



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
July 19, 2022

Administrator
Elim Wellspring
701 First Street
Princeton, MN 55371

RE: CCN: 245494
Cycle Start Date: May 31, 2022

Dear Administrator:

On July 12, 2022, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads '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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 13, 2022

Administrator
Elim Wellspring
701 First Street
Princeton, MN 55371

RE: CCN: 245494
Cycle Start Date: March 11, 2022

Dear Administrator:

On May 31, 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Susie Haben, Rapid Response
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 August 31, 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 1, 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/ltr_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.

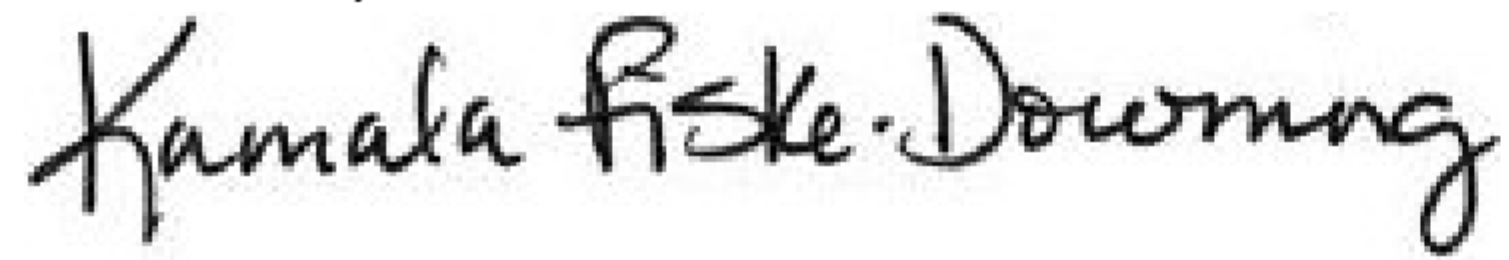
Elim Wellspring

June 13, 2022

Page 4

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "Kamala Fiske-Downing". The signature is written in a cursive, flowing style.

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 AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/22/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245494	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/31/2022
NAME OF PROVIDER OR SUPPLIER ELIM WELLSPRING			STREET ADDRESS, CITY, STATE, ZIP CODE 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
F 000	INITIAL COMMENTS On 5/31/22,a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H54941811C (MN83751 and MN83793). with deficiencies cited at F609. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	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	F 609			6/30/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/21/2022

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 609	Continued From page 1 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 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 incidents of alleged abuse were reported immediately, within two hours, to the State Agency (SA) for 1 of 3 residents (R1) reviewed for allegations of abuse who obtained a significant injury from a fall. Findings include: R1's Face Sheet undated indicated R1 admitted on 5/20/22, with recent fracture of right femur, dementia, repeated falls and aged related osteoporosis. R1's Care Plan with start date of 5/20/22, indicated R1 was a fall risk related to fall prior to admission resulting in a right hip fracture requiring surgical repair, pain, impaired mobility, medications, new environment and diagnoses. The Care Plan further indicated R1's interventions were to "Give verbal reminders not	F 609	F609 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. The facility failed to ensure incidents of alleged abuse were reported immediately, within two hours, to the State Agency of 1 of 3 residents reviewed for allegations of abuse who obtained a significant injury from a fall. It is the policy of Cassia (Princeton Elim Wellspring) to comply F609 to assure		

