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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 93MH

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00375

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245494**

2.STATE VENDOR OR MEDICAID NO.
(L2) **615342900**

3. NAME AND ADDRESS OF FACILITY
(L3) **ELIM HOME**
(L4) **701 FIRST STREET**
(L5) **PRINCETON, MN** (L6) **55371**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/29/2021** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **105** (L18)

13.Total Certified Beds **105** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	105			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Susie Haben, Unit Supervisor 05/12/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 05/12/2021 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
08/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/27/2021
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 12, 2021

CMS Certification Number (CCN): 245494

Administrator
Elim Home
701 First Street
Princeton, MN 55371

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective April 23, 2021 the above facility is certified for:

105 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 105 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Electronically Delivered
May 12, 2021

Administrator
Elim Home
701 First Street
Princeton, MN 55371

RE: CCN: 245494
Cycle Start Date: March 11, 2021

Dear Administrator:

On April 29, 2021, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 93MH

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00375

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245494**

2.STATE VENDOR OR MEDICAID NO.
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3. NAME AND ADDRESS OF FACILITY
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4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/29/2021** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
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FISCAL YEAR ENDING DATE: (L35)
09/30

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From (a) :
To (b) :

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And/Or Approved Waivers Of The Following Requirements:
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___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	105			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Susie Haben, Unit Supervisor 05/12/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 05/12/2021 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

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08/01/1987
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23. LTC AGREEMENT BEGINNING DATE
(L41)

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(L25)

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(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/27/2021
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

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Electronically delivered
May 12, 2021

CMS Certification Number (CCN): 245494

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Elim Home
701 First Street
Princeton, MN 55371

Dear Administrator:

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105 Skilled Nursing Facility/Nursing Facility Beds

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Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Electronically Delivered
May 12, 2021

Administrator
Elim Home
701 First Street
Princeton, MN 55371

RE: CCN: 245494
Cycle Start Date: March 11, 2021

Dear Administrator:

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Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
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Email: melissa.poepping@state.mn.us

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 93MH

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(L1) **245494**
2.STATE VENDOR OR MEDICAID NO.
(L2) **615342900**

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(L3) **ELIM HOME**
(L4) **701 FIRST STREET**
(L5) **PRINCETON, MN** (L6) **55371**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/11/2021** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
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FISCAL YEAR ENDING DATE: (L35)
09/30

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___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	105			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Timothy Rhonemus, HFE NE II — 04/20/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Melissa Poepping, Enforcement Specialist — 04/26/2021 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

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27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
March 30, 2021

Administrator
Elim Home
701 First Street
Princeton, MN 55371

RE: CCN: 245494
Cycle Start Date: March 11, 2021

Dear Administrator:

On March 11, 2021, 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" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Susie Haben, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by June 11, 2021 (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 September 11, 2021 (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,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

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 03/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM HOME	**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 3/08/21 and 3/11/21, a survey for compliance with CMS Appendix Z Emergency Preparedness was conducted during a recertification survey. The facility was NOT in compliance with the Appendix Z Emergency Preparedness, Requirements for Long-Term Care (LTC) Facilities.	E 000		
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2)	E 041		4/9/21

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

Electronically Signed | 04/09/2021

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 03/11/2021

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

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E 041	Continued From page 1 Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org,	E 041		

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	245494	A. BUILDING _____ B. WING _____	C 03/11/2021

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E 041	Continued From page 2 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide test documentation in accordance with the 2012 edition of the Life Safety Code (NFPA 101) section 9.1.3.1 and the 2010 edition of NFPA 110 the Standard for Emergency and Standby Power Systems, section 8.4.1. This deficient practice could affect the safety of all 105 residents and an undetermined amount of staff and visitors if the generator failed to operate during a power outage. Findings include: During documentation review between 8:00 AM to 12:30 PM on 03/15/2021 record review and staff	E 041	Tag 0041 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, Elim Home, to comply with 0041. To assure continued compliance, the following plan has been put into place;	

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E 041	Continued From page 3 interview revealed: 1) There were 46/52 of the weekly inspections completed within the calendar year at the time of the survey. 2) The monthly inspection records from March 2020 through March 2021 could not be located at the time of the survey. This deficient condition was confirmed by the Maintenance Engineer.	E 041	Weekly and Monthly generator inspections will be scheduled and documented by the maintenance team. Generator testing will be monitored by the safety committee at the monthly meeting. The documentation will be reviewed at the next quarterly Quality Improvement Meeting to demonstrate compliance with the Plan of correction Measures put in place to ensure deficient practice does not recur: •Re-education to staff regarding generator test standards 4/23/21. * Discussed citation and proper process testing process 4/23/21 • Effective implementation of actions will be monitored by: Results of these audits/interviews will be reviewed by the facility QAPI committee and they will make the decision if further monitoring/audits are recommended. Those responsible to maintain compliance will be: The Director of Environmental Services or designee is responsible to maintain compliance. Completion date for certification purposes only is: 4/23/21	
F 000	INITIAL COMMENTS On March 8, 2021, through March 11, 2021, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care	F 000		

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F 000	Continued From page 4 Facilities. The following complaints were found to be UNSUBSTANTIATED: H5494070C (MN00065683) no deficiency issued H5494072C (MN00066658) no deficiency issued H5494073C (MN00066760) no deficiency issued The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550		4/9/21

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F 550	Continued From page 5 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure resident's rights to privacy for 1 of 1 residents (R38) whom staff walked into room without receiving permission. Findings include: R38's quarterly minimum data set dated 1/20/21, indicated no cognitive impairment and required one assist with bed mobility and transfers and required two assist when walking. Resident is	F 550	It is the policy of Cassia (Elim Wellspring) to comply with (F550) To assure continued compliance, the following plan has been put into place; Residents has the rights to dignified existence, self-determination & communication with and access to person's and services inside and outside the facility. Regarding cited resident: Resident #38 on 3/8/21 it was observed	

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F 550	Continued From page 6 being monitored for mood and behaviors each shift. R38's care plan revised 3/4/21, indicated alteration in behavior related to major depressive disorder, psychosocial well-being, and being monitored mood as resident is on antidepressants. During observation on 3/8/21, at 4:46 p.m. staff knocked on R38's door and R38 told them to wait a minute as she was talking with someone. Staff observed walking into room and wanted R38 to take her medication, despite R38's request to wait. During interview on 3/8/21, at 4:46 p.m. R38 stated that staff just walk in her room all the time without her giving them consent. During interview on 3/9/21, at 8:40 a.m. R38 stated that staff do not always knock on the door before entering her room, stated staff also attempt to give her medications while she is sitting on the toilet. R38 further stated staff do not make her bed and when she was younger she was always taught to have a clean house and make your bed. R38 stated this was important to her as she likes to have her privacy and wishes respected. During observation on 3/10/21, at 8:00 a.m. R38 had two signs on her door, one stated; "keep door closed", "please give resident her privacy" and "only come in for necessary task" and the other sign indicated "please knock and give me a minute to put on my shield and mask, thanks." During interview on 3/10/21, at 9:26 a.m. R38	F 550	that staff knocked on resident's door and resident told them to wait a minute as she was talking with someone, staff observed walking into room and wanting her to take medications, despite her asking them to wait. • Educated staff that was observed entering resident room without knocking. Actions taken to identify other potential residents having similar occurrences: • RCA completed. RCA: Staff did not comply with resident's request to wait for permission to answer. Will be discussed at facilities QAPI committee meeting 4/23/21 with interim administrator, DON, medical director and IDT. • Customer Service Interviews conducted with all residents regarding privacy, call light functions and placement, meal alternatives offered and clean/comfortable living environment Measures put in place to ensure deficient practice does not recur: • Re-education to staff regarding resident rights and standards of care by 4/23/21. • Discussed citation and proper process at Nurse's meeting on 4/6/21 • Continued Audits for knocking on doors prior to entering with permission (weekly x3, monthly x3) Effective implementation of actions will be monitored by: Results of these audits/interviews will be reviewed by the facility QAPI committee and they will make the decision if further	

