DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 9, 2022

Administrator
The Birches At Trillium Woods
14585 59th Avenue North
Plymouth, MN 55446

RE: CCN: 245627
Cycle Start Date: June 2, 2022

Dear Administrator:

On August 8, 2022, the Minnesota Department 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, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245627	A. BUILDING _____ B. WING _____	C 06/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BIRCHES AT TRILLIUM WOODS	14585 59TH AVENUE NORTH PLYMOUTH, MN 55446

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E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 5/31/22- 6/2/22, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 5/31/22-6/2/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be UNSUBSTANTIATED: H5627017C/MN80382, H5627018C /MN80923. AND The following complaints were found to be UNSUBSTANTIATED, however related deficiencies were cited. H56271905C/MN83311, with a deficiency cited at F609, F610. H5627019C/MN81108, with a deficiency cited at F609, F610. H5627020C /MN82078, with a deficiency cited at F610. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/01/2022

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

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F 000	Continued From page 1 at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified	F 609		6/29/22

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F 609	Continued From page 2 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure an allegation of abuse were reported to the State Agency (SA) immediately (within two hours) for 3 of 4 residents (R31, R34, R35) reviewed for abuse. Findings include: Resident #31 R31's quarterly Minimum Data Set (MDS) dated 5/4/22, indicated R31 had mild cognitive impairment and diagnoses of dementia with behavioral disturbances and anxiety. R31's care plan reviewed on 6/1/22, indicated R31 was vulnerable due to residing in a long-term care setting and diagnosis of dementia. During an interview on 5/31/22, at 3:10 p.m. R31 stated she was hit in the back by a staff member last week. R 31 further stated she told other staff about it, but nothing was done. During an interview on 5/31/22, at 3:18 p.m. the Administrator received the above allegation from the surveyor. The administrator further stated she was aware of R31 having increased behaviors recently but was not aware of R31's allegation of being hit by staff. The facility's Nursing Home Incident Report (NHIR) dated 5/31/22, indicated R31's allegation was reported to the SA on 5/31/22, at 8:32 p.m. This report was not made immediately (within 2 hours) of receiving R31's allegation of abuse.	F 609	Preparation and execution of this plan of correction in no way constitutes an admission or agreement by The Birches at Trillium Woods of the truth or the facts alleged in this statement of deficiency and plan of correction. In fact, this plan of correction is submitted exclusively to comply with state and federal law. The Birches at Trillium Woods reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts, and conclusions that form the basis of the stated deficiency. This plan of correction serves as the allegation of compliance. This statement of deficiencies will be taken to The Birches at Trillium Woods Quality Assurance Performance Improvement Committee on July 19, 2022. F609: Reporting Allegations of Violations How the nursing facility will correct the deficiency as it relates to the resident: 1. Resident R31, R34, and R35 did not suffer adverse effects from the practice. No residents suffered adverse effects from this practice. Facility updated policy during survey to reflect abuse reporting within 2 hours of abuse. All staff were educated on this requirement. Facility to provide investigation summary results to State Survey Agency within five working days of the reported incident.	

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F 609	Continued From page 3 Resident #34 R34's admission Minimum Data Set (MDS) dated 2/16/22, indicated R34 had moderate cognitive impairment and diagnoses of hemiplegia following cerebral infarction affecting the left nondominant side. R34's care plan reviewed on 6/2/22, indicated R34 was vulnerable due to residing in a long-term care setting. The facility's Nursing Home Incident Report (NHIR) dated 2/16/22, indicated R34's family member (FM)-A reported the facility staff "forcibly changed [R34]" to the social worker (SW)-A on 2/16/22 at 10:30 a.m. The SW-A spoke with R34 immediately after speaking with FM-A when R34 reported the allegations of the alleged perpetrator "molested me", "touched me and I didn't like it", it "mentally hurt", and "I felt violated" and the alleged perpetrator put a "diaper" on [R34] and wasn't allowed to go to the bathroom. However, the facility reported to the SA on 2/16/22, at 3:14 p.m. This report was not made immediately (within 2 hours) of receiving R34's allegation of abuse. Resident #35 R35's admission Minimum Data Set (MDS) dated 4/26/22, indicated R35 was cognitively intact and diagnoses of dementia without behavioral disturbance. Further, indicated R35 had no hallucinations or delusions. R35's care plan reviewed on 6/2/22, indicated R35 was vulnerable due to residing in a long-term care setting.	F 609	How the nursing facility will identify other residents having the potential to be affected by the same practice: 1. All residents have the potential to be affected by this practice. No residents have been noted to be adversely affected by reporting outside of timely reporting. 2. All staff were immediately reeducated on the timing of reporting of abuse. Measures the nursing home will put in place or systematic changes made sure to ensure the practice will not reoccur: 1. Signage updated to reflect corrected timeframe. 2. Education of all staff. 3. The Birches has implemented the new policy with updated timeframes for abuse reporting upon identification of alleged deficient practice during survey. How does the nursing home plan to monitor its performance to make sure that solutions are sustained? 1. The Administrator or Designee will report timely any abuse. Reeducation will be done with any individual that reports outside of the timeframe. Compliance with timeframes of reporting of abuse incidents will be brought to QAPI. This audit will be brought to QAPI for the next six months to ensure compliance. Information from the audits will be reviewed monthly at our Quality Assurance Performance Improvement meetings. 2. The Director of Nursing or Designee will conduct random staff interviews to ensure proper reporting timeframes are	

