Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 30, 2023

Administrator
The Estates At Greeley LLC
313 South Greeley Street
Stillwater, MN 55082

RE: CCN: 245342
Cycle Start Date: July 12, 2023

Dear Administrator:

On August 2, 2023, we notified you a remedy was imposed. On August 23, 2023 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of August 18, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective October 12, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of July 25, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 12, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on August 18, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have 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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 30, 2023

Administrator
The Estates At Greeley LLC
313 South Greeley Street
Stillwater, MN 55082

Re: Reinspection Results
Event ID: 85VY12

Dear Administrator:

On August 23, 2023 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 July 12, 2023. 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

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July 25, 2023

Administrator
The Estates At Greeley LLC
313 South Greeley Street
Stillwater, MN 55082

RE: CCN: 245342
Cycle Start Date: July 12, 2023

Dear Administrator:

On July 12, 2023, a survey was completed at your facility by the Minnesota Department of Health 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"and/or an "E" tag), i.e., the plan of correction should be directed to:

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 12, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by January 12, 2024 (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,

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

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Electronically delivered
July 25, 2023

Administrator
The Estates At Greeley LLC
313 South Greeley Street
Stillwater, MN 55082

Re: State Nursing Home Licensing Orders
Event ID: 85VY11

Dear Administrator:

The above facility was surveyed on July 11, 2023 through July 12, 2023 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:

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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.

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
	245342	A. BUILDING _____ B. WING _____	C 07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT GREELEY LLC	313 SOUTH GREELEY STREET STILLWATER, MN 55082

(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 7/11/23 through 7/12/23, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed. H53423442C (MN00094923) with a deficiency issued at F689. 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 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to follow to ensure the	F 689	Affected resident's nutritional assessment and hot liquid evaluation has been	8/3/23

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

Electronically Signed | 08/02/2023

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 689	Continued From page 1 care plan was followed to prevent and/or reduce the risk of burns from hot liquid for 4 of 4 residents (R2, R3, R4, R5) who were observed who required coffee lids and/or assistance from staff for eating. Findings include: During observation and interview on 7/11/23 at 1:11 p.m., Food Service Manager (FSM)-A stated he was not sure the last time the liquid coffee dispenser had been maintainanced by the manufacturer or representative. FSM-A stated it was not the facility's practice to check coffee temperatures so there was no temperature logs. He explained a high end temperature for coffee would be 160-165 degrees. FSM-A then recanted the temperatures after referencing the facility policy and stated temperatures for coffee should be between 160-180 degrees. FSM used a digital thermometer that he said needed to be calibrated via ice bath. FSM took the temperature of the coffee that was dispensed from the coffee maker located in the kitchen. FSM took three temperatures of the coffee which included 166, 163, at 178 degrees. The temperature from the hot water dispenser measured 156 degrees. R2's face sheet included diagnosis of Parkinson's disease, neurocognitive disorder with lewy bodies and cerebral infarction R2's quarterly Minimum Data Set (MDS) dated 4/27/23, indicated R2 had moderate cognitive impairment and required set up assistance for eating. R2's Hot Liquid Evaluation dated 1/31/23, identified R2 required a cup with a lid or other	F 689	reviewed and revised according to the facility's policy and procedures. Affected resident's care plan and meal tickets have been updated to reflect any changes made on the affected residents updated nutritional assessment and hot liquid assessment. On 7/18/2023, the facility completed a house-wide audit of current resident's nutritional assessments, hot liquid evaluation, care plan, and meal tickets. The Admitting Nursing Team will complete the Hot Liquid Evaluation: Safety Evaluation of the Clinical Nutrition Evaluation within one day of admission; Sections 7 a. b. c. The Nursing Team will communicate the need for the Adaptive Equipment to the Dietary Team after the assessment is complete. The Dietary Director or Dietary Designee will input the required equipment communication onto the Meal Ticket and into the Dietary Summary. The Director of Nursing or Nurse Designee will complete the Quarterly, Annual and Significant Change Hot Liquid Evaluation: Safety Evaluation of the Clinical Nutrition Evaluation; Sections 7 a.b.c. at the time for assessment. The Director of Nursing or Nurse Designee will communicate the need for the Adaptive Equipment (if needed) to the Dietary Team after the assessment is complete. The Dietary Director or Dietary Designee will input the required equipment communication onto the Meal Ticket and	