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F 550	Continued From page 7 stated since state survey evaluators have arrived, staff have been good about making her bed and knocking on her door. In an interview on 3/10/21, at 1:27 p.m. nursing assistant (NA)-B stated R38 plays her music loud and when knocking on her door maybe she can't hear the knocking. NA-B stated she will peak her head in and ask to come in. NA-B stated R38 has a right to privacy and she respects that. During interview on 3/10/21, at 1:47 p.m. trained medication aide (TMA)-A stated all staff should be knocking before entering a resident's room as this is their home and they have a right to privacy. In an interview on 3/10/21, at 2:08 p.m. registered nurse (RN)-A stated she was unaware of staff just walking into R38's room and stated that it was unacceptable for staff to be walking into any resident's room without being invited to come in. RN-A stated this is the residents home and we should treat it as such and every resident is entitled to their privacy. During interview on 3/11/21, at 10:08 a.m. social worker stated R38 had reported on multiple occasions that her bed was left unmade which was very important to her and staff should respect this. Social worker stated she had addressed this concern with the unit manager. Social worker stated R38 had never came to her with concerns about staff not coming into her room. Social worker further stated that it is unacceptable for staff to barge into anyone's room without being let in as this is their home and they have a right to privacy. In a final interview on 3/11/21, at 11:58 a.m.	F 550	monitoring/audits are recommended. Those responsible to maintain compliance will be: The Director of Nursing or designee is responsible to maintain compliance. Completion date for certification purposes only is: 4/23/21	

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F 550	Continued From page 8 RN-A stated she spoke with R38 but R38 was unable to recall who the staff where that barged into her room or when this happened. RN-A further stated that they will be re-educating all staff about customer service as all residents have the right to privacy as this is their home. Resident's bill of rights "The right to privacy and the right to be treated with dignity."	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure call light was within reach for 1 of 1 (R36) residents reviewed for reasonable accommodations. Findings include: R36's face sheet dated 3/11/21, included diagnoses of myopathy (muscle disease resulting in weakness), colon cancer, hearing loss, anxiety, heart disease, chronic obstructive pulmonary disease (COPD) (progressive lung disease with shortness of breath and increased sputum production), and Alzheimer's disease. R36's quarterly minimum data set (MDS) dated 1/18/21, indicated moderate cognitive	F 558	It is the policy of Cassia (Elim Wellspring) to comply with (F558) To assure continued compliance, the following plan has been put into place; Residents has the rights reside and receive services in the facility with reasonable accommodations of resident needs and preferences except to do so would endanger the health or safety of resident or other residents. Regarding cited resident: Resident F36 Observed on 3/9/21 call light box was located on the floor between the bed and wall. No corded call light was found in room. • Updated Environmental Services	4/9/21

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F 558	Continued From page 9 impairment, able to understand others, make himself understood, and express his needs/wants. R36 was independent with bed mobility, transfers, dressing, ambulation with walker, and set up with food. R36 required assistance with grooming, toileting, and bathing. Review of R36's care plan dated 04/25/2017, indicated potential for falls related to history of falls, weakness, impaired mobility, incontinence, impaired cognition, medications and diagnosis of Alzheimer's and COPD. Call light was to be accessible and within reach whenever resident is was in own room. On 03/09/21, at 10:39 a.m. R36 stated he couldn't find his call light in his room. During an observation on 03/09/21, at 10:43 a.m. call light box was located on the floor between the bed and wall. No corded call light was found in the room. During an observation on 03/09/21, at 03:20 p.m. R36 call light box remained on the floor between the bed and wall. No corded call light was found in the room. During observation and interview on 03/10/21, at 09:40 a.m. call light box remained on the floor. R36 stated he could not find his call light. On 03/10/21, at 10:34 a.m. nursing assistant (NA) -C confirmed call light on the floor between wall and bed. She stated the call light holder is zip tied to the far bed rail and sometimes the call light box slips off the holder. NA-C confirmed it was the only call light R36 has. Further, she confirmed it was normal for him to sit in his room with the door	F 558	• Environmental Services Director immediately programmed and installed a second call light stationary on his wall with a cord that will reach his chair & bed on 3/9/21 • Original call light transmitter at resident's desk, per resident preference. Actions taken to identify other potential residents having similar occurrences: • RCA completed. RCA: Call light with cord, not in room. Will be discussed at facilities QAPI committee meeting 4/23/21 with interim administrator, DON, medical director and IDT. • Customer Service Interviews conducted with all residents regarding privacy, call light functions and placement, meal alternatives offered and clean/comfortable living environment- Findings will be discussed at QAPI committee meeting 4/23/21 Measures put in place to ensure deficient practice does not recur: • Re-education to staff regarding standards of care by 4/23/21. • Discussed citation and proper process at Nurse's meeting on 4/6/21 • Continued Audits for Call Light within reach (weekly x3, monthly x3) Effective implementation of actions will be monitored by: Results of these audits/interviews will be reviewed by the facility QAPI committee and they will make the decision if further	

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F 558	Continued From page 10 shut. NA-C stated call light should be in reach at all times. On 03/10/21, at 10:45 a.m. licensed practical nurse (LPN)-C stated the call light should not be on floor, nor placed on the far side of bed and R36 should have an additional one with a cord coming from the wall. LPN-C placed the call light box on his desk. Her expectations were for call light to be in reach at all times. During observation and interview on 03/10/21, at 02:08 p.m. the call light box was located on far bed rail and there was no call light with cord on the wall. R36 stated he is not sure why it is back on the bed rail. On 03/11/21, at 09:44 a.m. LPN-C confirmed the call light box was back on R36's bed rail and there was no call light on the wall. On 03/11/21, at 10:38 a.m. director of nursing (DON) stated call lights must be in reach at all times. The facility policy with subject: "Call Lights," dated 12/9/19, indicated the call light must be accessible to the resident at all times when in resident room. Secure the call light to stay within access of the resident.	F 558	monitoring/audits are recommended. Those responsible to maintain compliance will be: The Environmental Services Director or designee is responsible to maintain compliance. Completion date for certification purposes only is: 4/23/21	
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)	F 561		4/9/21

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F 561	Continued From page 11 (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure residents had meal time requests fulfilled for 1 of 2 resident (R43) who requested an extra portion of meat at breakfast. Findings include: R43's undated face sheet identified diagnoses of essential hypertension (high blood pressure), gastro-esophageal reflux disease without esophagitis, anemia (low iron), dysphagia (difficulty swallowing), and abnormal weight loss. R43's significant change minimum data set dated	F 561	It is the policy of Cassia (Elim Wellspring) to comply with (F561) To assure continued compliance, the following plan has been put into place; Residents has the rights to make choices about aspects of his or her life in the facility which are significant to the resident. Regarding cited resident: Resident R43 on 3/9/21 it was observed that asked dietary aide for an extra piece of sausage and the dietary aide stated that there were no sausages left.	