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F 609	Continued From page 4 The facility's Nursing Home Incident Report (NHIR) dated 5/6/22, indicated R35's allegation of a facility staff member stating "shut up" to R35 was reported to SW-A on 5/5/22, at 10:00 a.m. However, the facility reported to the SA on 5/6/22, at 9:53 a.m. This report was not made immediately (within 2 hours) of receiving R35's allegation of abuse. During an interview on 6/1/22, at 4:11 p.m. the director of nursing (DON) stated staff followed the facility policy when reporting allegations of abuse. DON expected staff to report any allegations to the Administrator or herself immediately and then the facility had 2 hours to report to the SA if abuse was determined or if the resident had serious bodily harm. During interview on 6/1/22, 4:13 p.m. the director of nursing (DON) verified the allegation of R35 stating NA-D told R35 to "shut up" was verbal abuse and should have been reported within two hours. During an interview on 6/1/22, at 5:08 p.m. Administrator stated allegations of abuse are reported within 2 hours if there was serious bodily injury, otherwise allegations were reported within 24 hours. The Administrator expected staff to report allegations right away. Administrator further stated a report of staff hitting a resident was considered physical abuse and had to be reported within 24 hours if there was no serious bodily harm. During an interview on 6/2/22, at 3:04 p.m. Administrator acknowledged the facility policy had an addendum reflecting federal regulations and	F 609	mentioned. Audits will occur weekly over the next six weeks and then monthly for the following six months. Compliance with the timeframes from the audits will be brought to QAPI. The audit will be brought to QAPI for the next 6 months. Information from the audits will be reviewed monthly at our Quality Assurance Performance Improvement meetings. Date of policy updated: June 1, 2022. Dates when signage and staff education was completed: June 1, 2022 for all staff onsite and ongoing for staff not onsite. All employee OneCall message (by phone/email) reminder sent again on June 29, 2022. Follow up audits will be ongoing per the above schedule. Title of the person responsible to ensure correction: Administrator, Director of Nursing, or Designee	

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F 609	Continued From page 5 reporting but acknowledged that time frame had not been followed. Administrator further stated policy revision and staff education had been started. The Trillium Woods Elder Justice Act policy dated August 2019, indicated an event suspicion resulting in serious bodily injury, the individual shall report the suspicion within two hours of forming a suspicion. If the event causing the suspicion does not result in serious bodily injury, the individual shall report the suspicion in 24 hours of forming a suspicion.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately put measures in	F 610	F610: Investigate/Prevent/Correct Alleged Violation	6/30/22

