DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 20, 2023

Administrator
Elim Wellspring
701 First Street
Princeton, MN 55371

RE: CCN: 245494
Cycle Start Date: November 3, 2022

Dear Administrator:

On December 21, 2022, the Minnesota Department(s) 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

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Electronically delivered
November 18, 2022

Administrator
Elim Wellspring
701 First Street
Princeton, MN 55371

RE: CCN: 245494
Cycle Start Date: November 3, 2022

Dear Administrator:

On November 3, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), 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:

Karen Aldinger, Unit Supervisor
St. Cloud A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

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 February 3, 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 May 3, 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/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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245494	A. BUILDING _____ B. WING _____	C 11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM WELLSPRING	701 FIRST STREET PRINCETON, MN 55371

(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
E 000	Initial Comments On October 31st - November 3, 2022, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On October 31, 2022 through November 3, 2022, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H54945401C (MN00086141). NO deficiencies were issued. The following complaint was found to be UNSUBSTANTIATED: H5494084C (MN00073601). H5494083C (MN00073662). H54945421C (MN00083280). H54945349C (MN00083399). H54945348C (MN00085398). The facility's plan of correction (POC) will serve as your allegation of compliance upon the	F 000		

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

Electronically Signed | 11/25/2022

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 000	Continued From page 1 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 substantial compliance with the regulations has been attained.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.	F 580		12/16/22

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F 580	Continued From page 2 (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on Interview and document review, the facility failed to ensure resident families and/or representatives were updated timely for a change in condition related to a fall for 1 of 2 residents (R34) reviewed for falls. Findings include R34's quarterly Minimum Data Set (MDS) dated 10/13/22, included severed cognitive deficit with diagnosis of Alzheimer's disease. R34's care plan listed problem of cognition/mood dated 10/10/22, indicated R34, "Relies on family to assist with major decision making prn [as	F 580	(F580) This Plan of Correction constitutes my 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 (Princeton Elim Wellspring) to comply with (F580 by prompt notification of the representative for change in condition.)	

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F 580	Continued From page 3 needed]," and directed staff to, "Encourage family support and involvement." When interviewed on 10/31/22, at 12:14 p.m. R34's responsible family member (FM)-A stated, R34 had a fall on 9/30/22, at around 1:00 a.m. The facility did not notify him until 9/30/22 around 3:30 p.m. He was traveling for work that day. He would have chosen not to travel if he had know R34 required family assistance. It should have been more timely, if not at the time of occurrence, at least way before 3:30 p.m. R34's fall event report indicated a fall on 9/30/22, at 12:56 a.m. and FM-A was notified at 3:51 p.m. R34's progress note dated 9/30/22, at 12:56 a.m. identified, "Resident found on the floor, lying on right side facing the bed. He was screaming for help. Wheelchair within reach. Denies pain, denies hitting his head. ROM [range of motion] intact. Wearing white whites. He reports he was trying to get up to go to the bathroom and slipped out of bed. Assisted off the floor with assist of Nurse and aide. Aide assisted to the bathroom. Skin check completed, no discoloration noted." R34's progress note dated 9/30/22, at 3:31 p.m. identified, "Updated [FM-A] this afternoon regarding fall that happened during previous shift. Was upset that he wasn't updated sooner than later. Said he was on the road and was 10 hours away and wouldn't have been able to get here had anything serious transpired. Was reassured that resident was stable and sustained no injuries from fall. [FM-A] said he would be contacting management regarding timely communication." When interviewed on 11/3/22, at 1:20 PM	F 580	To assure continued compliance, the following plan has been put into place; Regarding cited resident: Resident # R34's fall event report indicated a fall on 9/30/22, at 12:56am and FM-A was notified at 3:51pm. Identified R34's representative preference with notification related to fall: On 11/3/22, resident's son clarified that he "would like to be called day or night if resident has a fall." Care plan updated on 11/3/22 Actions taken to identify other potential residents having similar occurrences: Over the next quarter's care conferences, the interdisciplinary team will verify resident/representative satisfaction with current policy of notification pf falls without injury, or if a separate preference is desired. Will review and re-educated staff on the policy for notification on change for falls without injury by 12/16/22 Update resident fall care plans, if notification preferences is expressed for after-hours fall without injury by 12/16/22 DON to provide education to nurses about change in condition related to falls and preference of notification to representative by 12/16/22. To achieve at least 90% staff completion Measures put in place to ensure deficient practice does not recur: Will audit fall events to ensure that representative notification preferences are followed	