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F 561	Continued From page 12 2/23/21, identified severe cognitive impairment and was dependent on one assist with transfers and bed mobility. R43's nutritional assessment dated 2/23/21, indicated R43's weight is 96.4 lbs., received 4 ounces house supplements twice daily, 440 kilocalorie and 12 grams of protein daily with an average food intake of 50-100%; no changes were recommended but were to continue to monitor due to risk related to variable intake and history of significant weight loss. R43's care plan dated 2/23/21, nutritional/fluid intake appears inadequate to meet nutrition needs as evidenced by variable food/fluid intake and significant weight loss with intervention of regular diet, nutritional supplements twice daily, and monitor for high nutritional risk choices. On the morning of 3/9/21, a review of the facility's menu identified sausage as the breakfast meat being offered to the facility residents. During observation on 3/9/21, at 9:30 a.m. R43 asked dietary aide (DA)-A for an extra piece of sausage. DA-A stated that the kitchen only sends up one serving of meat per resident and she did not have any left. In an interview on 3/10/21, at 9:19 a.m. nursing assistant (NA)-A stated that all residents have the right to ask for seconds and if it wasn't in their diet they would discuss risk verse benefits, however they have the right to have what they want. NA-A stated they are monitoring R43's weight and stated if R43 asked for more meat she should have received it.	F 561	• Educated staff involved to policies regarding preferences and meal accommodations Actions taken to identify other potential residents having similar occurrences: • RCA completed. RCA: Staff did not comply with offering substitutions when a food was all gone. Will be discussed at facilities QAPI committee meeting 4/23/21 with interim administrator, DON, medical director and IDT. • Customer Service Interviews conducted with all residents regarding privacy, call light functions and placement, meal alternatives offered and clean/comfortable living environment Measures put in place to ensure deficient practice does not recur: • Re-education to staff regarding resident rights and standards of care by 4/23/21. • Re-education to dietary staff regarding dining room service on 3/29/21. • Discussed citation and proper process at Nurse's meeting on 4/6/21 • Continued Audits on meal accommodations of needs/preferences (weekly x3, monthly x3) Effective implementation of actions will be monitored by: Results of these audits will be reviewed by the facility QAPI committee and they will make the decision if further monitoring/audits are recommended. Those responsible to maintain compliance	

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	245494	A. BUILDING _____ B. WING _____	C 03/11/2021

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F 561	Continued From page 13 During interview on 3/10/21, at 9:21 a.m. DA-B stated that if a resident asked for extra food and she didn't have extra, she would call either the kitchen or another unit to see if they had extra meat. DA-B stated R43 should have received the extra piece of meat. In an interview on 3/10/21, at 1:39 p.m. trained medication aide (TMA)-A stated they are monitoring R43 for weight loss and she is currently getting nutritional supplements. TMA-A stated if R43 requested more protein at a meal, she should have received, it as it is good for her muscle strength, weight management, and she usually doesn't eat much. During interview on 3/10/21, at 2:03 p.m. registered nurses (RN)-B stated R43 had weekly weights to monitor weight management. RN-B stated it is important for R43 to have protein in her diet to protect her fragile skin and bone healing as she had a previous humerus fracture. RN-B further stated the staff should have called down and got her extra meat if that is what she requested. An interview on 3/11/21, at 9:38 a.m. Food service director stated any resident who requested extra protein should of received it, as staff are allowed to call down to either the kitchen or another unit to obtain more. Food service director added, that it was not ok for a resident to not get this request met, as this was their home. During interview on 3/11/21, at 10:53 a.m. DA-A stated she could have called down to the kitchen to get more sausage or to ask another co-worker if they had extra, but stated that she just didn't. DA-A stated that they are monitoring R43 for past	F 561	will be: The Director of Nursing or designee is responsible to maintain compliance. Completion date for certification purposes only is: 4/23/21	

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F 561	Continued From page 14 weight loss and it would be beneficial for her to have the extra protein. In a further interview on 3/10/21, at 2:30 p.m. RN-A stated any resident should receive seconds for meals as this is their home and we try to accommodate their needs. RN-A stated if a resident requested extras, they should call the kitchen to see if they are able to send up more. R43 had a fractured humerus and is currently being monitored for weight loss. Policy??	F 561		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584		4/9/21

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F 584	Continued From page 15 §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a clean and comfortable living environment that were free from urine odors for 1 of 1 (R26) resident reviewed for environmental concerns. Findings include: R26's face sheet dated 3/11/21, included diagnoses of myopathy (muscle disease resulting in weakness), Alzheimer's, anxiety, obstructive and reflux uropathy (inability of urine to drain through the urinary tract), pain, weakness, and history of brain cancer. R26's significant change of status minimum data set (MDS) dated 12/18/20, indicated she was able to understand others and usually make herself understood. R26 required extensive assistance with bed mobility, transfers, dressing,	F 584	It is the policy of Cassia (Elim Wellspring) to comply with (F584) To assure continued compliance, the following plan has been put into place; Residents has the rights to a safe, clean & comfortable homelike environment including but not limited to receiving treatment and supports for daily living safely. Regarding cited resident: Resident R26 on 3/9/21 R26□s room had a very strong urine odor. "RCA completed. RCA: Identified personal belonging: wooden television stand to be the object of urine smell due to catheter leg bag overnight storage. "Removed television stand with family permission, to dispose. Leg bag new storage location in a plastic basin in the closet.	