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F 610	Continued From page 6 place to prevent further potential abuse while the investigation was in process for 3 of 4 residents (R3, R34, R35) reviewed for abuse. Furthermore, the facility failed to thoroughly investigate an allegation of abuse for 1 of 4 residents (R34) reviewed for abuse. Findings include: Resident #3 R3's quarterly Minimum Data Set (MDS) dated 5/11/22, indicated R3 was cognitively intact and had diagnoses of peripheral vascular disease and weakness. R3's care plan reviewed on 6/1/22, indicated R3 was a vulnerable adult due to residing in a long-term care facility. A Nursing Home Incident Report (NHIR) dated 3/22/22, indicated R3 reported to the facility nursing assistant (NA)-E stated R3 would be "moved down with the crazies". The report further stated NA-E was suspended and a facility investigation was initiated. The facility investigation file dated 3/22/22, indicated NA-E was not suspended during the investigation of R3's allegations. The investigation file indicated R3's allegation was reported on 3/22/22. NA-E and other resident interviews were not completed until 3/24/22. On 3/24/22, NA-E was instructed to continue work, but do not enter R3's room until the investigation was completed. During an interview on 5/31/22, at 12:49 p.m. R3 stated NA-E had told her she was going to put me	F 610	How the nursing facility will correct the deficiency as it relates to the resident: 1. Resident R31, R34, and R35 did not suffer adverse effects from the practice. No residents suffered adverse effects from this practice. Facility to remove the alleged abusive perpetrator from working pending investigation results. Facility to provide investigation summary results to MDH within five working days of the reported incident. How the nursing facility will identify other residents having the potential to be affected by the same practice: 1. All residents have the potential to be affected by this practice. No residents have been noted to be adversely affected by this practice. 2. Administrator or Designee to immediately remove alleged abusive perpetrator from working pending investigation. Facility to provide investigation summary results to State Survey Agency within five working days of the incident. Measures the nursing home will put in place or systematic changes made sure to ensure the practice will not reoccur: 1. All abuse files moving forward to include checklist of items including: alleged individual suspended/removed pending investigation, staff interviews, resident interviews, skin assessment (if applicable), and 5 day report filed. How does the nursing home plan to monitor its performance to make sure that	

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F 610	Continued From page 7 downstairs with the "crazies". R3 further stated she felt threatened, but also felt safe. R3 stated NA-E had not provided cares since then. During an interview on 6/1/22, at 10:30 a.m. NA-E stated there has been no contact with R3 for months. NA-E verified working during the timeframe of the investigation. NA-E further stated on 3/23/22, R3 "kicked" her out of R3's room when NA-E went in to provide cares. At that time, NA-E was not aware of any allegations R3 had made, and had not found out until 3/24/22, when interviewed by the Administrator. NA-E stated she was not suspended and was told the concern was not serious enough. During an interview on 6/1/22, at 4:25 p.m. the director of nursing (DON) stated it was standard procedure to suspend staff immediately from all residents until investigation can determine if allegation can be substantiated. During an interview on 6/1/22, at 5:15 p.m. the Administrator stated the facility always wanted to ensure resident safety when any allegation was made. The Administrator verified the timeline in the investigation file. The Administrator stated R3 was ok with NA-E providing cares if NA-E "kept her mouth shut" on 3/22/22, and that was likely the reason NA-E was not suspended. The Administrator acknowledged there was a gap of time between when the allegation was known and when NA and other residents were interviewed and acknowledged NA-E should not have worked during that time. R34's admission Minimum Data Set (MDS) dated 2/16/22, indicated R34 had moderate cognitive impairment and diagnoses of hemiplegia following cerebral infarction affecting the left	F 610	solutions are sustained? 1. The Administrator or Designee will audit abuse files for completion, including: alleged individual suspended/removed pending investigation, staff interviews, resident interviews, skin assessment (if applicable), and 5 day report filed. 2. Abuse file audits will be brought to QAPI. The audit will be brought to QAPI for the next 6 months. Information from the audits will be reviewed monthly at our Quality Assurance Performance Improvement meetings. Dates of completion: 6/30/2022. Follow up audits will be ongoing per the above schedule. Title of the person responsible to ensure correction: Administrator, Director of Nursing, or Designee	

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F 610	Continued From page 8 nondominant side. R34's care plan reviewed on 6/2/22, indicated R34 was vulnerable due to residing in a long-term care setting. The facility's Nursing Home Incident Report (NHIR) dated 2/16/22, indicated R34's allegation was reported to the SA on 2/16/22, at 3:14 p.m. This report did not indicate R34 was protected from the alleged perpetrator during the investigation and did not reveal R34's complete allegation. A facility provided document titled "Time Detail", with a time period of 2/6/22 through 2/22/22, indicated the alleged perpetrator worked on 2/15/22 from 10:23 p.m. to 6:57 a.m., 2/16/22 from 10:23 p.m. to 7:16 a.m., and 2/18/22 from 10:23 p.m. to 6:59 a.m. A written statement (undated) from social worker (SW)-A, indicated on 2/16/22, R34 reported the alleged perpetrator "molested me", "touched me and I didn't like it", it "mentally hurt", and "I felt violated" when describing the night of the allegation. Further, R34 reported the alleged perpetrator put a "diaper" on [R34] and wasn't allowed to go to the bathroom. A written statement dated 2/17/22, nursing assistant (NA)-D indicated being busy and R34 kept calling so the "diaper" was placed for R34's safety. The statement did not address the complete allegation. A written statement dated 2/17/22, at 4:00 p.m. registered nurse (RN)-B indicated R34's family member (FM)-A reported placing a "diaper" on	F 610		

