Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 25, 2025

Administrator
THE LUTHERAN HOME: BELLE PLAINE
611 WEST MAIN STREET
BELLE PLAINE, MN 56011

RE: CCN: 245590
Cycle Start Date: July 9, 2025

Dear Administrator:

On August 21, 2025, the Minnesota Departments 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.

Feel free to contact me if you have questions.

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 28, 2025

Administrator
THE LUTHERAN HOME: BELLE PLAINE

611 WEST MAIN STREET
BELLE PLAINE, MN 56011

RE: CCN:245590

Cycle Start Date: July 9, 2025

Dear Administrator:

On July 9, 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:

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 October 9, 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 October 9, 2026 (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,

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

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Electronically delivered

July 28, 2025

Administrator
The Lutheran Home: Belle Plaine
611 WEST MAIN STREET
BELLE PLAINE, MN 56011
Re: Event ID: JVVH11

Dear Administrator:

The above facility survey was completed on July 9, 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,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **245590**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **07/09/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LUTHERAN HOME: BELLE PLAINE	**611 WEST MAIN STREET , BELLE PLAINE, Minnesota, 56011**

(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
F0000	INITIAL COMMENTS On 7/8/25, and 7/9/25, 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 complaint was reviewed: H55907539C (MN00113941), with deficiencies cited at F609. 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.	F0000		08/05/2025
F0609 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: §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	F0609	It is the policy, and intention, of The Lutheran Home: Belle Plaine, to be in full compliance with all regulations and requirements of both the Medicaid and Medicare Programs. These plans and responses to the findings are written solely to maintain certification in the Medicare and Medicaid Programs and, as required, are submitted as the facility's CREDIBLE ALLEGATION OF COMPLIANCE. The written response does not constitute an admission of noncompliance with any requirement. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The facility wishes to preserve its right to dispute these findings in their entirety should any remedies be imposed. It is the intention of The Lutheran Hone: Belle Plaine, to be compliant with the requirements at F0609 Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4). The facility's standard of practice is to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment,	08/05/2025

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245590	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LUTHERAN HOME: BELLE PLAINE	611 WEST MAIN STREET , BELLE PLAINE, Minnesota, 56011

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F0609 SS = D	Continued from page 1 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 record review the facility failed to report an allegation of deprivation of good within 2-hours to the State Agency (SA) for 1 of 1 resident (R1), who reported staff refused to transfer her to the toilet when requested and was incontinent of urine. Findings include: R1's nursing home incident report (NHIR) dated 6/16/25 at 3:07 p.m., identified R1 reported from 6/14/25-6/15/25 she put her call light on around midnight to use the toilet and sit in her recliner. Two aides came into the room and rudely told her "What do you want to get up for" and "it is time for bed". The aides turned off the call light and left the room. Staff did not come back to the room until 2:30 a.m. and told R1 they were very busy. R1 reported that she hated it but had to urinate in her brief because they would not help her. R1 stated she waited in the wet brief until the morning when new staff were available to help her. R1 also indicated when she asked staff to transfer her according to her preference, staff responded "I'm not going to lose my license, so we are not going to transfer you." Facility identified the nursing assistants through camera footage. R1's face sheet dated 7/9/25, identified diagnoses of mechanical complication of internal right hip prosthesis (presence of an artificial device to replace a missing body part), presence of artificial right hip. R1's comprehensive Minimum Data Set (MDS) dated 6/12/25, identified no issues with cognition, no behaviors towards staff or residents. Impairment on one side of lower extremity. Dependent on staff for toileting hygiene, lower body dressing, footwear; substantial assistance with movements in bed. Continent of bowel but frequent incontinence of urine.	F0609	Continued from page 1 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. Contributing factors to this finding includes a phone call to on-call nurse leadership LPN-B from LPN-A the morning of 6/15/2025 to discuss some care issues involving R1 during the early hours of 6/15/2025. LPN-B then contacted the DON about the reported concerns. Initially, what R1 shared was determined to be not reportable at F0609. On the morning of 6/16/2025, R1 shared her frustration with NA-E and NA-F during her interaction with them on 6/15/2025. She shared that the two NAs would not transfer her using the toe-touch technique. R1 shared this information with NA-A, who then reported it to SW-A. SW-A then conducted an in-depth interview with R1. Based upon the additional information R1 shared with SW-A, it was determined that the incident did meet reporting requirement at F0609. Additional contributing factors to this finding include a delay in interviewing R1 as to her initial complaint. Detailed toe-touch transfer technique, with a mechanical lift, instructions from the therapy department for nursing staff also may have changed the outcome of this incident. The NA's named as the alleged perpetrators in this incident were placed on administrative leave during the investigative process. *Facility Wide Response Addressing Other Residents with the potential to be Affected: 1. RN1 received a written notice and additional training on reporting of alleged vulnerable adult violations from the DON.	

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THE LUTHERAN HOME: BELLE PLAINE	611 WEST MAIN STREET , BELLE PLAINE, Minnesota, 56011