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F 584	Continued From page 16 locomotion, eating, bathing, and grooming. Wheelchair was used for mobility. R26's BIMS (cognitive assessment) was not scored. R26's care plan dated 08/09/2018, indicated alteration in bladder elimination due to diagnosis of obstructive uropathy with Foley catheter in place. R26 had impaired mobility, and cognition, and was weak/frail. Catheter care will be performed per facility protocol. Staff to empty Foley bag every shift. During observation on 03/09/21, at 4:18 p.m. R26's room and bathroom had a very strong urine odor. During observation on 03/10/21, at 9:02 a.m. R26's room and bathroom continued to have a strong urine odor. During observation and interview on 03/10/21, at 09:16 a.m. nursing assistant (NA)-E confirmed strong urine odor in R26's room. She stated the night shift washed out leg bags and kept them in the TV cabinet. NA-E stated R26's urine drainage bag was left open and leaked onto the floor two times on the night shift over the last week or two. NA-E stated she reported it but nothing had happened. Further, NA-E confirmed a new air freshener was placed in R26's room. On 03/10/21, at 09:34 a.m. Licensed Practical Nurse (LPN)-B confirmed strong urine odor in R26's room. During observation and interview on 03/10/21, at 09:42 a.m. (LPN)-C confirmed strong urine odor in R26's room. She confirmed R26 had a catheter bag and wondered if staff possibly had dribbled it	F 584	Maintenance notified 3/9/21 and took action immediately to clean room and eliminate odors with floor cleaner. Will be discussed at facilities QAPI committee meeting 4/23/21 with interim administrator, DON, medical director and IDT. Actions taken to identify other potential residents having similar occurrences: "Whole house audit completed on 4/7/21 to confirm there were no other issues related to foul odors. "Customer Service Interviews conducted with all residents regarding privacy, call light functions and placement, meal alternatives offered and clean/comfortable living environment. "Maintenance Care work request App system used to place work orders for staff to communicate maintenance and cleaning requests. Training provided to staff to use Maint. Care App to report urine odors. Floor care staff to record in Maint. Care App. floor care completed. Measures put in place to ensure deficient practice does not recur: "Re-education to staff regarding resident clean environment: odor-free "Discussed citation and proper process at Nurse□s meeting on 4/6/21 "Continued Audits on odor-free/clean environment (weekly x3, monthly x3) "Discuss customer service interview/audit results	

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F 584	Continued From page 17 on the floor when they emptied it, stated it could be splash over. LPN-B was standing nearby and stated R26's urine had spilled on the floor last week on night shift. LPN-C confirmed air freshener in R26's room and stated it is not allowed in facility, it was a scent free facility. LPN-C removed the air freshener and stated she would contact housekeeping to clean the floor. On 03/10/21, at 10:10 a.m. Housekeeper (H)-B stated she was not sure when R26's room was cleaned last and confirmed the urine odor. H-B stated Maintenance (M)-A was her supervisor and he had the log of when the rooms were cleaned last. She stated she would have another housekeeper come to clean R26's room as soon as possible. She stated she did not receive any communication about R26's room needing any special attention due to odor. During observation on 03/10/21, at 10:37 a.m. housekeeping staff mopped R26's room. During observation on 03/10/21, at 02:07 p.m. R26's room remained odorous of urine. On 03/11/21, at 09:30 a.m. M-A stated every resident room was cleaned weekly and as needed. He stated if there was an area that needed extra attention, any staff person could put in a work order, or just mention it as they walked by. Work orders were done through computer or iPhone app. M-A stated for cleaning urine areas, they used Clorox Disinfecting Bio Stain and Odor to spot clean or oxy clean/shampooing product for carpet cleaning. He stated for hard surface floors they would use the heavy duty floor cleaner machine, and use Diversey cleaning product. M-A stated no work order had been put in for R26's	F 584	Effective implementation of actions will be monitored by: Results of these audits will be reviewed by the facility QAPI committee and they will make the decision if further monitoring/audits are recommended. Those responsible to maintain compliance will be: The Director of Nursing or designee is responsible to maintain compliance. Completion date for certification purposes only is: 4/23/21	

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F 584	Continued From page 18	F 584		

room to address the floor or urine odor. He stated M-B operates the floor cleaner.

During observation and interview on 03/11/21, at 09:39 a.m. LPN-C stated she believed urine odor was coming from the TV stand, where the rinsed leg bags had been stored until the end of last year (R26 no longer required leg bags since she started on hospice in December). She had called R26's daughter today and received permission to remove the stand and replace it with a new one. After further discussion with LPN-C the observation was made that the urine odor remained even after the stand replacement. LPN-C then discussed the urine spillage on the floor, and stated the mopping should take care of that, and if it didn't, then the floor would have to be replaced.

On 03/11/21, at 10:38 a.m. director of nursing (DON) stated if urine odor was found in a resident room, staff was to investigate and find the source, making sure it was not a hygienic issue. DON went on to state regarding R26's, they had believed the urine odor had been coming from R26's TV stand, stating she could not imagine it would be coming from anywhere else. DON confirmed that there was a urine spill in R26's room previously. She stated R26's room was deep cleaned twice since the spill with a specialized floor cleaner and had just confirmed this with M-A. DON stated she was not certain when this was done and was not sure it was in the computer. She stated M-B was the one that did the floor care, staff did spot cleaning, and housekeeping mopped weekly. DON confirmed work orders were done in the computer by any staff.

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F 584	Continued From page 19 No work order was able to be provided upon request. The facility policy with subject "Cleaning a resident room," dated 12/20, indicated resident rooms will be cleaned per facility determined schedule. Further, the resident rooms are to be dry dusted and mopped Monday through Friday, and every bathroom was to be cleaned thoroughly and damp mopped daily.	F 584		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to reassess the resident's ability to utilize the standing lift for transfers for 1 of 1 residents (R62) observed to be transferred unsafely in a standing lift. Findings include: R62's face sheet dated 3/13/21, identified diagnoses hemiplegia and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke) affecting left dominant side, osteoarthritis right shoulder, chronic pain, and muscle weakness.	F 689	It is the policy of Cassia (Elim Wellspring) to comply with (F689) To assure continued compliance, the following plan has been put into place; Residents has the rights to be free of accident hazards/supervision/devices. Regarding cited resident: Resident R62 on 3/10/21 NAR placed sit to stand lift in front of resident and resident was unable to safely transfer appropriately between surfaces. • Physical Therapy referral and assessment for safe transfer with Stand Up mechanical lift	4/9/21

