Electronically delivered
July 21, 2021

Administrator
The Estates At Excelsior LLC
515 Division Street
Excelsior, MN 55331

RE: CCN: 245332
Cycle Start Date: July 1, 2021

Dear Administrator:

On July 1, 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), 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), i.e., the plan of correction should be directed to:

Jamie Perell, 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: jamie.perell@state.mn.us
Office: (651) 245-8094

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 October 1, 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 January 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/ltc_idr.cfm

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
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
	245332	A. BUILDING _____ B. WING _____	C 07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT EXCELSIOR LLC	**515 DIVISION STREET EXCELSIOR, MN 55331**

(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 6/30/21, through 7/1/21, 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 complaint was found to be SUBSTANTIATED: H5332064C (MN74235 and MN74232), with a deficiencies cited at F582, F801, and F804. 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 801 SS=E	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes:	F 801		8/2/21

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

Electronically Signed | 07/27/2021

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.

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F 801	Continued From page 1 §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who- (i) For designations prior to November 28, 2016, meets the following requirements no later than 5	F 801		

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F 801	Continued From page 2 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is: (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to designate a qualified person to serve as the director of food service in the absence of a full-time dietitian. The had the potential to affect 34 of 35 residents who consumed food from the facility kitchen. Findings include: Facility document titled Job Description: Culinary Director, undated, indicated the position was full-time Monday through Friday from 8:00 a.m. until 4:30 p.m. and was responsible for managing the culinary services department and all its personnel. When interviewed on 6/30/21, at 11:36 a.m. cook	F 801	Registered Dietitian or Certified Dietary Manager designee will be on-site for 35 hours per week to meet regulations until regularly scheduled culinary services director begins employment Appropriate RD and CDM's have been educated on regulation specific to the facility needing qualified dietary staff RD/CDM will complete a weekly schedule with hours. Administrator/Designee will audit weekly x 4 weeks, monthly x 3, to ensure adequate qualified dietary staff is provided per regulation. Facility will report results to the facilities	

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F 801	Continued From page 3 (C)-A stated, the facility kitchen did not have a supervisor and the dietician was filling in. When interviewed on 6/30/21, at 3:22 p.m. the executive director of nutrition services stated the facility culinary director was on a leave of absence since 5/17/21, and it was now an open position for a full-time culinary director. The executive director of nutrition services stated the facility was currently in transition and had "multiple" culinary directors and dieticians "floating" between several facilities. The executive director of nutrition services stated this had been occurring for "only a couple of weeks." The executive director of nutrition services believed full-time would be considered 34 hours per week. When interviewed on 7/1/21, at 7:15 a.m. culinary director (CD)-A stated she was covering at the facility for the day as no other director was available. CD-A stated she had not been at the facility in the previous six months. When interviewed on 7/1/21, at 11:40 a.m. registered dietitian (RD)-A stated there was an opening for a full-time culinary director and the facility was in a "transition." RD-A stated she had been helping out at the facility four hours per week. RD-A stated a full-time position would be considered 35 hours per week. When interviewed on 7/1/21, at 1:43 p.m. the administrator confirmed there was a position open for a culinary director. The administrator stated the previous culinary director left in May. The administrator stated multiple dietitians and the regional culinary director assisted with on-going coverage, but this was not completed full time, 34 hours a week.	F 801	QAPI committee for review and/or follow-up. Deficient practices will be corrected upon identification.	

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F 801	Continued From page 4 The facility culinary schedule dated 6/30/21, indicated the following number of hours were worked by a dietitian and/or qualified nutritional professional: 5/17/21 - 5/22/21: 10 hours 5/23/21 - 5/29/21: 8 hours 5/30/21 - 6/5/21: 4 hours 6/6/21 - 6/12/21: 13 hours 6/13/21 - 6/19/21: 18 hours 6/20/21 - 6/26/21: 23 hours 6/27/21 - 6/30/21 = 14 hours	F 801		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure food was served at a palatable and appetizing temperature for 1of 3 residents (R2) who recieved room meal trays. Findings include: R2's Face Sheet printed 7/1/21, indicated R2's diagnoses included dementia, type 2 diabetes, and gastroesophageal reflux disease (GERD).	F 804	R2 is served palatable and appetizing temperature foods. Facility will complete weekly resident interview to ensure residents feels her food is palatable, appetizing and the appropriate temperature. Residents will receive palatable and appetizing temperature foods whether via room tray or dining room. The facility will complete resident interviews to ensure residents feel their food is palatable,	8/2/21