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F 689	Continued From page 2 adaptive cup. R2's care plan dated 9/27/22, did not identify R2's safety interventions for hot liquids as identified per the Hot Liquid Evaluation. R2's meal tray ticket indicated no beverage requirements or modifications for safety according to the Hot Liquid Evaluation. During observation on 7/12/23 at 12:16 p.m., R2 was seated at dining table. Unidentified nursing assistant provided a hot cup of coffee with no lid and R2 was not informed or cautioned of the potential hot liquid. R3's face sheet included diagnosis of intercranial injury with loss of consciousness, hemiplegia, mild cognitive impairment, and dysphagia. R3's annual MDS dated 6/22/23, indicated R3 did not have cognitive impairment and required one physical assist for eating. R3's Hot Liquid Safety Evaluation dated 6/26/23, identified R3 required a cup with lid or other adaptive cup and staff assistance with eating or drinking. R3's care plan dated 12/10/19, did not address R4's safety intervention according to the Hot Liquid Evaluation. R3's meal tray ticket dated did not identify requirements or modifications for safety related to hot beverages according to the hot liquid evaluation and R3's care plan. During observation on 7/12/23 at 12:12 p.m., R3	F 689	into the Dietary Summary. The need for Adaptive Equipment will be communicated on the meal ticket and Adaptive Equipment Summary Report that will accompany each beverage distribution. Beverage Distribution will be coordinated by facility staff to ensure proper distribution and implementation of safety devices. Any changes in diet, liquids and adaptive equipment will be communicated via email group to ensure appropriate team members are notified of any revisions as a secondary form of communication to the IDT Team. The Director of Nursing or Nurse Designee will audit for the completion of the Hot Liquid Evaluation: Safety Evaluation of the Clinical Nutrition Evaluation; Sections 7 a. b. c. with new admissions and with all timed assessments. The Dietary Director or Designee will audit the findings of the evaluation needs are up-loaded into the Dietary Summary which prints to Meal Tickets and Dietary Summary Report with all new admissions and with all timed assessments.	

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F 689	Continued From page 3 was seated at dining table and was observed to be provided a hot cup of coffee with no lid by an unidentified kitchen staff. Staff assisted with R3's initial set up however then left table. R3 was not provided with direct supervision as staff were by meal carts near hallway. R3 was not provided with assistance with the coffee until 12:21 p.m. R4's face sheet included diagnosis of dementia and transient ischemic attack (brief stroke like attack). R4's annual MDS dated 6/22/23, indicated R4 did not have cognitive impairment and required assist of one person for eating. R4's Hot Liquid Evaluation dated 1/17/23, indicated R4 required a cup with lid or another adaptive cup and may only drink hot liquids at table. R4's care plan 10/3/22, did not address R4's safety intervention according to the hot liquid evaluation. R4's meal tray ticket indicated no beverage requirements or modifications for safety as per the Hot Liquid Evaluation. During observation on 7/12/23 at 12:23 p.m., R4 sat at the dining room table. R4 was provided with a cup of coffee by unknown nursing staff with no lid or assistance. R4 was not notified or cautioned of the potential hot liquid that was served. R5's face sheet included diagnosis of dementia, restless and agitation and altered mental status R5's annual MDS dated 5/12/23, indicated R5	F 689		