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F 609	Continued From page 2 to ambulate/transfer without assistance. Call light accessible and within reach whenever resident is in own room. Explain risks and benefits of asking for help to transfer or ambulate. Keep environment free of clutter. Keep personal items of interest within easy reach next to resident's chair and/or bed. Ensure use of proper, well-maintained footwear. Toilet per schedule. PT/OT as needed/ordered." A facility reported incident report dated 5/23/22, at 3:01 p.m. indicated on 5/22/22, at 10:00 a.m. just shortly after staff left the room staff heard commotion and upon entering R1's room, was found on the floor on her right side. Minor first aide applied to bump on resident's head and vital signs were within normal limits. Staff had just left R1's room and she was in her recliner and call light was found not next to her. There report further indicated R1 was a recent admission, had been noted to have confusion and not consistent with call light use during her stay at Elim. RE-education was provided to staff about appropriate placement of call light. Resident did report pain in right lower extremity when bearing weight and was sent to hospital for further imaging and confirmed fracture of femur. Surgical repair was scheduled for 5/24/22. During interview on 5/31/22, 1:40 p.m. director of nursing (DON) stated she was informed immediately of R1's fall and did not realize until the following day the report needed to be reported and in fact thought they had 24 hours to file the report to the state agency. In a follow up interview on 6/1/22, at 9:15 a.m. the DON stated after she reviewed the regulation and there policy the facility should have reported the	F 609	continued compliance, the following plan has been put into place: To assure continued compliance, the following plan has been put into place; How corrective action will be accomplished for the resident found to have been affected by the deficient practice: A Vulnerable Adult report was filed with MN Department of Health (OHFC) on date 5/23/22 under the category of fall with injury. How the facility will identify other residents having potential to be affected by the same deficient practice: Re-education was provided to staff in all departments related to the Vulnerable Adult policy and reporting time frames for "suspected/alleged violations of mistreatment, neglect, exploitation or residents, and abuse of residents and/or misappropriation of resident property, but no 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 24hours if the events that cause the allegation do not involve abuse or do not result in serious bodily injury." Vulnerable Adult policy reviewed and re-education was provided to DON and Corporate Nurse Consultants on 5/30/22 about timely reporting timeframes.		

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F 609	Continued From page 3 incident immediately with in 2 hours due to the serious injury of R1. Facility Policy Vulnerable adult-MN revised 10/31/19, indicated "each employee is responsible to report suspected/alleged violations of mistreatment, neglect, exploitation of residents, and abuse of residents and/or misappropriation of resident property immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury.	F 609	Audit completed on reported events: Falls with major injury in the past 120 days conducted to ensure that they were reported within required time frame. No additional concerns found during audit of records filed for falls with major injury reports conducted on 6/15/22. Education was provided by in-person training and written/quiz format, in addition to Read & Sign for all departments. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: Staff in all departments reviewed the Vulnerable Adult policy and acknowledged the reporting time frames for “suspected/alleged violations of mistreatment, neglect, exploitation or residents, and abuse of residents and/or misappropriation of resident property, but no 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 24hours if the events that cause the allegation do not involve abuse or do not result in serious bodily injury.” Education was provided by in-person training and written/quiz format, in addition to Read & Sign for all departments. Reviewed with staff that upon confirmation of a serious bodily injury such as, but not limited to, fractures		

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F 609	Continued From page 4	F 609	and/or bruises of unknown origin, that a report must be filed immediately, but no later than 2 hours. The Vulnerable Adult policy, including appropriate reporting timeframes, will be reviewed by all staff at minimum, upon hire and annually. Facility will interview staff randomly regarding the facilities Vulnerable Adult policy and appropriate reporting time frame. How will the facility monitor is corrective actions to ensure that the deficient practice is being corrected and will not recur: The facility will complete random staff interviews on 2 staff per week x4 weeks, and then 2 staff per month x3 regarding vulnerable adult reporting time frames. The findings will be brought forward to the month QI/QAA meeting for review and recommendations. Persons Responsible to maintain compliance: Director of Nursing or designee. Date that corrective action will be completed by: June 30, 2022		



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Electronically delivered
June 13, 2022

Administrator
Elim Wellspring
701 First Street
Princeton, MN 55371

Re: Event ID: ORP911

Dear Administrator:

The above facility survey was completed on May 31, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads '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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00375	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/31/2022
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2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/31/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaint was found to be	2 000			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

06/21/22

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00375	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/31/2022
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2 000	Continued From page 1 SUBSTANTIATED: H54941811C (MN83751 and MN83793). The Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000			