





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

Electronically delivered  
February 24, 2022

CMS Certification Number (CCN): 245628

Administrator  
Mn Veterans Home Silver Bay  
56 Outer Drive  
Silver Bay, MN 55614

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective February 2, 2022 the above facility is certified for:

83 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 83 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Joanne Simon', with a horizontal line extending to the right.

Joanne Simon, Enforcement Specialist  
Minnesota Department of Health  
Program Assurance Unit  
Health Regulation Division  
Telephone: 651-201-4161 Fax: 651-215-9697  
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File



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

Electronically Delivered  
February 24, 2022

Administrator  
Mn Veterans Home Silver Bay  
56 Outer Drive  
Silver Bay, MN 55614

RE: CCN: 245628  
Cycle Start Date: January 6, 2022

Dear Administrator:

On February 4, 2022, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Joanne Simon', with a horizontal line extending to the right.

Joanne Simon, Enforcement Specialist  
Minnesota Department of Health  
Program Assurance Unit  
Health Regulation Division  
Telephone: 651-201-4161 Fax: 651-215-9697  
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MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: BILY

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00381

1. MEDICARE/MEDICAID PROVIDER NO. (L1) <b>245628</b>	3. NAME AND ADDRESS OF FACILITY (L3) <b>MN VETERANS HOME SILVER BAY</b> (L4) <b>56 OUTER DRIVE</b> (L5) <b>SILVER BAY, MN</b> (L6) <b>55614</b>	4. TYPE OF ACTION: <u>2</u> (L8) 1. Initial                      2. Recertification 3. Termination              4. CHOW 5. Validation                 6. Complaint 7. On-Site Visit              9. Other 8. Full Survey After Complaint										
2.STATE VENDOR OR MEDICAID NO. (L2)	5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	FISCAL YEAR ENDING DATE: (L35)  <b>06/30</b>										
6. DATE OF SURVEY <b>01/06/2022</b> (L34)	7. PROVIDER/SUPPLIER CATEGORY <u>02</u> (L7) <b>01 Hospital      05 HHA      09 ESRD      13 PTIP      22 CLIA</b> <b>02 SNF/NF/Dual    06 PRTF      10 NF      14 CORF</b> <b>03 SNF/NF/Distinct 07 X-Ray      11 ICF/IID    15 ASC</b> <b>04 SNF              08 OPT/SP    12 RHC      16 HOSPICE</b>											
8. ACCREDITATION STATUS: _____ (L10) 0 Unaccredited              1 TJC 2 AOA                          3 Other	10.THE FACILITY IS CERTIFIED AS: A. In Compliance With Program Requirements _____ Compliance Based On: ____ 1. Acceptable POC B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: <b>B*</b> (L12)	11. LTC PERIOD OF CERTIFICATION From (a) : To (b) :										
12.Total Facility Beds <b>83</b> (L18) 13.Total Certified Beds <b>83</b> (L17)	14. LTC CERTIFIED BED BREAKDOWN <table style="width:100%; text-align: center;"> <tr> <td>18 SNF</td> <td>18/19 SNF</td> <td>19 SNF</td> <td>ICF</td> <td>IID</td> </tr> <tr> <td>(L37)</td> <td>83</td> <td>(L39)</td> <td>(L42)</td> <td>(L43)</td> </tr> </table>		18 SNF	18/19 SNF	19 SNF	ICF	IID	(L37)	83	(L39)	(L42)	(L43)
18 SNF	18/19 SNF	19 SNF	ICF	IID								
(L37)	83	(L39)	(L42)	(L43)								
15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)												

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE  <u>James Anderson SFM</u> Date : 01/28/2022 (L19)	18. STATE SURVEY AGENCY APPROVAL  <u>Joanne Simon, Enforcement Specialist</u> Date: 02/14/2022 (L20)
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**PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY**

19. DETERMINATION OF ELIGIBILITY  <input checked="" type="checkbox"/> 1. Facility is Eligible to Participate <input type="checkbox"/> 2. Facility is not Eligible (L21)	20. COMPLIANCE WITH CIVIL RIGHTS ACT:  _____	21. 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above : _____
22. ORIGINAL DATE OF PARTICIPATION <b>10/20/2015</b> (L24)	23. LTC AGREEMENT BEGINNING DATE (L41)	24. LTC AGREEMENT ENDING DATE (L25)
25. LTC EXTENSION DATE: (L27)	26. TERMINATION ACTION: (L30) <u>VOLUNTARY</u> <b>00</b> 01-Merger, Closure 02-Dissatisfaction W/ Reimbursement 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal <u>INVOLUNTARY</u> 05-Fail to Meet Health/Safety 06-Fail to Meet Agreement <u>OTHER</u> 07-Provider Status Change 00-Active	
27. ALTERNATIVE SANCTIONS A. Suspension of Admissions: (L44) B. Rescind Suspension Date: (L45)		28. TERMINATION DATE:
29. INTERMEDIARY/CARRIER NO. <b>06201</b> (L28)		30. REMARKS   DETERMINATION APPROVAL
31. RO RECEIPT OF CMS-1539 (L32)		32. DETERMINATION OF APPROVAL DATE (L33)



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Electronically delivered  
January 19, 2022

Administrator  
Mn Veterans Home Silver Bay  
56 Outer Drive  
Silver Bay, MN 55614

RE: CCN: 245628  
Cycle Start Date: January 6, 2022

Dear Administrator:

On January 6, 2022, 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.