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F 610	Continued From page 9 R34 "scares" [R34] and should not have been placed on R34. The statement did not address the complete allegation. After reviewing the facility investigation file, no evidence was provided of protection of R34, other resident interviews, other staff interviews, no body assessment was completed, and no five-day investigative report. After reviewing the SA reporting system, no evidence was noted the facility had completed the investigation and filed a five day investigative report. R35's admission Minimum Data Set (MDS) dated 4/26/22, indicated R35 was cognitively intact and diagnoses of dementia without behavioral disturbance. Further, indicated R35 had no hallucinations or delusions. R35's care plan reviewed on 6/2/22, indicated R35 was vulnerable due to residing in a long-term care setting. Further, the care plan did not have any evidence of R35 making false allegations towards staff. The facility's Nursing Home Incident Report (NHIR) dated 5/6/22, indicated R35's allegation was reported to the SA on 5/6/22, at 9:53 a.m. The report indicated R35 reported to SW-A on 5/5/22, at 10:00 a.m. NA-D came into R35's room and told R35 to "shut up". The report further indicated NA-D was suspended during the investigation however, NA-D continued to work. A facility provided document titled "Time Detail", with a time period of 5/5/22 through 5/11/22,	F 610		

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F 610	Continued From page 10 indicated the alleged perpetrator worked on 5/6/22 from 10:27 p.m. to 7:00 a.m., 5/7/22 from 10:24 p.m. to 6:43 a.m., 5/9/22 from 10:24 p.m. to 7:02 p.m., and 5/10/22 from 10:27 p.m. to 7:02 a.m. The "Trillium Woods Investigation Statement" dated 5/6/22, indicated R35 reported to RN-C "no one can tell me to shut up" and informed RN-C "I don't want NA-D to take care of me". The facility investigation file did not have any evidence of RN-C reporting the allegation to a supervisor. During an interview on 6/1/22, 4:13 p.m. the director of nursing (DON) verified the allegation of R35 stating NA-D told R35 to "shut up" was verbal abuse. During an interview on 6/1/22, at 4:24 p.m. SW-A stated when R34 was reporting the allegations of the alleged perpetrator "molested me", "touched me and I didn't like it", it "mentally hurt", and "I felt violated" and the alleged perpetrator put a "diaper" on [R34] and wasn't allowed to go to the bathroom the thought process was R34 was expressing feeling forced to wear a "diaper". Further stated, "yes forcing a resident to do anything is abuse" however, SW-A stated being hesitant to call anything abuse since it's such a "bad statement". During an interview on 6/1/22, at 4:25 p.m. the DON stated it is the standard to suspend an alleged perpetrator until the facility decides the allegation can't be substantiated. Further, stated it is not a formal suspension but rather it's between me and the employee. The DON	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245627	A. BUILDING _____ B. WING _____	C 06/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BIRCHES AT TRILLIUM WOODS	14585 59TH AVENUE NORTH PLYMOUTH, MN 55446

