Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 27, 2025

Administrator
THE GARDENS AT WINSTED LLC
551 FOURTH STREET NORTH
WINSTED, MN 55395

RE: CCN: 245459
Cycle Start Date: June 18, 2025

Dear Administrator:

On July 14, 2025, 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,

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 3, 2025

Administrator
The Gardens At Winsted
551 Fourth Street North
Winsted, MN 55395-0750

RE: CCN: 245459
Cycle Start Date: June 18, 2025

Dear Administrator:

On June 18, 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 no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting

the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Susie Haben, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction

occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by September 18, 2025 (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 December 18, 2025 (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)

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the

same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245459	A. BUILDING _____ B. WING _____	C 06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS AT WINSTED LLC	551 FOURTH STREET NORTH WINSTED, MN 55395

(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 6/17/25 through 6/18/25, 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 during the survey: H54596688C (MN00113696/MN00113837). As a result of the investigation, deficiences were cited at F609 and F943. 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 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 609		7/11/25

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

Electronically Signed | 07/08/2025

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 609	Continued From page 1 §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to report an allegation of sexual abuse to the State Agency (SA) within two hours, as required, for 1 of 3 residents (R1) reviewed. Findings include: R1's quarterly Minimal Data Set (MDS) dated 4/1/25, indicated R1 had diagnoses which included paraplegia, neurogenic bowel (neurological condition disrupt the normal communication between the brain and colon,	F 609	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by	

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F 609	Continued From page 2 leading to difficulties in controlling bowel movements), and major depressive disorder. R1 was cognitively intact and did not exhibit any behaviors. Review of facility report number 360763 to the SA dated 6/6/25 at 1:07 p.m., indicated R1 reported she used the call light to request assistance with a brief change. She was turned onto their left side and participated in the repositioning by gripping the grab bar on that side of the bed. R1 indicated the nursing assistant (NA), while cleaning the resident, informed her that they needed to see how much stool was coming out. R1 reported the NA put their right hand on her right hip and with the left hand put their finger into her anus. R1 reported they have never had anal sex but the way the NA put his finger in and out of R1's anus was anal sex to them. R1 described the sensation of the finger entering her as painful and upsetting. Further, report identified registered nurse (RN)-A was made aware of the allegation on 6/6/25, at 11:05 a.m. On 6/18/25 at 10:42 a.m., NA-A indicated R1 required assistance by staff for incontinent cares and R1 had no cognitive impairments or behaviors. NA-A stated on 6/6/25, at approximately 6:00 a.m., R1 requested assistance with changing her brief. During the encounter, NA-A stated R1 the allegation of sexual abuse that occurred on the overnight. NA-A stated R1 was stated her rectum was painful and R1 was in tears. Further, NA-A stated following assisting R1, she exited her room and continued to assist other residents with morning cares until she seen RN-A at the nursing station. NA-A stated she reported R1's allegation to RN-A at approximately 8:30 a.m., because she did not	F 609	the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facilitys credible allegation of compliance. F609 s/s D -The process for satisfying this requirement has been reviewed and revised as needed, to ensure allegations of abuse are reported to the State agency no later than 2 hours. - All residents residing in the facility have the potential to be affected if this requirement is not met. - The plan of care for R1 was reviewed and revised as needed to ensure there was no harm or lasting effects. - Other like residents were interviewed and a review of their medical record was completed to ensure there was no risk of harm. No harm was identified. - The agency nursing assistant (NA) who was involved in the said abuse was suspended pending investigation once the Administrator was made aware of the allegation. NA remains on the do not return (DNR) list and has not worked since the allegation was made.	

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F 609	Continued From page 3 see another other nurse around before that. In addition, NA-A stated staff were expected to report abuse immediately to the charge nurse. On 6/18/25 at 11:02 a.m., NA-B stated R1 was cognitively intact and did not exhibit any behaviors. NA-B stated she was made aware of R1's abuse allegation on 6/6/25, at approximately 9:00 a.m., when R1 had reported the overnight NA had "fingered her anus". NA-B stated she exited R1's room and reported the allegation to NA-A, who then reported the allegation to RN-A. In addition, NA-B stated staff were expected to report abuse to the charge nurse right away but within two hours. On 6/18/25 at 12:55 p.m., RN-A stated on 6/6/25, at approximately 11:05 a.m., NA-A approached him and stated R1 wanted to speak with him, but NA-A did not report any abuse concerns at that time. RN-A administered insulin to another resident, and then went to speak with R1. RN-A stated upon entering R1's room he observed R1 was very upset, and she was crying. RN-A stated R1 had reported the overnight NA was assisting with a brief change and R1 felt the NA's finger go into her anus. RN-A stated he immediately went to report the abuse concern to the administrator and a report was submitted to the SA. On 6/18/25 at 3:05 a.m., interim director of nursing (DON) stated staff are expected to report abuse allegations immediately to the administrator and/or DON and within two hours to the SA. Review of facility policy titled Abuse Prohibition/Vulnerable Adult Policy revised 4/25, directed staff suspected abuse shall be reported	F 609	- All necessary staff, including current contracted agency staff, have received training utilizing Monarch Healthcare Management abuse prohibition policy, with an emphasis on the incidents to be reported and the designated time frames of reporting requirements. - To ensure compliance, audits will be completed three (3) times per week for two (2) weeks; two (2) times per week for two (2) weeks; one (1) time per week for one (1) week; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI, with any deficient practice corrected at the time of occurrence. - Administrator or designee is responsible party. - Corrective action will be completed on or before 7/11/25.	