Mn Veterans Home Silver Bay

January 19, 2022

Page 2

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:

**Jen Bahr, RN, Unit Supervisor**  
**Bemidji District Office**  
**Licensing and Certification Program**  
**Health Regulation Division**  
**Minnesota Department of Health**  
**705 5th Street NW, Suite A**  
**Bemidji, MN 56601-2933**  
**Email: Jennifer.bahr@state.mn.us**  
**Office: (218) 308-2104 Mobile: (218) 368-3683**

## 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 April 6, 2022 (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 July 6, 2022 (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/lrc\\_idr.cfm](https://mdhprovidercontent.web.health.state.mn.us/lrc_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](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.

Mn Veterans Home Silver Bay

January 19, 2022

Page 4

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

**William Abderhalden, Fire Safety Supervisor**  
**Deputy State Fire Marshal**  
**Health Care/Corrections Supervisor – Interim**  
**Minnesota Department of Public Safety**  
**445 Minnesota Street, Suite 145**  
**St. Paul, MN 55101-5145**  
**Cell: (507) 361-6204**  
**Email: [william.abderhalden@state.mn.us](mailto:william.abderhalden@state.mn.us)**  
**Fax: (651) 215-0525**

Feel free to contact me if you have questions.

Sincerely,



Joanne Simon, Enforcement Specialist  
Minnesota Department of Health  
Program Assurance Unit  
Health Regulation Division  
Telephone: 651-201-4161 Fax: 651-215-9697  
Email: [joanne.simon@state.mn.us](mailto:joanne.simon@state.mn.us)

cc: Licensing and Certification File



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2022  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245628</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/06/2022</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MN VETERANS HOME SILVER BAY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>56 OUTER DRIVE</b> <b>SILVER BAY, MN 55614</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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E 000	Initial Comments  On 1/3/22 through 1/6/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was in compliance.  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. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS  On 1/3/22 through 1/6/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.  The following complaints were found to be SUBSTANTIATED: however no deficiencies were cited due to actions implemented by the facility prior to survey: H5628046C (MN72673) H5628048C (MN73641 & MN73755)  The following complaints were found to be UNSUBSTANTIATED: H5628044C (MN71246) H5628045C (MN77944) H5628047C (MN72673)  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. Although no plan of	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE  01/19/2022
--	-------	-----------------------------

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2022  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245628</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/06/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>MN VETERANS HOME SILVER BAY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>56 OUTER DRIVE</b> <b>SILVER BAY, MN 55614</b>		
(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	Continued From page 1 correction is required, the facility must acknowledge receipt of the electronic documents.	F 000			



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Electronically delivered  
January 19, 2022

Administrator  
Mn Veterans Home Silver Bay  
56 Outer Drive  
Silver Bay, MN 55614

Re: Event ID: BILY11

Dear Administrator:

The above facility survey was completed on January 6, 2022 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,

A handwritten signature in black ink, appearing to read 'Joanne Simon', with a long horizontal line extending to the right.

Joanne Simon, Enforcement Specialist  
Minnesota Department of Health  
Program Assurance Unit  
Health Regulation Division  
Telephone: 651-201-4161 Fax: 651-215-9697  
Email: joanne.simon@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:  <b>00381</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/06/2022</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MN VETERANS HOME SILVER BAY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>56 OUTER DRIVE SILVER BAY, MN 55614</b>
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(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	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p><b>NH LICENSING CORRECTION ORDER</b></p> <p>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.</p> <p>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.</p> <p>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.</p> <p><b>INITIAL COMMENTS:</b> On 1/3/22 through 1/6/22, a standard licensing survey was conducted completed at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found to be in compliance with the MN State Licensure.</p> <p>The following complaints were found to be</p>	2 000		

Minnesota Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE  
01/19/22

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>00381</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/06/2022</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MN VETERANS HOME SILVER BAY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>56 OUTER DRIVE</b> <b>SILVER BAY, MN 55614</b>
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(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	<p>Continued From page 1</p> <p>SUBSTANTIATED: however no licensing orders were issued. H5628046C (MN72673) H5628048C (MN73641 &amp; MN73755)</p> <p>The following complaints were found to be UNSUBSTANTIATED: H5628044C (MN71246) H5628045C (MN77944) H5628047C (MN72673)</p> <p>The Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.</p>	2 000		