DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
May 22, 2024

Administrator
Park View Care Center
200 Park Lane
Buffalo, MN 55313

RE: CCN: 245474
Cycle Start Date: April 10, 2024

Dear Administrator:

On May 16, 2024, 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.

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
April 23, 2024

Administrator
Park View Care Center
200 Park Lane
Buffalo, MN 55313

RE: CCN: 245474
Cycle Start Date: April 10, 2024

Dear Administrator:

On April 10, 2024, 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:

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 July 10, 2024 (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 10, 2024 (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

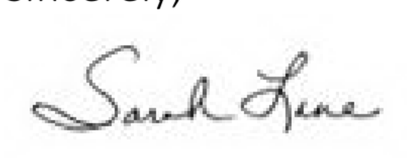
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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.

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 23, 2024

Administrator
Park View Care Center
200 Park Lane
Buffalo, MN 55313

Re: Event ID: 3OV711

Dear Administrator:

The above facility survey was completed on April 10, 2024 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,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245474	A. BUILDING _____ B. WING _____	C 04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK VIEW CARE CENTER	200 PARK LANE BUFFALO, MN 55313

(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 4/8/24 through 4/10/24, 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: H54742788C (MN00102156) with a deficiency issued at F684. 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 684 SS=D	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	F 684	This Plan of Correction constitutes my	5/10/24

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

Electronically Signed — 04/26/2024

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 684	Continued From page 1 facility failed to monitor and provide treatment for a resident following a fall with a head strike, hyperglycemia and changes in respiratory status for 1 of 3 residents (R1) reviewed for change of condition. Findings include: R1's Admission Record dated 8/2/22, indicated R1's diagnoses included diabetes mellitus type 1, chronic kidney disease, polyneuropathy (damage to the nerves in the hands and feet/legs), atherosclerotic heart disease and chronic pain syndrome. R1's quarterly Minimum Data Set (MDS) dated 1/8/24, indicated R1 had history of falls, required extensive assist of two persons for transfers, limited assistance with activities of daily living (ADLs) and had intact cognition. R1's care plan initiated 8/2/22, indicated R1 had type one diabetes mellitus and was at risk for decline in medical condition. Staff intervention included monitor for change of condition and notify provider and resident representative as indicated and administer medications and treatments per provider order. R1 had history of falls and scored 16 on the Johns Hopkins fall risk assessment tool indicating R1 was at high risk for falls. R1 required extensive assist of two persons for transfers using standing lift. R1 vital signs were stable and she was on room air. R1's Provider Orders for Life-Sustaining Treatment (POLST) dated 8/11/22 indicated R1 was a Do Not Resuscitate (DNR) resuscitation status, with comfort-focused treatment which directed nurses to transfer R1 if comfort needs	F 684	written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law. It is the policy of Cassia Sample Site to comply with F684 Actions taken for the identified resident: The resident R1 has since expired. Actions taken to identify other potential residents: The facility reviewed all residents who met the RAI definition of significant change within the dates of 3/25 -4/7/24. Two residents met that criteria r/t a transition to hospice care. The facility followed its current RAI significant change policy and procedure. The facility also completed the notification process to providers and family in a timely manner to ensure appropriate treatment interventions were put in place. The facility also reviewed all residents who were hospitalized from 3/25 -4/7. One resident was hospitalized related to cardiac issues. There was evidence of ongoing weight monitoring, oxygen monitoring, and communication to providers with updated orders.	