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F 689	Continued From page 20 R62's annual minimum data set (MDS) dated 2/16/21, identified R62 with severe impaired cognition, extensive assistance needed with bed mobility, transfers, locomotion on and off the unit, dressing, toileting, and personal hygiene. R62's care area assessment summary (CAA) dated 2/25/21, identified falls triggered due to balance impairment, non-ambulatory, all transfers are not steady and only able to stabilize with human assistance. Potential for falls r/t (related to) impaired mobility secondary to CVA (stroke) with left sided hemiparesis, weakness, medications, incontinence, and diagnoses of osteoarthritis, HTN (high blood pressure), and myalgia (muscle pain). R62's care plan dated 2/15/21, identified physical mobility as a problem r/t weakness, pain, medications, and impaired mobility secondary to CVA with left-sided hemiparesis affecting left dominant side, pain, osteoarthritis, and medications. Goal identified as upon therapy completion, R62 will require partial/moderate assist with sit to stand, chair/chair-to bed transfer and toilet transfer. Approaches included assist of 2 with stand-up lift for transfers, A2 (assist of 2) for bed mobility. Bilateral grab bars to bed to assist with bed mobility and transfers. Monitor for safety, PRN (as needed) PT/OT (physical /occupational therapy) as ordered, encourage participation as able, monitor for changes in mobility. During an observation on 3/10/21, at 8:01 a.m. R62 sat on edge of bed. Nursing assistant (NA)-F placed sit-to-stand lift in front of R62. NA-H placed R62's hands on the padded handles, positioned lift belt around her upper body, placed	F 689	Actions taken to identify other potential residents having similar occurrences: • RCA completed. RCA: Staff did not ensure that transfer was safe. Staff transported lift with resident in it, instead of accommodating resident's safety. Will be discussed at facilities QAPI committee meeting 4/23/21 with interim administrator, DON, medical director and IDT. • Completed assessments on all residents that use standup mechanical lift; initiated on 3/16/21. Measures put in place to ensure deficient practice does not recur: • Re-education to nursing department staff regarding safe transfers with mechanical lifts by 4/23/21. • Discussed citation and proper process at Nurse's meeting on 4/6/21 • Re-education (Relias) to clinical staff with sit to stand competency. • In-person training with SMT (Lift Manufacturer company) 3/24/21. • Continued Audits on safe- mechanical lift transfers (weekly x3, monthly x3) Effective implementation of actions will be monitored by: Results of these audits will be reviewed by the facility QAPI committee and they will make the decision if further monitoring/audits are recommended. Those responsible to maintain compliance will be: The Director of Nursing or designee is	

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F 689	Continued From page 21 feet on the foot plate lower legs into the shin pad, and secured the shin straps around R62's lower legs. NA-F lifted R62 off the bed with the sit-to-stand lift. R62 held onto padded handles and NA-F wheeled her into the bathroom and lowered her down onto the toilet. At 8:07 a.m. NA-F raised R62 up off the toilet with the sit-to-stand lift. R62 struggled to hold herself up and started to loose strength and sat downward and backwards while attached to the sit-to-stand lift. R62 stated "it hurts it hurts I am going to fall." R62's arms and elbows raised upwards as she tried to hold herself up. NA-H stated many times "stand up honey" and "stand up [R62]." Facility staff did not physically assist R62. R62 could not support herself and hung from the stand lift with her bottom positioned lower than her knees. R62's eyes started to get big and R62 said "I cannot stand, it hurts it hurts!" R62's bottom remained lower than her knees, staff applied the brief and pulled up her pants as R62 let go of her left hand from the gripper and stated "I cannot . . . I cannot stand" and sat further down while attached to the stand lift. NA-H placed R62's hand back onto the gripper and stated you really need to hang on here. NA-F and NA-H rushed R62 out of the bathroom and bumped R62's left elbow on the doorway. R62 stated "ouch" and NA-F quickly pushed R62 to the wheel chair (w/c) located in her room. NA-F lowered R62 down onto the w/c, released shin straps from lower legs, removed loop straps from the lift, and belt from R62's upper body. During a subsequent observation on 3/10/21, at 9:23 a.m. R62 requested to go to bathroom. NA-H pushed a sit-to-stand lift and licensed practical nurse (LPN)-G pushed R62 in w/c into her room. NA-H placed the sit-to-stand lift in front	F 689	responsible to maintain compliance. Completion date for certification purposes only is: 4/23/21	

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F 689	Continued From page 22	F 689		

of R62 (the same lift used on the previous observation). LPN-G fastened the shin straps around R39's lower legs and top harness around her upper body and tightened the loose strap. NA-H and LPN-D attached the first set of harness loops to the sit-to-stand lift. R62's arms and shoulders went upwards and she stated "ouch ouch." LPN-D stated the lift arm needed to be lowered down more. NA-H lowered the lift arm down. LPN-D attached the second set of harness loops to the sit-to-stand lift and placed R62's hands on the padded handles. NA-H raised R62 up to a standing position. R62 held herself up through the transfer to the bathroom and until NA-H lowered her onto the toilet. LPN-D exited the room and NA-F entered the room. At 9:30 a.m. NA-H placed R62's hands on padded handles and instructed F62 to hold on tight. NA-F wiped R62's perineal area from front to back. NA-F encouraged R62 to use her legs. R62 slowly lowered herself downwards in a sitting position still attached to the sit-to-stand lift and stated "I can't hold on." NA-F placed a clean brief on her and pulled up her pants quickly as resident sat lower and her bottom hung just above her knees. NA-F stated "hold on [R62]". R62 then attempted to stand. R62's bottom continued to hang down just above her knees while staff quickly wheeled/rushed her from the bathroom to her w/c located in her room. R62's bottom touched the wheelchair seat. NA-F grabbed hold of the R62's pants and lifted her bottom up onto the w/c seat. NA-H lowered her down onto the w/c. Staff removed the loops from the sit-to-stand lift, shin pad straps, the top harness around R62's upper body, and placed a lap blanket across her.

During an interview on 3/10/21, at 11:43 a.m. NA-G stated R62 sometimes held on to the

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F 689	Continued From page 23	F 689		

padded handles when she used the stand lift but it depended on how she was doing in the morning. NA-G indicated she had informed a staff nurse R62 did not transfer safely at times. NA-G did not identify she reported the previous unsafe transfer observed on 3/10/21, at 8:01 a.m.

During an interview on 3/10/21, at 11:58 a.m. NA-F indicated she charted R62 transfers had been unsafe and worse since she had a stroke and COVID the last two months. NA-F stated she's unaware of any assessment that had been done. NA-F indicated R62 let go of the padded handles and lost her strength in her legs during the transfer that morning. NA-F stated she was really afraid she was going to fall. NA-F also indicated R62 should have been lowered back onto the toilet to prevent a fall. NA-F indicated R62 should have been transferred back to the w/c a different way instead to help prevent a fall.

R62's medical record lacked any evidence R62's mechanical lift transfer had been reassessed within the last two months, related to unsafe transfers.

During an interview on 3/10/21, at 12:47 p.m. NA-H stated the R62's transfer with the sit-to-stand lift earlier today was "nerve racking." R62 should have been placed back onto the toilet to prevent a fall and then staff figure out what to do from there. NA-H indicated the staff nurse LPN-B was notified.

During an interview on 3/10/21, at 3:19 p.m. RN-C stated the nursing assistant 24 hour report sheets are used by staff to communicate to each other and the staff nurse reviews them to assure the information was passed on. R62 used the

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sit-to-stand lift and when it was unsafe staff should have placed her back onto the toilet and used a 4 point lift instead to safely transfer. Those 2 transfers on 3/10/21 were not safe and when staff saw it the first time they should have used the Hoyer lift the next time. RN-C identified PT and OT had not re-evaluated R62. RN-C indicated she had not been informed of the unsafe transfers.