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F 804	Continued From page 5 R2's quarterly Minimum Data Set (MDS) dated 4/9/21, indicated R2 had a moderate cognitive impaired and required supervision eating. R2's care plan dated 11/2/20, indicated, "Resident has mentioned many times that her food is cold, staff and daughter have encouraged her to go to the dining room and resident does not go. Dietary staff also heat up resident's food and put hers on the cart near the end so that it is one of the last plates dished off the warmer" and "Encourage resident to eat in dining room if she has complaints that her food is cold. Encourage resident to ask for it to be heated up as well if needed." A facility grievance form dated 1/29/21, indicated R2 reported to her daughter that her food was cold. The facility grievance form further indicated R2 indicated the food was "cold enough that a dog wouldn't eat it." A facility grievance form dated 4/23/21, indicated R2 expressed concern food was "not always the temp [temperature] she would like it." The facility grievance form further indicated staff would not always reheat the food in a timely manner when asked. Review of the facility June 2021 Food Temperature Logs revealed food temperatures were not documented on the following dates: Breakfast: 6/22/21, 6/7/21, 6/12/21, 6/13/21, 6/17/21, 6/21/21, and 6/30/21, 7/1/21. Lunch: 6/7/21, 6/12/21, 6/17/21, 6/21/21, and 6/30/21. Dinner: 6/7/21, 6/8/21, 6/11/21, 6/12/21, 6/17/21, 6/18/21, 6/21/21, and 6/25/21.	F 804	appetizing and the appropriate temperature. The facility will continue with resident/food council. Culinary Staff education initiated regarding food preparation and food handling policies related to internal food temperatures. Culinary staff education initiated specifically on food temperatures, appearance, palatability, and overall food quality. New hires will be trained on pertinent policies, procedures, and regulations regarding food temperatures, appearance, palatability, and overall food quality. RD/CDM and/or Designee will complete tray audits weekly x 4 weeks and monthly x 3 months to ensure food temperatures and palatability are consistently adequate per state/federal regulations. RD/CDM and/or Designee will complete food temperature log audits weekly x 3 weeks and monthly x 3 months to ensure these are being obtained. RD/CDM and/or Designee will complete 3 resident interviews weekly specific to food temperatures, palatability and appearance. Facility will report results to the facilities QAPI committee for review and/or follow-up. Deficient practices will be corrected upon identification.	

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F 804	Continued From page 6	F 804		

When interviewed on 6/30/21, at 11:40 a.m. cook (C)-A verified the facility June 2021 Food Temperature Log had missing entries. C-A stated they were not working on the dates in which the temperatures were missing. C-A every food item needed a temperature recorded.

When interviewed on 6/30/21, at 12:25 p.m. R2 stated she was served ham, scalloped potatoes, vegetables, ice cream, and juice which was delivered to her room. R2 stated her lunch was, "not hot enough."

Review of the facility July 2021 Food Temperature Logs revealed food temperatures were not documented on the following dates:
- Breakfast: 7/1/21.

When interviewed on 7/1/21, at 7:20 a.m. the culinary director (CD)-A verified she did not record food temperatures for breakfast items other than sausage on the morning of 7/1/21. CD-A stated she believed the sausage had a final temperature of 167 degrees F. CD-A stated temperatures were taken to ensure safety as resident were "high risk."

On 7/1/21, at 8:25 a.m. meal trays were observed being passed to rooms. Prior to serving, a temperature check of the last meal tray to be passed was requested. Food temperatures were as follows:
- Oatmeal: 116 degrees Fahrenheit (F).
- Sausage: 90 degrees F
The meal tray was held at this time.

When interviewed on 7/1/21, at 8:45 a.m. R2 stated she was served sausage, oatmeal, a muffin, and juice for breakfast. R2 stated her food

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F 804	Continued From page 7	F 804		

was cold, however, did not express any additional concerns.

When interviewed on 7/1/21, at 11:40 a.m. registered dietitian (RD)-A stated culinary staff should record final cooking temperatures for each item at each meal, to ensure food was safely cooked and palatable.

When interviewed on 7/1/21, at 1:39 p.m. the director of nursing (DON) stated the facility had recent grievances regarding food temperatures and stated she expected food was cooked and delivered to resident's the proper temperature. The DON stated food not cooked or held at the appropriate temperature was a concern for food borne poisoning.