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F 684	Continued From page 2 could not be met in current location. R1's oxygen saturation levels never got above 88% (normal is 90% or above) on 4 Liters of oxygen from 6:00 a.m. to 9:30 a.m. R1's medical record lacked evidence of other interventions implemented to alleviate her respiratory distress. On 3/15/24 at 7:12 a.m., a progress note indicated R1 had unwitnessed fall with 0.5 centimeter (cm) x 0.4 cm bruise at right side of her forehead in her room at 4:59 a.m. She was disoriented, alert and had mild lack of energy. R1's vital signs and blood glucose (BG) levels dated 3/15/24 revealed the following: -5:00 a.m.: blood pressure (BP) 95/59; temperature (temp) 97.1; pulse 126; respirations (RR) 28 -5:15 a.m.: BP 103/61; temp 97.2; pulse 113; RR 25 -5:30 a.m.: BP 110/70; temp 97.2; pulse 109; RR 25 -5:45 a.m.: BP 101/63; temp 97.2; pulse 101; RR 27 -6:00 a.m.: BG 521 mg/dl -6:15 a.m.: BP 101/65; temp 97.2; pulse 101; RR 23 -6:45 a.m.: BP 108/63; temp 97.3; pulse 120; RR 21 -6:56 a.m.: BG 489 mg/dl -7:37 a.m.: BG 479 mg/dl -7:45 a.m.: BP 113/71; temp 97.4; pulse 119; RR 22, oxygen saturation (O2 sats) 84% -9:30 a.m.: BG 544; BP 82/54; temp 97.7; pulse 117; RR 16; O2 sats 74% On 3/15/24 at 8:25 a.m., a progress note indicated R1 had at 6:00 a.m. blood glucose	F 684	Furthermore, the facility reviewed all residents with falls from 3/25 -4/7. One of these was also listed in the RAI list as a resident who had transitioned to hospice. Again, the facility followed its current falls policy and procedure of notifying providers and family timely to ensure appropriate interventions were put in place. Measures put in place to ensure deficient practice does not recur: The facility reviewed the current policy on change in condition with its nurses to ensure full understanding of the steps required to take whenever residents experienced changes in status. Re-education was provided to nurses regarding change of condition, timely provider notification for various resident conditions including falls. The IDT will continue reviewing resident progress notes daily to ensure all appropriate steps needed to comprehensively complete change in notification are completed. The facility will continue to follow our policies and procedures regarding change of condition, falls, and updating providers in a timely manner. Effective implementation of actions will be monitored by: All falls and changes in condition will be monitored in the ongoing daily Interdisciplinary team and Falls meeting. DON/IDT will audit 3 residents with change of condition weekly for 4 weeks.	

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F 684	Continued From page 3 reading of 512 mg/dl, O2 sats of 80-81%, oxygen 4-5 L was applied via nasal canula, but her O2 sats remained at 83-85%. The note also indicated the on-call provider (MD)-A was notified, and ordered to give scheduled 10 units insulin, continue monitoring the resident's condition, and update the nurse practitioner (NP)-A for any sudden changes on R1's status. The note indicated family member (FM)-A was updated and aware of the resident's condition, and agreed to send R1 to the hospital for evaluation if needed. On 3/15/24 at 9:30 a.m., a progress note indicated R1 had crackles to her lungs upon auscultation. R1 was lethargic, in respiratory distress with O2 sat at 69 to 74% on 4L of O2. The note also indicated NP-A was notified, and ordered R1 to be sent to the hospital per family request. On 3/15/24 at 11:30 a.m., a progress note indicated R1 had passed away at the hospital with the family at the bedside. R1's hospital Patient Discharge Note dated 3/15/24 at 12:11 p.m. indicated R1 had coarse breath sounds bilaterally right worse than left, gasping for air, was unresponsive and was requiring bag-valve-mask (BVM), a handheld tool to deliver possitive pressure ventilation support to maintain O2 sats upon arrival at the hospital. It was suspected R1's hyperglycemia (high blood glucose level) was from severe sepsis/septic shock from pneumonia. The note also indicated R1 passed away at 11:38 a.m. on 3/15/24. MD-A's progress note dated 3/15/24 at 6:33 a.m. indicated R1 was found down on the floor with a BG of 552, systolic BP of 95, pulse 104, and O2	F 684	Trends and patterns will also be reviewed in QAPI meetings with necessary improvement steps taken as recommended. Those responsible to maintain compliance will be: The Director of Nursing, or designee, is responsible for maintain compliance. Completion date for certification purposes only is: 5/10/2024	

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F 684	Continued From page 4 sats of 80-84% on 4 L of O2. R1 had a few basilar crackles, an abnormal breath sounds at the bases of the lungs with no apparent injuries. The note also indicated to update primary team in two hours depending upon BP, and anything further regarding BG and O2 sats. NP-A's note dated 3/15/24 at 1:06 p.m. indicated R1 had unwitnessed fall in her room at 5:00 a.m., received a head strike and had an acute change in condition. Family did not want to send R1 to the hospital at that time. NP-A observed R1 sitting slumped over in bed, with the head of the bed (HOB) elevated because of labored/congested breathing. R1 was unresponsive and appeared at the end of life. On 4/8/24 at 12:42 p.m. family member (FM)-A stated she got a call from the facility around 7:00 a.m. on 3/15/24 regarding R1's fall. She told the facility to send R1 to the hospital for further evaluation. At around 10:00 a.m. she got another call again from NP-A who told her R1 was at the end of life. She requested R1 to be sent to the hospital for further care. On 4/9/24 at 8:14 a.m. registered nurse (RN)-A stated nurses were responsible for monitoring residents. RN-A stated R1 was found on the floor in her room at 5:00 a.m. and sustained an injury on her forehead. R1's BP was 90/69, her O2 sats were below 90%, O2 was applied at 4L and her O2 sats increased to 86%, but remained below 90%. She acknowledged she did not document the O2 sats. She called MD-A at 6:00 a.m. and was directed to hold R1's BP medications, continue supplemental oxygen, encourage R1 to do deep breathing, and to continue monitor R1's respiratory status. She was to update the primary	F 684		

