



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 15, 2023

Administrator
Providence Place
3720 23rd Avenue South
Minneapolis, MN 55407

RE: CCN: 245271
Cycle Start Date: May 18, 2023

Dear Administrator:

On June 9, 2023, the Minnesota Department of Health, 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.

Please contact me with any questions regarding this letter.

Sincerely,

A handwritten signature in black ink that reads 'Lori Hagen'.

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 1, 2023

Administrator
Providence Place
3720 23rd Avenue South
Minneapolis, MN 55407

RE: CCN: 245271
Cycle Start Date: May 18, 2023

Dear Administrator:

On May 19, 2023, a survey was completed at your facility by the Minnesota Department of Health, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

Providence Place

June 1, 2023

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:

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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 August 19, 2023, (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 November 19, 2023, (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

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.

Providence Place

June 1, 2023

Page 4

Please contact me with any questions regarding this letter.

Sincerely,

A handwritten signature in black ink, appearing to read "Lori Hagen". The signature is fluid and cursive, with the first name "Lori" and last name "Hagen" clearly distinguishable.

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

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

PRINTED: 06/16/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245271	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/19/2023
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407		
(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 5/18/23, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H52712252C (MN93531 and MN93312) with a deficiency issued at F689. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000			
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the care plan was followed	F 689			5/31/23
			F550 The preparation of the following plan of		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/01/2023

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: 245271	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/19/2023
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407		
(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 689	Continued From page 1 to ensure staff used an Arjo Master Lift (a full body mechanical lift that aids in the transfer of a person from one surface to another who is unable to bear weight) instead of an EZ stand (a device that aids in the transfer of a person from one surface to another for a person who is able to bear weight) for 1 of 3 residents (R1) reviewed for falls. Findings include: R1's Diagnoses Sheet printed 5/18/23, indicated diagnoses of polymyalgia rheumatica (an inflammatory disorder causing muscle pain and stiffness around the shoulders and hips) and morbid obesity. R1's Medicare 5-day Minimum Data Set (MDS) dated 3/22/23, indicated R1 was cognitively intact, was unable to walk, required total assist for transfers with two or more staff, and had right shoulder impairment. R1's care plan dated 3/17/23, indicated R1 required a full body mechanical lift with assist of two staff for transfers. R1's nursing assistant care guide for R1 dated 5/5/23, indicated use a mechanical lift with the assistance of two staff. R1's Functional and Safe Handling Review assessment dated 3/21/23, indicated R1 was not able to walk, could partially bear weight for transfer, had impairment in one upper extremity (shoulder, elbow, wrist, hand) and both lower extremities (hip, knee, ankle, foot), and required a full mechanical lift for transfers.	F 689	correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: 1. R1 was immediately transferred back into bed with the assist of 2 staff and a full mechanical lift. NAR's involved with incident received immediate re-education and appropriate disciplinary action for not following the plan of care as written. 2. Nursing staff will complete a facility wide audit of those using a mechanical lift of any type for transfers. NAR care guides and resident care plans have been reviewed to ensure both reflect resident need and the type of lift is clearly stated. 3. All Nursing staff will be re-educated on the 2 different types of lifts that the facility uses – Arjo full body lift or Volaro stand lift, as well as receive re-educate on following exactly what is written on the NAR care sheets and plan of care. 4. DNS or designee will complete random weekly audits x 1 month to ensure compliance to this standard of practice. Results of these audits will be brought to QAPI monthly for review and further discussion.		