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F0609 SS = D	Continued from page 2 R1’s care plan on 6/10/25, identified R1 was a vulnerable adult and staff should report any witnessed or suspected abuse per facility protocol. During an interview on 7/8/25 at 1:10 p.m., R1 stated the two nursing assistants should never have been nursing assistants. They are authoritative and drag one foot in front of the other. R1 felt that they just were not doing their jobs. If R1 asked for something it would take forever for them to do it but that night, they were not budging. R1 stated she had to use the bathroom, and they had gotten her up and were on the way and then could not do it saying things like they would lose their license and all sorts of things. R1 decided that it would be best to “pee in my pants and not damage my leg”. R1 decided that she should report the aides that morning and the aides were gone quick after she reported the incident. During a phone interview on 7/9/25 at 9:59 a.m., registered nurse (RN)-A stated she had worked the overnight shift on 6/14/25 into 6/15/25. NA-F had come to her because she felt unsafe transferring R1 using a mechanical lift because of the way R1 was demanding to be transferred. NA-F was very adamant about not transferring R1 in that manner. RN-A asked NA-E to transfer R1. It was not until the next morning or two days later that RN-A discovered that R1 had never been transferred. R1 was sleeping in her recliner that night and had never gotten into bed. NA-E was working on R1’s unit that night and NA-F was scheduled as the float person that would help other NA’s where needed. As far as RN-A was aware, NA-E and NA-F were never in R1’s room together. RN-A had never had any issues with NA-E or NA-F prior to this. RN-A stated she reported the incident during shift to shift report the morning of 6/15/25. RN-A had not received concerns from R1 or about R1 that occurred during the night other than the transfer incident. During an interview on 7/8/25 at 1:45 p.m., licensed practical nurse (LPN)-A believed it was the morning of 6/14/25 when RN-A reported R1 was upset with the NA's for not transferring her the way she wanted to be transferred; NAs had thought the way R1 wanted to be transferred was unsafe so they did not transfer her the rest of the night to the bathroom. LPN-A did not know which NAs were involved. LPN-A thought the incident happened around 3:00 am and R1 was really frustrated the NAs would not listen. LPN-A explained she reported R1 was unhappy about the concerns pertaining to R1's transfers to LPN-B sometime that morning. During an interview on 7/9/25 at 9:53 a.m., LPN-B	F0609	Continued from page 2 2. All staff received renewal education on reporting of alleged violations of resident rights including all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, and the necessity that these allegations are to be 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. 3. The charge nurse on each unit and/or social worker, will be responsible for ensuring that every residents' complaint is followed up by an interview and/or investigation. 4. Nursing Services will collaborate with Rehabilitation Therapy Services to provide detailed resident mobility transfer instructions, for atypical resident transfers (including photos, in certain situations), for direct care providers. 5. In addition to the Resident Bill of Rights, which accompanies the admission packet and is reviewed annually at Resident Council, a document from the Minnesota Department of Human Services, entitled 'Report suspected abuse, neglect, self-neglect or financial exploitation of vulnerable adults, will be included in the resident admission packet. 6. NA-E & NA-F were terminated on 6/19/2025. SW-A followed up with R1 after the termination to inquire as to how her nights had been of recent. R1 reported that her nights had been a lot better and that the NA's have been very kind and patient with her, after the change. 7. Ongoing: In response to identifying, and reviewing, how other residents potentially impacted, the facility will implement quarterly audits of a random sample of residents regarding their understanding of reporting any complaint, concern, or suspected abuse, neglect, or financial exploitation immediately. Additionally, residents will be reminded of their right to be free from abuse, neglect and financial exploitation, and how to report potential violations, at the residents' quarterly care conferences. Data obtained from the	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LUTHERAN HOME: BELLE PLAINE	**611 WEST MAIN STREET , BELLE PLAINE, Minnesota, 56011**

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F0609 SS = D	Continued from page 3 stated LPN-A had called her on 6/15/25 and said there was an issue with R1's transfer status and questions between the nurses and aides on night shift with turning off her light. LPN-B notified the director of nursing (DON) of the situation and tried to get ahold of RN-A to discuss what had happened. During an interview on 7/9/25 at 1:14p.m., DON stated LPN-B had reached out to her on 6/15/25 that there were some complaints regarding staff with R1. DON did not feel that what was reported seemed neglectful from her perception, if it had, an investigation would have begun. After R1's interview on the afternoon of 6/16/25, management staff felt that rather than provide education to staff, the incident needed to be reported. During an interview on 7/9/25 at 9:46 a.m., NA-A stated she reported to social worker (SW)-A on 6/16/25 that R1 was mad because the night aides would not take her to the bathroom because they did not feel comfortable with her toe-touch. R1's brief was soaked when NA-A assisted her on the morning of 6/15/25. R1 was upset about the incident because she paid a lot of money to be at the facility and felt that those NA's tag-teamed against her and did not want to help her. During an interview on 7/9/25 at 10:15 a.m. and 1:46 p.m., SW-A heard about the situation from NA-A and NA-B when they reported it to her on 6/16/25. DON, LPN-B, and RN-A did not inform SW-A of the situation. SW-A immediately went to R1 and interviewed her. SW-A filled out the NHIR form after the interview with R1 and that was why the report was made late. The Abuse, Neglect and Exploitation policy revised 5/23/24, identified the facility maintained an environment where resident are free form abuse, neglect, exploitation and misappropriation of property and all residents, staff, families, visitors, volunteers, and resident representatives are encouraged and supported in reporting any suspected acts of abuse, neglect, misappropriation of property, or exploitation. Deprivation by staff of goods or services include those that are necessary to attain or maintain physical, mental, and psychosocial well-being. In these cases, staff has the knowledge and ability to provide care and services, but choose not to do it, or acknowledge the request for assistance from a resident(s), which result in care deficits to a resident(s).	F0609	Continued from page 3 aforementioned audits will be incorporated into the facility's Quality Assurance and Performance Improvement (QAPI) program. If a variation from the requirement is noted, a root cause analysis of collected data will be implemented to identify contributing factors, so that they may be mitigated. Audits will be continued for not less than one year.	

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/09/2025

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THE LUTHERAN HOME: BELLE PLAINE	**611 WEST MAIN STREET , BELLE PLAINE, Minnesota, 56011**

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20000	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 7/8/25, and 7/9/25, 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: H55907539C (MN00113941). NO licensing orders were issued.	20000		08/05/2025

Office of Primary Care and Health Systems Management

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

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **07/09/2025**

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20000	Continued from page 1 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.	20000		