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F 684	Continued From page 5 team in two hours. On 4/9/24 at 11:51 a.m. RN-C stated if a resident had a change of condition, she would assess the resident. Based on the findings, she would notify the provider and the family, and would continue to monitor the resident every 15 minutes. If the resident's condition had not improved, she would call the provider to request sending the resident to the hospital for further care, and document everything. On 4/9/24 at 1:33 p.m. NP-A stated RN-B updated her about R1's deteriorating condition. She arrived at the facility at about 8:30 a.m. Upon assessment, R1 appeared at the end of life, she was unresponsive, pale, diaphoretic, hypotensive and had agonal breathing with 4 L of O2 on. She directed RN-B to update the family as R1's condition looked poor. She ordered to send R1 to the hospital per family request. On 4/9/24 at 3:05 p.m. MD-A stated he did not recall the nurse informing him of any injury to R1. He gave orders to manage R1 comfort based on the information provided by the nurse. The plan was to manage R1's BG, to continue with supplemental O2, and update the primary care team in two hours. The plan was to focus on comfort care according to R1's advance directives. On 4/10/24 at 9:59 a.m. RN-B stated the last respiratory assessment she did on R1 was around 7:45 a.m. with O2 sats of 84% on 4L of O2. She called the unit manager around 8:15-8:30 a.m. to come and assess R1. R1 was lethargic with O2 sats of 74% to 69% around 9:00 a.m. and she immediately notified NP-A who was	F 684		

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F 684	Continued From page 6 on site. On 4/10/24 at 10:51 a.m. RN-D (the unit manager) stated when RN-B told him about R1's change in condition, he went to see R1 in her room but did not do a full assessment. RN-D stated he just wanted to check R1's cognition, and she was able to tell him his name, but was still having hard time breathing. He did not know what R1's O2 sats were when he got to her room, nor did he check. He left R1, and went to his office to be prepare for his daily meeting. Around 9:15 a.m. he saw NP-A who told him R1 was actively dying, and he was surprised. R1 was unresponsive when emergency medical service (EMS) arrived, and EMS put R1 on high flow O2 with BVM support. After a fall with a head strike, nurses should to initiate neuro check and vital signs (VS) which would include O2 sats every 15 minutes. On 4/10/24 at 12:22 a.m. the director of nursing (DON) stated she got a report from RN-B between 8:00 a.m. and 9:30 a.m. regarding R1's fall, and was not told of any respiratory distress. After a fall with a head strike, nurses should initiate neuro checks and full VS every 15 minutes, assess the resident frequently, and report to the provider and the family. The facility Fall Assessment and Managing Fall Risk policy revised 11/6/23 directed nurses to assess the resident VS and to complete the neuro checks form every 15 minutes (min) times (x) one hour, every 30 min x one hour, every one hour x one hour, and then every 4 hours until 24 hours post fall. Notify the provider and resident representative of the fall for residents with unwitnessed fall.	F 684		

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F 684	Continued From page 7 The facility Notification to Physician/Family/Resident Representative of Change in Resident Health Status policy reviewed 4/14/23 defined a significant change of condition as a major decline or improvement in the resident's status which will not normally resolve itself without intervention by staff or by implementing standard disease related clinical intervention. The policy directed nurses to make detailed observations and gather relevant and pertinent information for the provider.	F 684		

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	00719	A. BUILDING: _____ B. WING _____	04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK VIEW CARE CENTER	200 PARK LANE BUFFALO, MN 55313

(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 4/8/24 through 4/10/24, 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 complaint was reviewed: H54742788C (MN00102156). NO licensing	2 000		

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

Electronically Signed | 04/26/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00719	A. BUILDING: _____ B. WING _____	04/10/2024

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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		