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F 689	Continued From page 4 had severe cognitive impairment and required set up assist for eating. R5's care plan dated 6/28/23, identified R5 required lids with warm beverages and add ice cubes prior to serving. Furthermore care plan indicated R5 had a burn on upper thighs due to a hot coffee spill on 8/5/22 and hot beverages to be served with a lid and staff assist. R5's meal tray ticket indicated Hot beverage with lid and staff assist. R5's Hot Liquid Evaluation dated 5/12/23, indicated R5 required a cup with lid or other adaptive cup. During interview and observation on 7/11/23 at 5:12 p.m., R5 was seated at dining table with family member (FM)-C. An uncovered cup of coffee was provided to R5 by an unidentified staff member. FM-C moved the coffee out R5's reach. FM-C indicated the coffee was super-hot and moved it out of R5's way due to the temperature and safety concern reporting "it could burn her". During observation on 7/11/23 at 1:02 p.m., beverage cart with coffee carafes in north hallway noted to be unattended. During observation on 7/11/23 at 4:04 p.m., beverage cart in the west hallway with coffee carafes was left unattended; an unidentified family member was self-serving coffee to an unidentified resident. During an observation and interview on 7/11/23 at 4:26 p.m., cook (C)-C stated they had never completed a Hot Liquid Evaluation and did not	F 689		

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F 689	Continued From page 5 believe culinary was involved in the process. C-C took the temperature of the coffee after dispensing it from the machine; coffee temperature was 170 degrees and hot water to be at 172 degrees. During observation on 7/12/23 at 11:45 a.m., beverage cart in the west hallway was left unattended by staff. During interview on 7/11/23 at 1:06 p.m., C-A and FSM-A, C-A indicated the facility had one main kitchen with a liquid coffee dispenser as the main point of obtaining coffee. Coffee either was dispensed either from the machine or carafes were filled and placed onto serving carts in hallways an hour prior to each meal. FSM-A stated the facility took temperatures all food items but had never temped coffee. During interview on 7/11/23 at 1:20 p.m., C-C indicated the residents prefer the coffee very hot, and some residents and aids would put the coffee in the microwave to warm it as needed. The temperature of the coffee was not checked after microwaving. During interview on 7/12/23 at 1:07 p.m., NA-B indicated the level of assistance with feeding a resident was determined by observation and by resident request. NA-B explained if staff were not aware of a resident's level of assistance the information could be located in their chart at the nurse's station. NA-B indicated to have seen cups with lids in the facility but had never worked with a resident with a cup and lid. During interview on 7/12/23 at 1:12 p.m., NA-C indicated the meal cards instructed staff what	F 689		

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F 689	Continued From page 6 residents needed for the meal. NA-C was unaware of any restrictions or modifications for hot coffee. Furthermore, NA-C was unaware some residents required lids. During interview on 7/12/23 at 1:23 p.m., NA-D indicated if a coffee cup came from the kitchen with a white lid on it NA-D would take it off and throw it away and provide the resident with the hot beverage. During interview on 7/12/23 at 1:34 p.m., LPN-A was not aware of the Hot Liquid Evaluation. LPN-A indicated there were lids for coffee cups, and some residents required it. LPN-A explained if an NA were to ask if a resident required a lid, he would provide one to be on the safe side, unless the resident did not want one. LPN-A stated he would then let therapy know. During interview on 7/11/23 at 3:23 p.m., LPN-B stated they had never completed a hot liquid evaluation. LPN-B indicated the coffee was safe to serve to residents because kitchen staff took the temperatures. During interview on 7/11/23 at 3:04 p.m., registered nurse (RN)-A indicated when residents requested coffee, staff would fill a cup from the machine in the kitchen and serve it to the resident. RN-A indicated the determination of temperature was assessed by steam level and if the coffee was steaming too much then it was hotter than normal. RN-A indicated the hot liquid machine in the kitchen managed the coffee temperature level. RN-A indicated he had never done a Hot Liquid Safety Evaluation and had never heard of it.	F 689		

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	245342	A. BUILDING _____ B. WING _____	C 07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT GREELEY LLC	313 SOUTH GREELEY STREET STILLWATER, MN 55082

