322
Cycle Start Date: December 4, 2020

Dear Administrator:

On December 24, 2020, we informed you that we may impose enforcement remedies.

On January 14, 2021, the Minnesota Department(s) of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found 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.

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:

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 4, 2021.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 4, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 4, 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.

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 March 4, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Covenant Living Of Golden Valley Care & Rehab Ctr will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 4, 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:

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 - 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 June 4, 2021 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 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,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245322	A. BUILDING _____ B. WING _____	C 01/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT LIVING OF GOLDEN VALLEY CARE & REHAB CTR	**5825 ST CROIX AVENUE GOLDEN VALLEY, MN 55422**

(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 000	INITIAL COMMENTS Revised 2567 as a result of MDH's Informal Dispute Resolution and/or Quality Assurance review. On 1/14/21, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found NOT to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5322043C-MN69055 with no deficiency issued. The following complaint was found to be UNSUBSTANTIATED: H5322044CMN64837 H5322045CMN68157 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		

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

Electronically Signed | 02/08/2021

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 000	INITIAL COMMENTS On 1/14/21, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found NOT to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5322043C-MN69055 with a deficiency cited at F600. The following complaint was found to be UNSUBSTANTIATED: H5322044CMN64837 H5322045CMN68157 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse,	F 600		1/15/21

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

Electronically Signed | 02/08/2021

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F 600	Continued From page 1 neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents were free from abuse for 1 of 3 residents (R1) reviewed who was hit by a staff member in the facility. R1's minimum data set dated 10/1/20, indicated no impairment of cognition. Moderate assistance with dressing and max assistance with transfers and repositioning. R1's care plan revised on 12/24/20, indicated R1 is a vulnerable adult and unable to protect self from harmful situations due to reduced mobility. Risk for bleeding related to anticoagulant (blood thinner) therapy for atrial fibrillation (heart arrhythmia). Alternation in ability to perform activity of daily living related to atrial fibrillation, fatigue, tremors, history of falls, instability with gait and balance, advanced age, edema, congestive heart failure. R1's progress notes dated 1/13/21, at 11:27 a.m. during care conference VA had expressed concerns over some cares that staff are addressing.	F 600	This plan and response to these survey findings is written solely to maintain certification in Medicare programs. These written responses do not constitute an admission of non-compliance with any requirement nor an agreement with any findings. We wish to preserve our right to dispute these findings in their entirety at any time and in any legal action. F 600 SS D = Abuse Prevention Program Our facility has a zero tolerance for any form of abuse, neglect or exploitation. All employees are required to report all occurrences of possible abuse, mistreatment or neglect of a resident and crimes against misappropriation of a resident's property immediately to the administrator or a designated representative and to other officials in accordance with State law within two hours. The allegations are dealt with per policy, state and federal regulations that prohibit abuse or mistreatment of the vulnerable. The policy has been reviewed	

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F 600	Continued From page 2 R1's progress noted dated 1/14/21, at 9:29 a.m. by clinical manager (CM)-A "During head to toe assessment resident was noted to have bruises on both arms: Rt (right) arm: 2 bruise 1 cm in diameter each above elbow and 2 bruises 1 cm in diameter below elbow. Lt (left) arm: one bruise 1.5 in diameter below elbow and one bruise 1.5 cm in diameter mid forearm. Resident said that the bruises on her arms are from her bumping against her w/c (wheelchair) arm rests during self-transfers. Will monitor for changes. During interview on 1/14/20, at 11:00 a.m. R1 stated "Mr. rough" (alleged perpetrator) (AP) took care of me a few nights ago. He was rough with everything he did. R1 stated AP is rough and he should not be working with people like me. R1 further stated that AP came into her room and stated "whaa" then pushed her on her arm. R1 denied any injury. R1 then stated that he then picked up her legs and threw them in the bed. R1 stated that none of the other aids have ever treated her this way. R1 further stated that this has been going on for a while with AP and his rough cares. R1 stated when AP was ready to leave the room she told him goodbye Mr. Rough. R1 stated that this made her feel like he was more of an enemy than a friend. R1 stated she feels safe in the facility and hopes that she never sees AP again. R1 was not able to describe AP just that he was her male nurse the other night and I should talk with the nurse to find out his name. During interview on 1/14/21, at 11:47 a.m. nursing assistant (NA)-A stated she is not aware of any rough cares with R1, however she would report immediately to the nurse if she had	F 600	and it remains accurate and supportive of the regulations as written. R1 was assessed after reporting the incident. Although she was noted to have bruises on her arm, those were caused by bumping her arms while in her wheelchair and were not from any physical abuse. R1 has further expressed that she feels safe at the facility. All residents have the potential to be affected by the alleged deficiency. The facility conducts resident interviews when allegations are reported to ensure that other residents are unaffected by the same deficient practice. Resident interviews after this incident revealed no further abuse allegations or concerns. Immediately after the allegation was reported, the facility followed the abuse prevention policy to include removal of the employee from the schedule, assessing the resident and other residents for injuries or psychosocial disturbance; reporting to law enforcement and MDH within the specified time frame and re-educating staff on the Abuse Prevention Program with emphasis on zero tolerance of any form of abuse, neglect or exploitation. Re-education was completed on 1/15/2021. DON or designee will to continue reviewing random nursing progress notes 5 times a week for 4 weeks and any allegations of abuse will be addressed per policy and regulation within 2 hours of	

