



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 14, 2025

Administrator
Woodbury Health Care Center
7012 Lake Road
Woodbury, MN 55125

RE: CCN: 245235
Cycle Start Date: March 7, 2025

Dear Administrator:

On March 7, 2025, 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 immediate jeopardy (Level J),

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

REMOVAL OF IMMEDIATE JEOPARDY

On March 4, 2025, the situation of immediate jeopardy to potential health and safety cited at F684 was removed.

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 listed below to the CMS location.

- Civil money penalty, (42 CFR 488.430 through 488.444).

You will receive a formal notice from the CMS location only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding

Woodbury Health Care Center

March 14, 2025

Page 2

of substandard quality of care; has been assessed a total civil money penalty of not less than \$13,343; 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.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective March 7, 2025. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

The CMS location may notify you of their determination regarding any imposed remedies.

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Woodbury Health Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective March 7, 2025. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

DEPARTMENT CONTACT

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

Nikki Harvey, Regional Operations Supervisor
St. Cloud A District Office

Woodbury Health Care Center

March 14, 2025

Page 3

Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: Nikki.Harvey@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

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

Sincerely,



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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

PRINTED: 03/14/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245235	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/07/2025
NAME OF PROVIDER OR SUPPLIER WOODBURY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7012 LAKE ROAD WOODBURY, MN 55125		
(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 On 3/5/25 through 3/7/25, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following complaint was reviewed H52359161C (MN00111194) and a deficiency was issued at F684 at PAST NON-COMPLIANCE. Although the provider had implemented corrective action prior to survey, immediate jeopardy was sustained prior to the survey. No plan of correction is required for a finding of past non-compliance; however, the facility must acknowledge receipt of the electronic documents.	F 000			
F 684 SS=J	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 accurately assess and implement interventions to prevent hypoglycemia (low blood sugar) for 1 of 1 resident who was diabetic, had a blood sugar of 30 mg/dl (milligrams per deciliter;	F 684	Past noncompliance: no plan of correction required.		

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245235	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/07/2025
NAME OF PROVIDER OR SUPPLIER WOODBURY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7012 LAKE ROAD WOODBURY, MN 55125		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page 1 normal range is 80-130 mg/dl) and was unresponsive at dialysis. This resulted in an immediate jeopardy for R1 who was hospitalized with hypoglycemia. The IJ began on 3/1/25 at 5:00 p.m. when R1 was admitted to the facility with orders for insulin but lacked orders to check blood sugars. The facility did not implement standing orders or request orders to monitor R1's blood glucose levels, resulting in a severe drop in R1's blood sugar level and hospitalization. The administrator, director of nursing (DON), and regional nurse were notified of the IJ on 3/7/25 at 11:50 a.m. The facility had implemented immediate corrective action on 3/4/25 to prevent recurrence prior to the survey, therefore, the IJ was issued at past none compliance. Findings include: R1 admitted to the facility on 3/1/25 with a diagnoses of dependence on renal dialysis, pleural effusion, Type 2 Diabetes Mellitus (DM) with diabetic chronic kidney disease, acute respiratory failure with hypoxia, chronic atrial fibrillation, and chronic systolic congestive heart failure. R1's physician admission orders indicated that he was to receive 35 units Lantus (insulin) once daily at bedtime, and to use nursing home standing orders. Admission orders lack direction for blood sugar checks. A facility document, Standing Orders for Skilled Nursing Facilities dated 2023, directed to initiate four times daily blood glucose monitoring upon admission for three days for all diabetic patients	F 684			

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

PRINTED: 03/14/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245235	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/07/2025
NAME OF PROVIDER OR SUPPLIER WOODBURY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7012 LAKE ROAD WOODBURY, MN 55125		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page 2 unless ordered otherwise. R1's hospital discharge summary, dated 3/1/25, indicated he was hospitalized from 1/21/25 through 3/1/25 and his insulin requirements had been decreasing and he started having hypoglycemia episodes after being started on hemodialysis on 2/13/25. The discharge summary also directed R1 to have a continuous Dexcom 7 sensor (a continuous glucose monitoring system that provides real-time glucose readings, alerts for highs and lows) to be changed every ten days. R1's care plan indicated R1 had a diagnosis of diabetes and took hypoglycemic medication (insulin). R1's progress note dated 3/3/25 at 7:45 a.m., indicated writer received call from Fresenius dialysis clinic regarding R1, who was found unresponsive upon arrival at the dialysis clinic and sent to the hospital. R1's hospital note, dated, 3/3/25, indicated he was admitted for hypoglycemia, tachypnea (rapid breathing) and tachycardia (fast heart rate) with the plan to remain hospitalized for at least two additional days to monitor and stabilize. R1's progress notes lacked any blood sugar readings from 3/1/25 through 3/3/25. R1's MAR (medication administration record)/TAR (treatment administration record) lacked instruction for blood sugar monitoring. On 3/6/25, registered nurse (RN)-A (dialysis nurse) stated R1 was dropped off at the dialysis clinic at 7:50 a.m., on 3/3/25. RN-A stated R1 was	F 684			