During an interview on 3/10/21, at 3:41 p.m. LPN-B stated staff informed her R62's transfer the morning of 3/10/21, was difficult from the bathroom to the w/c. LPN-B indicated she informed staff they should have used the sit-to-stand lift. LPN-B also indicated there was some miscommunication with staff. LPN-B indicated R62 should have been lowered back onto the toilet when she let go of the padded handles. LPN-B stated R62 has had many events lately such as COVID, hospitalization, and the unexpected death of her son. LPN-B stated it is unsafe for R62 to use the sit-to-stand lift and when staff saw it was not safe the first time they should have used the 4 point (total lift) next time.

During an interview on 3/11/21, at 8:15 a.m. PT-D indicated R62 had just been re-evaluated for transfers (3/11/21), following concerns related to unsafe transfer on 3/10/21). R62 stood 1 1/2 minutes then her bottom started to sink and put it back up to stand another 30 seconds for a total of 2 minutes. PT-D identified R62 held on to the paddled handles during the transfer. PT-D stated R62 could use the 2 point sit-to-stand lift but if unable R62 would benefit from the use of the 4 point (total lift).

During an interview on 3/11/21, at 8:20 a.m.

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F 689	Continued From page 25	F 689		

occupational therapist (OT)-E stated R62 was able to stand 4 minutes in December (2020) and January (2021). R62 stood up, pivoted and transferred with a walker January (2021). OT-E also stated R62 would vary on her ability to stand depending on the day. OT-E indicated staff should be aware and know when it is unsafe to transfer R62 with the sit-to-stand lift and use the 4 point lift instead. OT-E stated we expect staff to report issues if they noticed a change in a resident.

During a follow-up interview on 3/11/21, at 8:50 a.m. NA-G stated R62 had the same difficulty with a transfer about one week ago. NA-G indicated yesterday (3/10/21) was the second time R62 have trouble with a transfer. NA-G stated I told another staff member one week ago R62 let go of the padded handles while standing in the lift.

During a follow-up interview on 03/11/21 at 9:41 a.m. NA-F indicated the beginning of January 2021, R62 pivoted once she stood up without the sit-to-stand lift and the beginning of February 2021, R62 used only the sit-to-stand lift. NA-F identified R62 let go many times of the paddled handles during the sit-to-stand transfer on 3/10/21. NA-F stated she worried R62 would fall and should have indicated this on the nursing assistant 24 hour report sheet for that day. NA-F indicated immediately after the sit-to-stand transfer with R62 on 3/10/21 at 8:01 a.m., she notified LPN-B. NA-F stated LPN-B asked if the stand up lift was used and NA-F replied yes. NA-F indicated LPN-B did not recommend anything different be done regarding the transfer.

The facility policy Sit-to-Stand revised 1/3/20,

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F 689	Continued From page 26 identified residents who use a sit-to-stand lift must be able to bear some of their weight. Position the resident's arms on the outside of the harness and place their hands on the padded handles. Take the hand control and stand beside the resident. Press the up button until there is slight tension on the harness loops. Perform safety check.	F 689		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 761		4/9/21

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F 761	Continued From page 27 Based on observation, interview and document review, the facility failed to ensure open vials of tuberculin identified as expired, were discarded according to manufactuers recommendations. This had the potential to affect the 15 residents whom were admitted after the tuberculin had expired. Findings include: During observation on 3/10/21, at 10:46 a.m. with licensed practical nurse (LPN)-A noted there were two open vials: 1st vial was opened 1/25/2021- lot 346607 10354825420034202310 4014 which had a manufacturer's expiration date of 2/2022 2nd vial was opened 1/21/21- lot 346607 114596070060 00342023104014 which had a manufacturer's expiration date of 2/2022. During interview on 3/10/21, at 10:46 a.m. LPN-A stated she thinks the vials are only good for 30 days but was not sure, adding she would call the pharmacy to find out. LPN-A stated she would go off the expiration date on the vial. LPN-A stated they are not currently administering TB tests on their floor at this time, but they may be using it on other floors. LPN-A then called the pharmacy and verified TB vials are only good for 30 days after being expired and stated she will dispose of these vials immediately. During interview on 3/10/21, at 11:10 a.m. LPN-B stated if she would give a TB test she would go off of the expiration date on the vial. LPN-B stated she would get the TB solution from 1st floor. During interview on 3/10/21, at 11:20 a.m. LPN-C	F 761	It is the policy of Cassia (Elim Wellspring) to comply with (F761) To assure continued compliance, the following plan has been put into place; Drugs and biologicals use the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory & cautionary instructions, and the expiration date when applicable. Regarding cited resident: No resident cited. Expired vial of Tuberculin identified in med room fridge. Actions taken to identify other potential residents having similar occurrences: • RCA completed. RCA: Expired vial of tuberculin (unused) found in med room fridge. Was not identified and disposed of. Will be discussed at facilities QAPI committee meeting 4/23/21 with interim administrator, DON, medical director and IDT. Measures put in place to ensure deficient practice does not recur: • Re-education to (licensed staff) regarding on medication storage and disposal & A&E pharmacy medication and expiration guidelines by 4/23/21. • Discussed citation and proper process at Nurse's meeting on 4/6/21 • Continued Audits on med rooms, med carts and medication storage (weekly x3, monthly x3) Effective implementation of actions will be monitored by:	

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F 761	Continued From page 28 stated they are still conducting tuberculin testing (TB) on the 2nd floor, but stated due to resident receiving the covid vaccination it is contraindicated at this time. LPN-C stated TB vials should be discarded after 30 days from opening as the medication is less effective after 30 days from opening. LPN-C stated they get all of their TB solution from down stairs on 1st floor. LPN-C stated no residents had recieved the TB test in the last 3 weeks from these vials. Form provided by LPN-C in regards to medication vial openings. A & E pharmacy-medication and expiration guidelines undated, "Tuberculin PPD, refrigerated expires 30 days after first use." Tuberculosis screening and prevention dated 10/26/18, indicated "All new admissions will receive a 2-step tuberculin skin test or a one time TB blood test unless contraindicated."	F 761	Results of these audits will be reviewed by the facility QAPI committee and they will make the decision if further monitoring/audits are recommended. Those responsible to maintain compliance will be: The Director of Nursing or designee is responsible to maintain compliance. Completion date for certification purposes only is: 4/23/21	
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain tub equipment in a safe operating condition, which had the potential to effect all 14 residents residing on the Skyview unit. Findings include: During observations of the Skyview Unit, on 3/10/21, at 10:08 a.m. the following	F 908	It is the policy of Cassia (Elim Wellspring) to comply with (F908) To assure continued compliance, the following plan has been put into place; Maintain all mechanical, electrical and patient care equipment in safe operating condition. Regarding cited resident: No resident cited. During observation of	4/9/21