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

PRINTED: 06/16/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245271	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/19/2023
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407		
(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 689	Continued From page 2 On 5/18/23 at 11:42 a.m., R1 was interviewed. R1 stated staff was using the EZ stand lift with her when she either fell to the floor or was lowered to the floor. R1 stated she was sure she was on the floor after she slid off the EZ Stand when she couldn't stand on her own anymore. R1 stated staff used the "other" lift with the sling [Arjo lift] to get her off of the floor and onto the bed. R1 stated she was unable to stand or walk prior to the fall, and said she usually had pain in the right shoulder, but not the left. R1 denied injury from the fall. On 5/18/23 at 11:59 a.m., nursing assistant (NA)-A was interviewed and stated she was re-trained on the use of a mechanical lift in April after R1's EZ Stand fall incident. NA-A stated someone who could stand and hold objects in their hands could use an EZ Stand, and residents who could not bear weight required a full mechanical lift. NA-A stated the directions for each resident's transfer needs were on the NA care sheets. NA-A stated R1 was not approved for use of the EZ Stand, but it was used when NA-A and NA-B could not get the sling for the mechanical lift under R1 after her shower. NA-A stated a NA was not allowed to make the determination to use an EZ Stand instead of a full body mechanical lift. NA-A further stated a nurse was supposed to assess a resident before getting them off the floor from a fall, and acknowledged the nurse assessed R1 after NA-A and NA-B put R1 back in bed. Additionally, NA-A stated when the wrong lift was used for a resident, the resident could be injured. On 5/18/23 at 12:25 p.m., physical therapy assistant (PTA)-C stated the selection of a Arjo lift or an EZ Stand was dependent upon a resident's	F 689	5. Date of completion: May 31,2023		

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

PRINTED: 06/16/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245271	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/19/2023
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407		
(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 689	Continued From page 3 ability to stand up and tolerate going from one surface to another. With an EZ Stand, the resident was actively standing, and was required to be able to do the work to be able to stand. PTA-C stated R1, "100% required the Arjo," and could not tolerate the EZ Stand. PTA-C stated therapy staff made recommendations for the kind of lift to use, and the recommendations were expected to be on the care plan and NA care sheets. PTA-C further stated a NA was not allowed to adjust from an Arjo to an EZ Stand without a nurse or therapist approval. On 5/18/23 at 1:21 p.m., licensed practical nurse (LPN)-A was interviewed and stated she was working when R1 fell from the EZ Stand. LPN-A stated the NAs should not have used the EZ Stand for R1; the care plan indicated the Arjo lift. On 5/18/23 at 1:41 p.m., registered nurse (RN)-A was interviewed and stated the NAs were not allowed to change the lift from the Arjo to an EZ Stand. On 5/18/23 at 1:47 p.m., NA-B stated when R1 slipped off the EZ Stand when R1 was not able to hold on to it, and the NAs helped R1 to the floor. Additionally, NA-B stated R1 should have been assessed prior to being lifted off the floor by a nurse and was not. NA-B further stated although she was trained recently about the use of the lifts after R1 fell, either the Arjo or EZ Stand could be used with R1, as long as two staff helped. NA-B again incorrectly stated the care sheet instructions indicated mechanical lift with assist of two staff, so either lift was allowed, as long as two staff performed the lift together. NA-B stated the Arjo lift was used for resident transfers when the resident was in a lying position, and the EZ Stand	F 689			

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

PRINTED: 06/16/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245271	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/19/2023
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407		
(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 689	Continued From page 4 was used when the resident was transferred from a seated position. On 5/18/23 at 3:15 p.m., the director of nursing (DON) was interviewed and stated the staff received training on the lifts in orientation and it was very clear which lift to use for which resident. The DON stated staff was expected to follow the recommendations for each resident as seen on the resident care plan and care sheets. The DON further stated if staff did not follow the recommendations, a resident could be injured. A policy on mechanical lifts was requested and not provided.	F 689			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 1, 2023

Administrator
Providence Place
3720 23rd Avenue South
Minneapolis, MN 55407

Re: Event ID: WTTC11

Dear Administrator:

The above facility survey was completed on May 19, 2023, 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 contact me with any questions regarding this letter.

Sincerely,

A handwritten signature in black ink that reads 'Lori Hagen'.

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00096	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/19/2023
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407		
(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 5/18/23, 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:		2 000		

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/01/23

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00096	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/19/2023
NAME OF PROVIDER OR SUPPLIER PROVIDENCE PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 3720 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407			
(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 H52712252C (MN00093531 and MN00093312). 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			