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 610	Continued From page 11 verified the employee was able to work the same day for both allegations. The Trillium Woods Elder Justice Act policy dated August 2019, indicated employees of this community who have been accused of abuse, neglect, or mistreatment will be immediately suspended until the results of the investigation have been reviewed by the administrator or designee. Any incident or allegation involving abuse, neglect, or financial exploitation will result in an abuse investigation. The administrator or designee is responsible for submitting a final written report of the results of the investigation and of any corrective action taken to the Minnesota Department of Health (MDH) within five working days of the reported incident.	F 610		
F 730 SS=C	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete annual performance reviews for 3 of 5 nursing assistants (NA-A, NA-B, and NA-C) whose employee files were reviewed. This had the potential to affect all 32 residents who resided at the facility. Findings include:	F 730	F730 How the nursing home will correct the deficiency as it relates to the resident: 1. All residents did not experience adverse effects as a result of this practice. Employee reviews will be given to employees. How the nursing home will identify other	7/31/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 730	Continued From page 12 A facility provided document which was unnamed (undated) identified NA-A was hired on 4/25/2016, NA-B was hired on 1/25/2016, and NA-C was hired on 1/25/2016. Performance reviews were requested from the respective employee files of NA-A, NA-B, and NA-C, however, not provided by the facility. During an interview on 6/2/22, at 3:03 p.m. the director of nursing (DON) verified she did not complete staff performance evaluations in 2021/2022 for NA-A, NA-B, and NA-C. Further, The DON stated performance evaluations should had been completed annually for feedback to help with resident care. During an interview on 6/2/22, at 3:05 p.m. the administrator stated employee performance evaluations should be completed annually so the supervisor could give feedback on the employee's performance and the opportunity for the employee to provide feedback. An email dated 6/2/22, at 3:32 p.m. with the subject line "Performance Evals", indicated "Performance evaluations are conducted to ensure that you have a clear understanding of your job performance. During the evaluation process, your strengths, weaknesses, potential, and work quality will be identified. Performance evaluations are normally completed at the end of any introductory period and annually thereafter."	F 730	residents having the potential to be affected by the same practice: 1. The practice did not adversely impact residents. 2. All staff will be provided their annual reviews. Measures the nursing home will put in place or systematic changes made to ensure the practice will not reoccur: 1. The Birches re-educated supervisors and leaders of performance review due dates. How the nursing home plans to monitor performance to make sure that solutions are sustained: 1. The Human Resources Director, Administrator, Director of Nursing, or Designee will monitor compliance with this standard by employee. Reports of compliance will be brought to QAPI on a monthly basis for the next 3 months to ensure compliance. The audits will be reviewed monthly at our Quality Assurance Performance Improvement meetings. Dates when corrective action will be completed: 1. Re-education of directors was completed on June 29, 2022. Follow-up audits will be ongoing per the above schedule. Annual evaluations will be completed by July 31,2022. The title of the person responsible to ensure correction: Human Resources, Administrator, Director of Nursing, or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BIRCHES AT TRILLIUM WOODS	14585 59TH AVENUE NORTH PLYMOUTH, MN 55446

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F 730	Continued From page 13	F 730	Designee	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 9, 2022

Administrator
The Birches At Trillium Woods
14585 59th Avenue North
Plymouth, MN 55446

Re: Reinspection Results
Event ID: O1Y912

Dear Administrator:

On August 8, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 2, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Electronically delivered
June 24, 2022

Administrator
The Birches At Trillium Woods
14585 59th Avenue North
Plymouth, MN 55446

Re: State Nursing Home Licensing Orders
Event ID: O1Y911

Dear Administrator:

The above facility was surveyed on May 31, 2022 through June 2, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction

order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

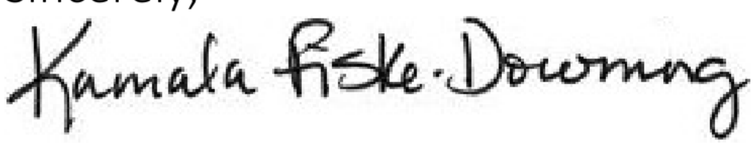
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Sarah Grebenc, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: sarah.grebenc@state.mn.us
Office: (651) 201-3792 Mobile (651)238-8786

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,



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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 9, 2022

CMS Certification Number (CCN): 245627

Administrator
The Birches At Trillium Woods
14585 59th Avenue North
Plymouth, MN 55446

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 June 30, 2022 the above facility is certified for:

44 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 44 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, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Electronically delivered
June 24, 2022

Administrator
The Birches At Trillium Woods
14585 59th Avenue North
Plymouth, MN 55446

RE: CCN: 245627
Cycle Start Date: June 2, 2022

Dear Administrator:

On June 2, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

DEPARTMENT CONTACT

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

Sarah Grebenc, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: sarah.grebenc@state.mn.us
Office: (651) 201-3792 Mobile (651)238-8786

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by September 2, 2022 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by December 2, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245627	A. BUILDING **01 - TRILLIUM WOODS** B. WING _____	**06/02/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE BIRCHES AT TRILLIUM WOODS	**14585 59TH AVENUE NORTH PLYMOUTH, MN 55446**

(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
K 000	INITIAL COMMENTS FIRE SAFETY An annual life safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 06/02/2022. At the time of this survey, The Birches At Trillium Woods was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/01/2022

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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THE BIRCHES AT TRILLIUM WOODS	**14585 59TH AVENUE NORTH PLYMOUTH, MN 55446**

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K 000	Continued From page 1	K 000		

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

By email to:
FM.HC.Inspections@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A detailed description of the corrective action taken or planned to correct the deficiency.