(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 689	Continued From page 7 During interview on 7/11/23 at 3:10 p.m., RN-C indicated the facility completed Hot Liquid Safety Evaluations at the time of admission. RN-C indicated the evaluation was completed to identify residents who were at risk for spills so that interventions could developed to protect residents from burns. During interview on 7/11/23 at 5:47 p.m., director of nursing (DON), indicated culinary and nursing staff completed the Hot Liquid Safety Evaluation shortly after admission and with a change in condition. During a subsequent interview on 7/12/23 at 2:01 p.m., DON indicated dietary is responsible for putting the information into their system. If it were deemed not safe it flows into the care plan as well as the meal tickets that are provided with the meal so staff know how to serve the meal. Policy and procedure titled safety of hot liquids dated October 2014, indicates residents who prefer hot beverages with meals will have a hot liquid evaluation completed by staff and the risk factors for scalding and burns will be placed in the care plan. Once risk factors from hot liquid are identified appropriate interventions should be implemented such as: " Maintaining a hot liquid serving temperature of not more than 180 degrees Fahrenheit; " Serving hot beverages in a cup with a lid; " Encouraging residents to sit at a table while drinking or eating hot liquids; " Providing protective lap covering or clothing to protect skin from accidental spills; and " Staff supervision or assistance with hot beverages. Furthermore the policy states food service staff	F 689		

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F 689	Continued From page 8 will monitor and maintain food temperatures that comply with food safety requirements but do not exceed recommended temperatures to prevent scalding. Policy and procedure titled Hot Beverages, undated indicates beverage carts delivered to units or dining rooms for meals should not be left unattended. If staff is not available at the time of delivery, place the cart in an area not accessible to residents. Policy indicates to notify a resident when a hot liquid is being served. Furthermore the policy indicates if a resident is at risk for spills consider supervising the resident at all times with drinking the hot beverage.	F 689		

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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 7/11/23 through 7/12/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed. H53423442C (MN00094923) with a licensing order issued at 0830 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 ePOC and therefore a signature is not required at the bottom of the first page of	2 000		

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2 000	Continued From page 2 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		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to follow to ensure the care plan was followed to prevent and/or reduce the risk of burns from hot liquid for 4 of 4 residents (R2, R3, R4, R5) who were observed who required coffee lids and/or assistance from staff for eating. Findings include: During observation and interview on 7/11/23 at	2 830	Corrected	8/3/23

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2 830	Continued From page 3 1:11 p.m., Food Service Manager (FSM)-A stated he was not sure the last time the liquid coffee dispenser had been maintainanced by the manufacturer or representative. FSM-A stated it was not the facility's practice to check coffee temperatures so there was no temperature logs. He explained a high end temperature for coffee would be 160-165 degrees. FSM-A then recanted the temperatures after referencing the facility policy and stated temperatures for coffee should be between 160-180 degrees. FSM used a digital thermometer that he said needed to be calibrated via ice bath. FSM took the temperature of the coffee that was dispensed from the coffee maker located in the kitchen. FSM took three temperatures of the coffee which included 166, 163, at 178 degrees. The temperature from the hot water dispenser measured 156 degrees. R2's face sheet included diagnosis of Parkinson's disease, neurocognitive disorder with lewy bodies and cerebral infarction R2's quarterly Minimum Data Set (MDS) dated 4/27/23, indicated R2 had moderate cognitive impairment and required set up assistance for eating. R2's Hot Liquid Evaluation dated 1/31/23, identified R2 required a cup with a lid or other adaptive cup. R2's care plan dated 9/27/22, did not identify R2's safety interventions for hot liquids as identified per the Hot Liquid Evaluation. R2's meal tray ticket indicated no beverage requirements or modifications for safety according to the Hot Liquid Evaluation.	2 830		