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F 580	Continued From page 4 registered nurse (RN)-C stated, with any resident fall or incident, facility protocol is to notify resident's primary care provider, family or representative and nurse managers. RN-C stated if a resident had a fall that did not result in an injury on an overnight shift facility protocol was for the incoming day shift nurse to make those notifications. When interviewed on 11/3/22, at 2:36 p.m. RN-A stated, [FM-A] had not made a complaint to any management staff that she was aware of therefore no grievance had been initiated. RN-A stated nurse managers normally reviewed all facility progress notes and any noted concerns should have been brought forward to the interdisciplinary team. RN-B stated she had spoken to FM-A on 9/30/22, regarding another matter and he had expressed no concern regarding lack of notification. RN-B stated normally if there is no resident injury or transfer to the emergency room, the day shift staff would make notifications of any incidents on overnights. RN-B stated she did follow-up with FM-A today (11/3/22) to discuss his concern. RN-B stated FM-B had agreed to a care plan change for R34 instructing staff to notify family no matter what the time of day. The facility policy titled, Notification of Physician and Resident Representative, dated 5/4/22, included, "Primary physicians, residents, and the resident representative, consistent with their authority, will be updated with all resident condition changes as soon as possible. The names of those contacted will be documented in the progress note."	F 580	90% of fall events x 1 month 50% of fall events x1 month Then audits will be reviewed at QAPI to determine if further audits are needed. Effective implementation of actions will be monitored by: The results of these audits will be reviewed by the facility QAPI committee until substantial compliance is achieved and they will make the decision if further monitoring/audits are recommended. Those responsible to maintain compliance will be: The Director of Nursing/Team Leads or designee is responsible for maintain compliance. Completion date for certification purposes only is: 12/16/2022	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 18, 2022

Administrator
Elim Wellspring
701 First Street
Princeton, MN 55371

Re: Event ID: 5KAD11

Dear Administrator:

The above facility survey was completed on November 3, 2022 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
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00375	A. BUILDING: _____ B. WING _____	C 11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM WELLSPRING	701 FIRST STREET PRINCETON, MN 55371

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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 October 31, 2022 through November 3, 2022, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found to be IN compliance with MN State Licensure. The following complaint was found to be	2 000		

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2 000	Continued From page 1 UNSUBSTANTIATED: H5494084C (MN00073601). H5494083C (MN00073662). H54945421C (MN00083280). H54945349C (MN00083399). H54945348C (MN00085398). The following complaint was found to be SUBSTANTIATED: H54945401C (MN00086141). NO licensing 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245494	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/31/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM WELLSPRING	**701 FIRST STREET** **PRINCETON, MN 55371**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Elim Wellspring was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Healthcare Fire Inspections	K 000		

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

Electronically Signed | 11/25/2022

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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ELIM WELLSPRING	**701 FIRST STREET** **PRINCETON, MN 55371**

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K 000	Continued From page 1 State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Elim Home Princeton is a 3 story building with no basement. The original building was constructed in 1971 and was determined to be of Type II(222) construction. Additions were built on in 1989 of the same construction type. In 2003, a 3 story addition was added and determined to be of Type II(222) Construction. The building also has an apartment complex attached that is properly separated. The building is fully fire sprinkler protected throughout and has a fire alarm system with	K 000		