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F 609	Continued From page 4 to the SA online reporting process no later than 2 hours after forming the suspicion of abuse.	F 609		
F 943 SS=D	Abuse, Neglect, and Exploitation Training CFR(s): 483.95(c)(1)-(3) §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure contracted agency staff were trained on the facility's abuse policy and annual abuse training which had the potential to affect all 37 residents currently residing in the facility at the time of the survey. Findings include: Review of facility report number 360763 to the SA dated 6/6/25 at 1:07 p.m., indicated R1 reported she used the call light to request assistance with a brief change. She was turned onto their left side and participated in the repositioning by gripping the grab bar on that side of the bed. R1 indicated	F 943	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations.	7/11/25

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F 943	Continued From page 5 the nursing assistant (NA)-C, while cleaning the resident, informed her that they needed to see how much stool was coming out. R1 reported the NA-C put his right hand on her right hip and with the left hand put his finger into her anus. R1 reported they have never had anal sex but the way the NA-C put his finger in and out of R1's anus was anal sex to them. R1 described the sensation of the finger entering her as painful and upsetting. Further, report identified registered nurse (RN)-A was made aware of the allegation on 6/6/25, at 11:05 a.m. Review of New Employee Orientation dated 12/24, document provided by NA-C's contracted agency staffing company revealed training on resident abuse, physical abuse, emotional abuse, financial abuse, neglect, and reporting abuse and neglect. The document failed to provide evidence of education related to sexual abuse and the reporting requirements. On 6/17/25 at 2:17 p.m., requested NA-C's abuse training. At 5:06 p.m., email was received from administrator stating the facility did not have abuse training for NA-C. On 6/18/25 at 9:43 a.m., NA-C stated he was contracted through an agency and had been working at the facility for two years but has only picked up about 10 shifts so far in 2025. NA-C stated through his agency he had completed some training regarding abuse and reporting, however, had not completed any training with the facility in regard to their abuse policy and procedure. On 6/18/25 at 10:34 a.m., director of recruitment from contracted staffing agency confirmed their	F 943	Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facilitys credible allegation of compliance. F943 s/s D -The process for satisfying this requirement has been reviewed and revised as needed, to ensure agency staff are trained as required on the facility's abuse policy. -All residents residing in the facility have the potential to be affected if this requirement is not met. - The plan of care for R1 was reviewed and revised as needed to ensure there was no harm or lasting effects. - Other like residents were interviewed and a review of their medical record was completed to ensure there was no harm. -An investigation was initiated and concluded that there was no abuse (to any residents) and the claims were unsubstantiated. - All staff have received training utilizing the Monarch Healthcare Management abuse prohibition policy, with an emphasis on providing required training to contracted agency staff as required prior to the start of their first shift at the facility. - To ensure compliance, audits will be	

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F 943	Continued From page 6 employees received abuse training as part of their orientation and confirmed NA-C had not completed abuse training since October 2023. On 6/20/25 at 4:22 p.m., email received from administrator with NA-C education records from contracted agency company verified abuse training was completed on 8/21/24. However, training completed lacked evidence of sexual abuse training and reporting requirements. Review of facility policy titled Abuse Prohibition/Vulnerable Adult Policy revised 4/20/25, indicated the facility would provide orientation to all new employees which Resident Rights and Vulnerable Adult Law policies and procedures would be reviewed, and staff receive an employee policy book which outlines these policies/procedures, all new employees receive training on how to report alleged abuse/neglect upon hire, and all employees received annual in-service training on Vulnerable Adult Policies and Procedures. The policy lacked evidence of how contracted staff would be included and who would ensure contracted staff received education and training.	F 943	completed three (3) times per week for two (2) weeks; two (2) times per week for two (2) weeks; one (1) time per week for one (1) week; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI, with any deficient practice corrected at the time of occurrence. -Administrator or designee is responsible party. -Corrective action will be completed by 7/11/25.	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 3, 2025

Administrator
The Gardens At Winsted
551 Fourth Street North
Winsted, MN 55395-0750

Re: Event ID: 5BUD11

Dear Administrator:

The above facility survey was completed on June 18, 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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00352	A. BUILDING: _____ B. WING _____	06/18/2025

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 6/17/25 through 6/18/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00352	A. BUILDING: _____ B. WING _____	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS AT WINSTED LLC	551 FOURTH STREET NORTH WINSTED, MN 55395

(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 The following complaints were reviewed during the survey: H54596688C (MN00113696/MN00113837). 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		