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F 600	Continued From page 3 witnessed any rough cares or was made aware of any rough cares for the safety of the residents. During interview on 1/14/21, at 11:52 a.m. licensed practical nurse (LPN)-A stated he was just made aware about the rough cares with R1. LPN-A stated that R1 is alert and oriented and if she said something happened it happened. LPN-A further stated that if he was made aware of any abuse he would make sure resident is safe and then would report to nurse manger, director of nursing (DON), or administrator immediately. During interview on 1/14/21, at 11:59 CM-A stated she was made aware of incident during R1's care conference with R1 and R1's niece. CM-A stated R1 said AP was rough with her and that AP said something to her and then hit her, and then he threw her legs in the bed. CM-A further stated R1 stated she told AP goodbye Mr. Rough. CM-A stated R1 stated he should not be working with her any longer. CM-A stated AP was suspended immediately pending investigation. CM-A stated if R1 stated it happened, then it did, as she is accurate in what she says. CM-A stated she conducted head to toe assessment and R1 had bruising above and below elbows, however R1 stated this was due to bumping them on her wheelchair arm rest. CM-A denied any bruising to upper arms wear AP hit her. CM-A stated abuse is never ok and is not tolerated. During interview on 1/14/21, at 1:40 p.m. registered nurse (RN)-B stated abuse is never ok as they are there to help the residents and if staff don't want to work then they should just go home. RN-B further stated if she was made aware of rough cares she would make sure the resident was safe, remove the staff, and report	F 600	being discovered. Administrator or designee will interview up to 7 random residents per week for 4 weeks on all neighborhoods to ensure that they are free of abuse. Any allegations of abuse will be addressed per policy and regulations within the specified time frames. The Administrator and/or designee is responsible for maintaining compliance with this requirement. Audits will be reviewed at the monthly QAPI meetings for direction or change as well as timeline for completion based on compliance. Completion date for the plan is January 15th, 2021.	

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F 600	Continued From page 4	F 600		

immediately.

During interview on, 1/14/21, at 1:48 p.m. RN-A stated if made aware of abuse she would make sure resident is safe, remove staff and then let nurse manager know immediately.

During interview on 1/14/21, at 2:13 p.m. AP stated he is unsure of what incident they are talking about, he would never abuse anyone. Stated R1 was tripping and he held her back to prevent her from falling. denies hitting R1 or throwing her legs into the bed. AP stated he would never hurt anyone.

During interview on 1/14/21, at 3:25 p.m. CM-B stated abuse is never ok nor is rough cares. Rough cares and abuse should be reported immediately after making sure the resident is safe and the AP is sent home immediately.

During interview on 1/14/21, at 3:31 p.m. DON stated she reported on 1/13/21 about abuse with AP and his rough cares. DON stated she immediately suspended AP and then as of 1/14/21 had terminated AP's employment as abuse is never ok and is not tolerated. DON stated R1 reported AP came into her room and said "whaa" then hit her on the arm, and then picked her legs up and threw them in the bed and R1 felt that this was rough. DON stated this behavior is not tolerated and is considered abuse in different forms. DON stated there were a few facility investigations with other residents who stated that they are glad he is not working on there side any longer. DON stated would need to speak with the individual who did the interviews.

During interview on 1/14/21. at 3:52 life

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F 600	Continued From page 5	F 600		

enrichment director stated R1 made staff aware of incident during a care conference that "Mr Rough" hit her arm and then threw her legs on the bed. Life enrichment director further stated they reassured her that she is safe and they were going to fix this concern. Life enrichment director further stated one resident had stated that she was glad that AP was no longer working her side. Life enrichment director stated that abuse is not ok as these residents are vulnerable adults and they cannot protect themselves.

During interview on 1/14/21, at 4:00 p.m. administrator stated she was made aware of abuse from R1 during a care conference by the nurse manager and they reported it immediately. Administrator stated the police responded and they went into R1's room together to speak with R1. Administrator stated R1 stated AP came in room and stated "whaa" and hit her on the arm, then grabbed her legs and threw them into bed, and before he left she told him "goodbye Mr. Rough." AP was suspended immediately and fired. Administrator stated that on 1/15/21, they are having another session about abuse and this has been ongoing training since 12/4/20.

During interview on 1/14/21, at 6:00 p.m. NA-B stated abuse is never ok and would report immediately to nurse if witness any type of abuse or if a resident had reported abuse or rough cares.

Policy Abuse Prevention Program revised 6/10/20, "The policy of Covenant Retirement Communities is zero tolerance of any for of abuse, neglect, or expoitation."

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 4, 2021

Administrator
Covenant Living Of Golden Valley Care & Rehab Ctr
5825 St Croix Avenue
Golden Valley, MN 55422

Re: Event ID: 8UPQ11

Dear Administrator:

The above facility survey was completed on January 14, 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

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT LIVING OF GOLDEN VALLEY CAR	**5825 ST CROIX AVENUE GOLDEN VALLEY, MN 55422**

(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) COMPLETE DATE
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 1/14/21, 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 | 02/08/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00183	A. BUILDING: _____ B. WING _____	C 01/14/2021

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2 000	Continued From page 1 H5322043C-MN69055 The following complaints were found to be unsubstantiated: H5322044CMN64837 H5322045CMN68157 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, however, it is required the facility acknowledge receipt of the electronic documents.	2 000		