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2 830	Continued From page 4 During observation on 7/12/23 at 12:16 p.m., R2 was seated at dining table. Unidentified nursing assistant provided a hot cup of coffee with no lid and R2 was not informed or cautioned of the potential hot liquid. R3's face sheet included diagnosis of intercranial injury with loss of consciousness, hemiplegia, mild cognitive impairment, and dysphagia. R3's annual MDS dated 6/22/23, indicated R3 did not have cognitive impairment and required one physical assist for eating. R3's Hot Liquid Safety Evaluation dated 6/26/23, identified R3 required a cup with lid or other adaptive cup and staff assistance with eating or drinking. R3's care plan dated 12/10/19, did not address R4's safety intervention according to the Hot Liquid Evaluation. R3's meal tray ticket dated did not identify requirements or modifications for safety related to hot beverages according to the hot liquid evaluation and R3's care plan. During observation on 7/12/23 at 12:12 p.m., R3 was seated at dining table and was observed to be provided a hot cup of coffee with no lid by an unidentified kitchen staff. Staff assisted with R3's initial set up however then left table. R3 was not provided with direct supervision as staff were by meal carts near hallway. R3 was not provided with assistance with the coffee until 12:21 p.m. R4's face sheet included diagnosis of dementia and transient ischemic attack (brief stroke like attack).	2 830		

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2 830	Continued From page 5 R4's annual MDS dated 6/22/23, indicated R4 did not have cognitive impairment and required assist of one person for eating. R4's Hot Liquid Evaluation dated 1/17/23, indicated R4 required a cup with lid or another adaptive cup and may only drink hot liquids at table. R4's care plan 10/3/22, did not address R4's safety intervention according to the hot liquid evaluation. R4's meal tray ticket indicated no beverage requirements or modifications for safety as per the Hot Liquid Evaluation. During observation on 7/12/23 at 12:23 p.m., R4 sat at the dining room table. R4 was provided with a cup of coffee by unknown nursing staff with no lid or assistance. R4 was not notified or cautioned of the potential hot liquid that was served. R5's face sheet included diagnosis of dementia, restless and agitation and altered mental status R5's annual MDS dated 5/12/23, indicated R5 had severe cognitive impairment and required set up assist for eating. R5's care plan dated 6/28/23, identified R5 required lids with warm beverages and add ice cubes prior to serving. Furthermore care plan indicated R5 had a burn on upper thighs due to a hot coffee spill on 8/5/22 and hot beverages to be served with a lid and staff assist. R5's meal tray ticket indicated Hot beverage with lid and staff assist.	2 830		

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2 830	Continued From page 6 R5's Hot Liquid Evaluation dated 5/12/23, indicated R5 required a cup with lid or other adaptive cup. During interview and observation on 7/11/23 at 5:12 p.m., R5 was seated at dining table with family member (FM)-C. An uncovered cup of coffee was provided to R5 by an unidentified staff member. FM-C moved the coffee out R5's reach. FM-C indicated the coffee was super-hot and moved it out of R5's way due to the temperature and safety concern reporting "it could burn her". During observation on 7/11/23 at 1:02 p.m., beverage cart with coffee carafes in north hallway noted to be unattended. During observation on 7/11/23 at 4:04 p.m., beverage cart in the west hallway with coffee carafes was left unattended; an unidentified family member was self-serving coffee to an unidentified resident. During an observation and interview on 7/11/23 at 4:26 p.m., cook (C)-C stated they had never completed a Hot Liquid Evaluation and did not believe culinary was involved in the process. C-C took the temperature of the coffee after dispensing it from the machine; coffee temperature was 170 degrees and hot water to be at 172 degrees. During observation on 7/12/23 at 11:45 a.m., beverage cart in the west hallway was left unattended by staff. During interview on 7/11/23 at 1:06 p.m., C-A and FSM-A, C-A indicated the facility had one main kitchen with a liquid coffee dispenser as the main	2 830		