When interviewed on 7/1/21, at 1:43 p.m. the administrator stated the facility culinary services director left in May. The administrator stated dietitians and the regional culinary director had been assisting with coverage. The administrator stated her expectation was for culinary staff to comply with all food safety and temperature requirements. The administrator stated room trays should not sit and could "result in cold food" temperatures. The administrator stated the facility planned to conduct audits of tray delivery times and temperatures.

Facility policy titled Food Preparation and Service revised 4/19, directed proper hot and cold temperatures were maintained during food service and the temperatures of foods held in steam tables were monitored throughout the meal by staff.

Electronically delivered
July 21, 2021

Administrator
The Estates At Excelsior LLC
515 Division Street
Excelsior, MN 55331

Re: State Nursing Home Licensing Orders
Event ID: PG4G11

Dear Administrator:

The above facility was surveyed on June 30, 2021 through July 1, 2021 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:

Jamie Perell, 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: jamie.perell@state.mn.us
Office: (651) 245-8094

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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program

Program Assurance Unit
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
	00988	A. BUILDING: _____ B. WING _____	C 07/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT EXCELSIOR LLC	515 DIVISION STREET EXCELSIOR, MN 55331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 6/30/21, through 7/1/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5332064C (MN74235 and MN74232) with a licensing orders issued at 0980. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. 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/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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. The facility is enrolled in	2 000		

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2 000	Continued From page 2 ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	2 000		
2 980	MN Rule 4658.0605 Subp. 2 Director of dietary service; Director Subp. 2. Director of dietary service. If a qualified dietitian is not employed full time, the administrator must designate a director of dietary service who is enrolled in or has completed, at a minimum, a dietary manager course, and who receives frequently scheduled consultation from a qualified dietitian. The number of hours of consultation must be based upon the needs of the nursing home. Directors of dietary service hired before May 28, 1995, are not required to complete a dietary manager course. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to designate a qualified person to serve as the director of food service in the absence of a full-time dietitian. The had the potential to affect 34 of 35 residents who consumed food from the facility kitchen. Findings include: Facility document titled Job Description: Culinary Director, undated, indicated the position was full-time Monday through Friday from 8:00 a.m.	2 980	corrected	8/2/21

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2 980	Continued From page 3 until 4:30 p.m. and was responsible for managing the culinary services department and all its personnel. When interviewed on 6/30/21, at 11:36 a.m. cook (C)-A stated, the facility kitchen did not have a supervisor and the dietician was filling in. When interviewed on 6/30/21, at 3:22 p.m. the executive director of nutrition services stated the facility culinary director was on a leave of absence since 5/17/21, and it was now an open position for a full-time culinary director. The executive director of nutrition services stated the facility was currently in transition and had "multiple" culinary directors and dieticians "floating" between several facilities. The executive director of nutrition services stated this had been occurring for "only a couple of weeks." The executive director of nutrition services believed full-time would be considered 34 hours per week. When interviewed on 7/1/21, at 7:15 a.m. culinary director (CD)-A stated she was covering at the facility for the day as no other director was available. CD-A stated she had not been at the facility in the previous six months. When interviewed on 7/1/21, at 11:40 a.m. registered dietitian (RD)-A stated there was an opening for a full-time culinary director and the facility was in a "transition." RD-A stated she had been helping out at the facility four hours per week. RD-A stated a full-time position would be considered 35 hours per week. When interviewed on 7/1/21, at 1:43 p.m. the administrator confirmed there was a position open for a culinary director. The administrator stated the previous culinary director left in May.	2 980		

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2 980	Continued From page 4 The administrator stated multiple dietitians and the regional culinary director assisted with on-going coverage. The facility culinary schedule dated 6/30/21, indicated the following number of hours were worked by a dietitian and/or qualified nutritional professional: 5/17/21 - 5/22/21: 10 hours 5/23/21 - 5/29/21: 8 hours 5/30/21 - 6/5/21: 4 hours 6/6/21 - 6/12/21: 13 hours 6/13/21 - 6/19/21: 18 hours 6/20/21 - 6/26/21: 23 hours 6/27/21 - 6/30/21 = 14 hours SUGGESTED METHOD OF CORRECTION: The Administrator or designee, could develop, review, and/or revise policies and procedures to ensure the Dietary Manager has the proper qualifications for the position and/or a full-time dietician was available. The Administrator, or designee, could educate all appropriate staff on the policies and procedures. The Administrator, or designee, could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 980		