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

PRINTED: 03/14/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245235	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/07/2025
NAME OF PROVIDER OR SUPPLIER WOODBURY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7012 LAKE ROAD WOODBURY, MN 55125		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page 3 very weak and could not answer questions. R1 was not responding to verbal cues, his head was tilted to the side, and his mouth was wide open. She called for help right away and checked his blood sugar which was 30 mg/dl (normal range is 80-130 mg/dl, per the American Diabetes Association). Emergency medical services (EMS) called. EMS transported R1 to the hospital for evaluation. RN-A also stated R1 was not provided a lunch in anticipation of dialysis. On 3/6/25, at 12:28 p.m., RN-B (RN nurse manager) stated at admission, nurses should initiate standing orders for blood sugar checks for three days for any diabetic residents who did not have a physician order to check blood sugars and notify the provider to request orders. RN-B stated nurses should check blood sugar and vital signs for any diabetic residents before sending them to dialysis treatment. On 3/6/25, at 1:24 p.m., the director of nursing (DON) stated she expected nursing staff to ensure residents received breakfast, checked blood sugar and vital signs for diabetic residents before sending them to dialysis. On 3/6/25, at 2:18 p.m., licensed practical nurse (LPN)-A, an agency nurse assigned to R1 the morning of 3/3/25, stated he did not check R1's blood sugar and vital signs prior to his dialysis appointment. LPN-A stated he did not give R1 breakfast before R1 left for dialysis. LPN-A did not know R1 had diabetes at the time and no report was given to him about R1's diabetic status. On 3/6/25 at 3:24 p.m., medical provider (MD)-A stated she expected nursing staff to check the	F 684			

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

PRINTED: 03/14/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245235	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/07/2025
NAME OF PROVIDER OR SUPPLIER WOODBURY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7012 LAKE ROAD WOODBURY, MN 55125		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page 4 blood sugar of diabetic residents, even if they do not have order from the hospital, before sending them to the dialysis treatment. On 3/7/25, at 1:29 p.m., LPN-A stated R1 was brought to the lobby of the facility around 6:30 a.m. on 3/3/25. LPN-A stated transportation was scheduled for 7:00 a.m. to pick R1 up for dialysis. LPN-A stated he wasn't sure why R1 didn't receive breakfast. On 3/7/25, at 1:36 p.m., RN-C stated he and another nurse entered R1's orders on 3/1/25. RN-C stated he was aware diabetic residents should have blood sugar checks for the first few days, per the standing orders. RN-C confirmed this was missed. On 3/7/25, at 1:40 p.m., RN-D stated she and RN-C worked together to enter R1's orders on 3/1/25. RN-D stated she would expect blood sugar checks for a diabetic resident on insulin. RN-D stated they should have called to clarify R1's orders. On 3/7/25, at 2:15 p.m. family member (FM)-A stated R1 remained hospitalized but his status was improving. A facility policy regarding caring for diabetic residents was requested, but not received. The facility implemented corrective action prior to the start of survey. The IJ is issued at past noncompliance. IJ began on 3/1/25 and was corrected by 3/4/25. Facility action included: The facility identified like residents and ensured appropriate blood glucose monitoring was in place.	F 684			

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

PRINTED: 03/14/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245235	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/07/2025
NAME OF PROVIDER OR SUPPLIER WOODBURY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7012 LAKE ROAD WOODBURY, MN 55125		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page 5 Education was provided to all nursing staff on standing orders and when to implement standing orders, specifically to diabetic care. Reviewed and educated nursing staff regarding the importance of nutrition for vulnerable residents including those with diabetes or on dialysis. Re-educated staff who provide diabetic care to the dialysis residents on these policies and procedures. Orientation training package to be provided to all agency staff with competencies test.	F 684			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 14, 2025

Administrator
Woodbury Health Care Center
7012 Lake Road
Woodbury, MN 55125

Re: Event ID: 3I4S11

Dear Administrator:

The above facility survey was completed on March 7, 2025 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 'M. Poepping'.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00803	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/07/2025
NAME OF PROVIDER OR SUPPLIER WOODBURY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7012 LAKE ROAD WOODBURY, MN 55125		
(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 3/5/25 through 3/7/25, 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: H52359161C (MN00111194). NO licensing	2 000			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00803	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/07/2025
NAME OF PROVIDER OR SUPPLIER WOODBURY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7012 LAKE ROAD WOODBURY, MN 55125		
(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	Continued From page 1 orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000			