2. Address the measures that will be put in place to ensure the deficiency does not reoccur.

3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.

4. Identify who is responsible for the corrective actions and monitoring of compliance.

5. The actual or proposed date for completion of the remedy.

Trillium Woods is a 3-story building with a partial basement built of Type II(111) construction built in 2015. Each floor is divided into 2 smoke compartments by smoke barriers. The basement and first floor are separated from the rest of the campus by a 2 hour fire barrier.

The facility has a capacity of 44 beds and had a census of 32 at the time of the survey.

The requirements at 42 CFR, Subpart 483.70(a),

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	Continued From page 2 are NOT MET as evidenced by:	K 000		
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect their emergency lighting per NFPA 101 (2012 edition), Life Safety Code, section 7.9.3.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/02/2022 between 09:30 and 12:30, it was revealed by a review of available documentation that the facility did not have a current inspection for their emergency egress lighting. An interview with the Director of Plant Operations verified these deficient finding at the time of discovery.	K 291	Preparation and execution of this plan of correction in no way constitutes an admission or agreement by The Birches at Trillium Woods of the truth or the facts alleged in this statement of deficiency and plan of correction. In fact, this plan of correction is submitted exclusively to comply with state and federal law. The Birches at Trillium Woods reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts, and conclusions that form the basis of the stated deficiency. This plan of correction serves as the allegation of compliance. This statement of deficiencies will be taken to The Birches at Trillium Woods Quality Assurance Performance Improvement Committee on July 19, 2022. K291 (SS=F) – Emergency Lighting 1. A detailed description of the corrective action taken or planned to correct the deficiency. The Birches at Trillium Woods tested emergency lighting of at least 1-1/2 hour duration on the date of June 3, 2022.	6/3/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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THE BIRCHES AT TRILLIUM WOODS	**14585 59TH AVENUE NORTH PLYMOUTH, MN 55446**

(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
K 291	Continued From page 3	K 291	2. How the facility will identify other residents who have the potential to be affected by the same deficient practice. All residents have the potential to be affected; no adverse events occurred as a result of this practice. 3. Address the measures that will be put in place to ensure the deficiency does not reoccur. The facility will add emergency lighting to the routine maintenance schedule. 4. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. The facility will bring results of the emergency lighting testing to the next Quality Assurance Performance Improvement. The facility will audit monthly and provide audit results to QAPI for the next 6 months or longer if non-compliance is noted. The facility will add the emergency lighting testing to the reoccurring routine work orders system to populate monthly including the annual to be performed in the Month of June. 5. Identify who is responsible for the corrective actions and monitoring of compliance. Director of Plant Operations, Maintenance Supervisor, or Designee. 6. The actual or proposed date for completion of the remedy. June 3, 2022; re-occurring work order entered in the work order system.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245627	A. BUILDING **01 - TRILLIUM WOODS** B. WING _____	**06/02/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 914	Continued From page 4	K 914		
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct the electrical receptacle testing and maintenance at resident bed locations per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.3.4.1.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 06/02/2022, between 09:30 AM and 12:30	K 914	K914 (SS=F) □ Electrical Systems □ Maintenance and Testing 1. A detailed description of the corrective action taken or planned to correct the deficiency. The Birches at Trillium Woods tested electrical receptacles on June 4th, 2022. 2. How the facility will identify other residents who have the potential to be affected by the same deficient practice.	6/4/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245627	A. BUILDING **01 - TRILLIUM WOODS** B. WING _____	**06/02/2022**

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K 914	Continued From page 5 PM, it was revealed by a review of available documentation that the required annual receptacle inspection documentation was not current at the time of the survey. An interview with the Director of Plant Operations verified this deficient finding at the time of discovery.	K 914	All residents in the community had the potential to be affected. No residents experienced adverse events as a result of this practice. 3. Address the measures that will be put in place to ensure the deficiency does not reoccur. The Birches at Trillium Woods added receptacle testing to the routine maintenance schedule. 4. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Documentation will be reviewed at the next Quality Assurance Performance Improvement meeting. The facility will add the receptacle testing to reoccurring the routine work orders system to populate annually in the Month of June. 5. Identify who is responsible for the corrective actions and monitoring of compliance. Director of Plant Operations, Maintenance Supervisor, or Designee. 6. Date it will be corrected June 4th, 2022; re-occurring work order entered in the work order system.	