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2 830	Continued From page 7 point of obtaining coffee. Coffee either was dispensed either from the machine or carafes were filled and placed onto serving carts in hallways an hour prior to each meal. FSM-A stated the facility took temperatures all food items but had never temped coffee. During interview on 7/11/23 at 1:20 p.m., C-C indicated the residents prefer the coffee very hot, and some residents and aids would put the coffee in the microwave to warm it as needed. The temperature of the coffee was not checked after microwaving. During interview on 7/12/23 at 1:07 p.m., NA-B indicated the level of assistance with feeding a resident was determined by observation and by resident request. NA-B explained if staff were not aware of a resident's level of assistance the information could be located in their chart at the nurse's station. NA-B indicated to have seen cups with lids in the facility but had never worked with a resident with a cup and lid. During interview on 7/12/23 at 1:12 p.m., NA-C indicated the meal cards instructed staff what residents needed for the meal. NA-C was unaware of any restrictions or modifications for hot coffee. Furthermore, NA-C was unaware some residents required lids. During interview on 7/12/23 at 1:23 p.m., NA-D indicated if a coffee cup came from the kitchen with a white lid on it NA-D would take it off and throw it away and provide the resident with the hot beverage. During interview on 7/12/23 at 1:34 p.m., LPN-A was not aware of the Hot Liquid Evaluation. LPN-A indicated there were lids for coffee cups,	2 830		

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2 830	Continued From page 8 and some residents required it. LPN-A explained if an NA were to ask if a resident required a lid, he would provide one to be on the safe side, unless the resident did not want one. LPN-A stated he would then let therapy know. During interview on 7/11/23 at 3:23 p.m., LPN-B stated they had never completed a hot liquid evaluation. LPN-B indicated the coffee was safe to serve to residents because kitchen staff took the temperatures. During interview on 7/11/23 at 3:04 p.m., registered nurse (RN)-A indicated when residents requested coffee, staff would fill a cup from the machine in the kitchen and serve it to the resident. RN-A indicated the determination of temperature was assessed by steam level and if the coffee was steaming too much then it was hotter than normal. RN-A indicated the hot liquid machine in the kitchen managed the coffee temperature level. RN-A indicated he had never done a Hot Liquid Safety Evaluation and had never heard of it. During interview on 7/11/23 at 3:10 p.m., RN-C indicated the facility completed Hot Liquid Safety Evaluations at the time of admission. RN-C indicated the evaluation was completed to identify residents who were at risk for spills so that interventions could developed to protect residents from burns. During interview on 7/11/23 at 5:47 p.m., director of nursing (DON), indicated culinary and nursing staff completed the Hot Liquid Safety Evaluation shortly after admission and with a change in condition. During a subsequent interview on 7/12/23 at 2:01 p.m., DON indicated dietary is responsible for putting the information into their	2 830		

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2 830	Continued From page 9 system. If it were deemed not safe it flows into the care plan as well as the meal tickets that are provided with the meal so staff know how to serve the meal. Policy and procedure titled safety of hot liquids dated October 2014, indicates residents who prefer hot beverages with meals will have a hot liquid evaluation completed by staff and the risk factors for scalding and burns will be placed in the care plan. Once risk factors from hot liquid are identified appropriate interventions should be implemented such as: " Maintaining a hot liquid serving temperature of not more than 180 degrees Fahrenheit; " Serving hot beverages in a cup with a lid; " Encouraging residents to sit at a table while drinking or eating hot liquids; " Providing protective lap covering or clothing to protect skin from accidental spills; and " Staff supervision or assistance with hot beverages. Furthermore the policy states food service staff will monitor and maintain food temperatures that comply with food safety requirements but do not exceed recommended temperatures to prevent scalding. Policy and procedure titled Hot Beverages, undated indicates beverage carts delivered to units or dining rooms for meals should not be left unattended. If staff is not available at the time of delivery, place the cart in an area not accessible to residents. Policy indicates to notify a resident when a hot liquid is being served. Furthermore the policy indicates if a resident is at risk for spills consider supervising the resident at all times with drinking the hot beverage.	2 830		

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2 830	Continued From page 10 Suggested Method of Correction: The Directior of Nursing or designee could review policies and procedures, train staff, and implement measures to assure residents are receiving the necessary services to prevent or improve areas from occuring. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to better ensure implementation of treatment. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		