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F 908	Continued From page 29 environmental concerns were noted: the bath tub (MasterCare brand) seat cushion had a worn vinyl and exposed foam to both front outer edge corners, along with cracked vinyl and exposed foam to the seams of the middle oval cutout section. In addition, the seat had approximately four inches of cracked vinyl and exposed foam to the left front edge. The leg rest cushion had numerous areas of cracked vinyl with exposed foam along the surface and sides. Many of the worn and cracked vinyl areas were jagged and had the potential to scratch a residents skin due to the rough edges. In an interview on 3/11/21, at 9:24 a.m. registered nurse (RN)-B stated, after she was shown the Skyview unit bath tub chair cushions and touched the cushions' surface, the cracked and worn areas on the cushions were "rough" and had the potential to "cut their [residents] skin," along with an additional statement that "bacteria could get in there [the cushions]." RN-B explained a maintenance request should be filled out due to the damaged chair cushions and risk of injury to the residents. Further, RN-B explained due to the nature of the tub chair cushions a sign should be put into place which indicated staff should not use the tub until it could be fixed. RN-B denied knowledge of the damaged cushions and had been unable to identify how long the cushions had been damaged; however, she stated she had felt the damage had been present "for some time" due to the nature of the damage. During interview on 3/11/21, at 10:11 a.m. trained medication aide (TMA)-A stated she had recently assisted staff with managing the tub door during a bath for R57; however, she had not visualized the tub chair at that time. TMA-A explained she would	F 908	Skyview unit, the bathtub seat cushion had a worn vinyl and exposed foam to both front outer edge corners along with cracked section. Actions taken to identify other potential residents having similar occurrences: • Whole house audit on spa/tub rooms • RCA completed. RCA: seat was compromised. • Ordered Neoprene (non-foam) seat on 3/11/21 • Ordered back up Neoprene seat to have on hand for immediate replacement if appropriate • Replaced compromised seat cushion on 3/15/21 • Will be discussed at facilities QAPI committee meeting 4/23/21 with interim administrator, DON, medical director and IDT. Measures put in place to ensure deficient practice does not recur: • Auditing mechanical & electrical patient care equipment for safety and compromise (weekly x3, monthly x3). • Discussed citation and proper process at Nurse’s meeting on 4/6/21 • Re-education to staff regarding on mechanical and equipment being in safe condition for use by 4/23/21. • Discuss audit findings at QAPI to determine if audits to need to be ongoing based off of data Effective implementation of actions will be monitored by:	

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F 908	Continued From page 30 have filled out a maintenance work order to have the chair cushions replaced or to have something placed over them to prevent the cushions from being sharp as there had been a potential to cause resident skin tears. Further, TMA-A explained the damaged cushions "could harbor microorganisms if they became wet." When interviewed on 3/11/21, at 2:36 p.m. nursing manager RN-A denied any knowledge of Skyview unit tub chair concerns. RN-A verbalized she expected staff to report any tub chair damage to maintenance. RN-A explained, after she was shown the Skyview unit bath tub chair cushions and touched the cushions' surface, the cushions should be replaced due to an infection control risk and due to the cracked vinyl having been "a little bit sharp." RN-A stated all surfaces need to be "cleanable" and "cannot be porous." RN-A had been unable to identify how long the cushions had been damaged; however, she stated the damage "did not happen overnight." RN-A denied knowledge of facility bath equipment audit processes. During the interview, RN-A filed a maintenance request to have the tub cushions replaced. During interview on 3/11/21, at 2:58 p.m. the plant operations director (POD) stated maintenance work orders were reviewed daily and prioritized based on fire, water, and resident safety hazards. The POD explained it should not take more then two days to fix a tub cushion if concerns were reported. During the interview, the POD reviewed the last 30 days of maintenance work orders for the Skyview tub chair in which he identified a work order had been placed that day by RN-A. The POD denied any other work orders had been submitted. Further, the POD denied knowledge of	F 908	Results of these audits will be reviewed by the facility QAPI committee and they will make the decision if further monitoring/audits are recommended. Those responsible to maintain compliance will be: The Environmental Services Director or designee is responsible to maintain compliance. Completion date for certification purposes only is: 4/23/21	

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F 908	Continued From page 31 concerns with the Skyview tub chair. After the POD visualized the tub chair cushions, he stated the seat and foot pads needed to be replaced. The POD felt the cushion damage had not "happened over night" and he would have expected to see a maintenance work order submitted prior to RN-A's. The POD denied maintenance staff performed routine audits on tub bathing equipment. Point of Care History reports, dated 2/11/21 through 3/11/21, identified R35 had received a tub bath on 3/7/21 and R57 had received a tub bath on 2/13/21 and 2/26/21. On 3/11/21, at 2:58 p.m. the Skyview unit tub room lacked any indication which alerted staff not to use the tub. A Reporting of Repairs Needed policy, dated 7/13/20, indicated staff were to immediately report any facility area that was in need of repair to maintenance or the environmental services department.	F 908		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 919	It is the policy of Cassia (Elim Wellspring)	4/9/21

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F 919	Continued From page 32 review the facility failed to ensure functional call lights for 1 of 11 Residents (R34) whom resided in the dementia unit. Findings include: R34's quarterly Minimum Data Set (MDS) dated 1/11/21, identified moderately impaired cognition, total dependence with transfers, extensive assistance with personal hygiene, toilet use, dressing, locomotion on and off the unit, and bed mobility, always incontinent of bladder and frequently incontinent of bowel. Further the MDS identified the following diagnoses hemiplegia (weakness on one side), diabetes mellitus, and left knee non-healing fracture, renal insufficiency. During an observation on 3/08/21, at 6:02 p.m. R34's call light did not function when checked. During an interview on 3/08/21, at 6:22 p.m. R34 stated she placed the call light on when she needed help with something and eventually the staff answered it. During an interview on 3/8/21, at 6:24 p.m. trained medication assistant (TMA)-C stated staff laid the the soft touch call light on R34's chest and she pushed it when she needed help. TMA-C pushed the soft touch call light and nothing happened. TMA-C verified the call light did not function properly. TMA-C stated maintenance was responsible to fix the call lights. CMA-A reported these findings immediately to the licensed practical nurse (LPN)-D. During an observation on 3/8/21, at 6:30 p.m. LPN-D entered R34's room and pressed the soft touch call light. LPN-D verified the call light	F 919	to comply with (F919) To assure continued compliance, the following plan has been put into place; Resident call system must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to staff members or to a centralized staff work area. Regarding cited resident: R34 during observation on 3/8/21 staff verified that the call light functioned intermittently. • Maintenance request submitted. • Call light box replaced immediately by maintenance. Actions taken to identify other potential residents having similar occurrences: • Whole house audit completed on 4/6/21 to ensure resident calls and nurse call system in working order • RCA completed. RCA: call light was only working intermittently. • Will be discussed at facilities QAPI committee meeting 4/23/21 with interim administrator, DON, medical director and IDT. Measures put in place to ensure deficient practice does not recur: • Auditing resident room call lights for proper functioning (weekly x3, monthly x3). • Discussed citation and proper process at Nurse's meeting on 4/6/21 • Re-education to (all) staff regarding	