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	245494	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/31/2022**

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K 000	Continued From page 2 smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 86 beds and had a census of 66 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection,	K 353	This Plan of Correction constitutes my 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	12/16/22

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K 353	Continued From page 3 Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.1.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/31/2022 between 09:00AM and 02:00 PM, it was revealed by a review of available documentation that the facility did not perform quarterly fire sprinkler inspections during the second and third quarters of 2022. An interview with Maintenance Director and Campus Administrator verified these deficient findings at the time of discovery.	K 353	one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law. To assure continued compliance, the following plan has been put into place; K353 Annual inspection was scheduled and completed on 11/8/2022. While annual was being done, maintenance was made aware how to properly conduct quarterly sprinkler test. Maintenance director and/or designee will conduct quarterly sprinkler tests and document them going forward. They have been scheduled to complete in February, May, August and November of 2023. Quarterly sprinkler tests will be audited on a quarterly basis to ensure that they have been completed and documented. The month and date completed will be added to our QAPI meeting to ensure follow up and compliance. Maintenance Director or designee is responsible to maintain compliance. Completion date for certification purposes only is: 12/16/2022	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of	K 712		12/16/22

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K 712	Continued From page 4 established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, section 19.7.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/31/2022 at 10:00AM, it was revealed by a review of available documentation that the following fire drills could not be verified for completion: 1) Second Shift of the First Quarter of 2022 2) Second and Third Shifts of the Second Quarter of 2022 3) First Shift of the Third Quarter of 2022 An interview with Maintenance Director and Campus Administrator verified these deficient findings at the time of discovery.	K 712	K712 Fire Drills have been scheduled out in advance and will be followed by the maintenance team as a guide to ensure appropriate number of fire drills per year and the appropriate times and shifts. Monthly audit of fire drills will be conducted; results will be followed up on by the QA Committee at our QAPI meeting and reviewed for compliance. Maintenance Director or designee is responsible to maintain compliance. Completion date for certification purposes only is: 12/16/2022	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are	K 761		12/16/22

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K 761	Continued From page 5 routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct inspections of all fire rated doors required per NFPA 101 (2012 edition), Life Safety Code, sections 7.2.1.15.2 and 7.2.1.15.4 and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.4.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/31/2022 at 10:15 AM, it was revealed by a review of available documentation of the annual fire rated doors was not available at the time of the survey. An interview with Maintenance Director and Campus Administrator verified these deficient findings at the time of discovery.	K 761	K761 New form being utilized and labeling of door frames to be able to identify which doors have been inspected to meet the requirements. All required doors will be inspected on an annual basis. Once new annual audit is completed for this year, it will be added to the QAPI plan for follow up and compliance. It will also be scheduled for next year to ensure ongoing completion of annual door inspection. Facility will monitor this through our QAPI meeting to ensure that the annual door audit is completed annually. Maintenance Director or designee is responsible to maintain compliance. Completion date for certification purposes only is: 12/16/2022	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial	K 914		12/16/22

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K 914	Continued From page 6 installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct the electrical receptacle testing and maintenance at resident bed locations per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.3.4.1.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/31/2022 at 10:30 AM, it was revealed by a review of available documentation that the required annual receptacle inspection documentation was not completed at the time of the survey. An interview with Maintenance Director and Campus Administrator verified these deficient	K 914	K914 New form is being utilized to conduct receptacle audit. This will allow clearer documentation of annual outlet testing and replacement. Once new annual audit is completed for this year, it will be added to the QAPI plan for follow up and compliance. It will also be scheduled for next year to ensure ongoing completion of annual outlet testing and replacement. Facility will monitor this through our QAPI meeting to ensure that the annual door audit is completed annually. Maintenance Director or designee is responsible to maintain compliance. Completion date for certification purposes only is: 12/16/2022	

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K 914	Continued From page 7 findings at the time of discovery.	K 914		