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F 919	Continued From page 33 functioned properly however it turned off when the connection of the cord was moved around. LPN-D stated maintenance checked the call lights frequently. LPN-D also stated a call light maintenance report would be completed. During an observation on 3/09/21, at 08:49 a.m. the surveyor checked call light and verified it functioned properly. During an interview on 03/11/21, at 3:34 p.m. plant operations director (POD) stated he received an alert on a call light when batteries were low. POD also stated work orders received weekly are completed by staff when a call light did not function due to either a bad cord or a malfunctioning soft touch call light. POD verified R34's call light was a soft touch call light and POD would not know it did not function unless staff informed him. POD stated he received a maintenance report on R34's soft touch call light. POD failed to get 34's call light to function, removed it, and replaced it with a new one. During an interview on 03/11/21, at 3:44 p.m. director of nursing (DON) stated a call light report indicated staff tried the call light many times and it worked however, there is not way to immediately know when it did not work. Review of facility policy titled Call Lights last reviewed on 12/19/19 identified if call light is not working properly, notify maintenance immediately and provide alternative call light if indicated.	F 919	on proper functioning of call lights and to report any non-functioning call lights immediately. Education to be completed by 4/23/21. • Discuss audit findings at QAPI to determine if audits to need to be ongoing based off of data Effective implementation of actions will be monitored by: Results of these audits will be reviewed by the facility QAPI committee and they will make the decision if further monitoring/audits are recommended. Those responsible to maintain compliance will be: The Environmental Services Director or designee is responsible to maintain compliance. Completion date for certification purposes only is: 4/23/21	

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

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Elim Home Princeton 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. 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 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. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections	K 000		

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

Electronically Signed | 04/09/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245494	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/15/2021**

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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 description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The facility was inspected as one building: 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 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 105 beds and had a census of 77 at the time of the survey.	K 000		

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K 000	Continued From page 2 The requirement at 42 CFR Subpart 483.70(a) is NOT MET.	K 000		
K 353 SS=D	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 observation and staff interview, the facility failed to maintain the sprinkler system in accordance with the 2012 Life Safety Code (NFPA 101) and NFPA 25 The Standard for Testing and Maintenance of Sprinkler Systems, section 5.2.1.2 This deficient condition could cause the sprinkler system not to function properly and allow for the spread of fire. This could affect an undetermined amount of residents, staff and visitors.	K 353	Tag 0353 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.	4/9/21

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K 353	Continued From page 3 Findings include: On the facility tour between 8:00 AM to 12:30 PM on 03/15/2021 observations revealed: 1. Stored items within 18 inches of a sprinkler in the storage room 152 for physical therapy. 2. Stored items within 18 inches of a sprinkler in the storage room for activities. This deficient condition was confirmed by the Maintenance Engineer.	K 353	All storage rooms were assessed and any item stored closer than 18 inches to the ceiling were moved to meet compliance. All rooms were marked with a line with the appropriate storage height and will be monitored by the maintenance team weekly for the next 30 days and then monthly for the next 90 days. The audits will be documented and reviewed at the quarterly Quality Improvement Meeting to demonstrate compliance. Those responsible to maintain compliance will be: The Director of Environmental Services or designee is responsible to maintain compliance. Completion date for certification purposes only is: 4/23/21	
K 364 SS=F	Corridor - Openings CFR(s): NFPA 101 Corridor - Openings Transfer grilles are not used in corridor walls or doors. Auxiliary spaces that do not contain flammable or combustible materials are permitted to have louvers or be undercut. In other than smoke compartments containing patient sleeping rooms, miscellaneous openings are permitted in vision panels or doors, provided the openings per room do not exceed 20 square inches and are at or below half the distance from floor to ceiling. In sprinklered rooms, the openings per room do not exceed 80 square inches. Vision panels in corridor walls or doors shall be fixed window assemblies in approved frames. (In fully sprinklered smoke compartments, there are no restrictions in the area and fire resistance of	K 364		4/9/21

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K 364	Continued From page 4 glass and frames.) 18.3.6.5.1, 19.3.6.5.2, 8.3 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to control the openings in a corridor wall in accordance with the 2012 edition of the Life Safety Code (NFPA 101) section 19.3.6.4.1. This deficient practice could allow for smoke to enter the corridor and make it untenable, affecting the exiting of all residents and staff in the lower level. Findings include: On the facility tour between 8:00 AM to 12:30 PM on 03/15/2021 observations and staff interview revealed a corridor wall has a louvered transfer grill next to a storage room door on the first floor. This deficient condition was confirmed by the Maintenance Engineer.	K 364	K 0364 All items from room were removed to be in compliance until the room can be remodeled and appropriate for storage. The louvers will be removed from the wall so that the room is self-contained and no opening to the hallway. The hole will be replaced with appropriate construction for the finished wall. Those responsible to maintain compliance will be: The Director of Environmental Services or designee is responsible to maintain compliance. Completion date for certification purposes only is: 4/23/21	
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 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	K 712		4/9/21

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K 712	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide documentation of fire drills at least quarterly on each shift as required by the Life Safety Code (NFPA 101) 2012 edition, section 19.7.1.4 to 19.7.1.7. This deficient practice could reduce the ability of staff to conduct a safe and timely response to a fire emergency, which would affect all 105 residents and an undetermined amount of staff and visitors. Finding include: During documentation review between 8:00 AM to 12:30 PM on 03/15/2021, it was discovered the facility did not conduct a Night-shift fire drill in the second quarter of 2020. This deficient condition was confirmed by the Maintenance Engineer.	K 712	K 0712 The maintenance team is now using a corporate provided schedule for fire drills and will meet the regulation of one drill per shift per quarter. The safety committee will monitor monthly to ensure the compliance of fire drills. The documentation will be reviewed at the next quarterly Quality Improvement Meeting to demonstrate compliance with the Plan of correction. Those responsible to maintain compliance will be: The Director of Environmental Services or designee is responsible to maintain compliance. Completion date for certification purposes only is: 4/23/21	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised	K 918		4/9/21

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K 918	Continued From page 6 under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide test documentation in accordance with the 2012 edition of the Life Safety Code (NFPA 101) section 9.1.3.1 and the 2010 edition of NFPA 110 the Standard for Emergency and Standby Power Systems, section 8.4.1. This deficient practice could affect the safety of all 105 residents and an undetermined amount of staff and visitors if the generator failed to operate during a power outage. Findings include: During documentation review between 8:00 AM to 12:30 PM on 03/15/2021 record review and staff	K 918	K 0918 Weekly and Monthly generator inspections will be scheduled and documented by the maintenance team. Generator testing will be monitored by the safety committee at the monthly meeting. Documentation will be reviewed at the next quarterly Quality Improvement Meeting to demonstrate compliance with the Plan of correction. Those responsible to maintain compliance will be: The Director of Environmental Services or	

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K 918	Continued From page 7 interview revealed: 1) There were 46/52 of the weekly inspections completed within the calendar year at the time of the survey. 2) The monthly inspection records from March 2020 through March 2021 could not be located at the time of the survey. This deficient condition was confirmed by the Maintenance Engineer.	K 918	designee is responsible to maintain compliance. Completion date for certification purposes only is:4/23/21	