DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 11, 2022

Administrator
Centracare-Willmar
1801 Willmar Avenue Southwest
Willmar, MN 56201

Re: Reinspection Results
Event ID: Z5OZ12

Dear Administrator:

On July 5, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 5, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

Electronically delivered
May 25, 2022

Administrator
Carris Health Care Center & Therapy Suites
1801 Willmar Avenue Southwest
Willmar, MN 56201

RE: CCN: 245410
Cycle Start Date: May 5, 2022

Dear Administrator:

On May 5, 2022, 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 isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective June 9, 2022.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective June 9, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 9, 2022.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by June 9, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Carris Health Care Center & Therapy Suites will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 9, 2022. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 5, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C)

and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245410	A. BUILDING _____ B. WING _____	C 05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIS HEALTH CARE CENTER & THERAPY SUITES	1801 WILLMAR AVENUE SOUTHWEST WILLMAR, MN 56201

(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 5/4/22- 5/5/22, a standard abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was not found NOT to be in compliance with the requirements of 42 CFR Part 483, Subpart B, requirements for Long Term Care Facilities. The following complaints was found to be SUBSTANTIATED: H54101086C (MN00083144), with a deficiency cited at F684 and 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of	F 684		6/30/22

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

Electronically Signed | 06/07/2022

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 684	Continued From page 1 practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to investigate the cause of a skin injury and assess for appropriate treatment for 1 of 1 resident (R1) who sustained a burn from hot liquids served at the facility. This deficient practice resulted in actual harm for R1. Findings include: A Nursing Home Incident Report (NHIR) dated 4/28/22, indicated R1 had sustained a burn on her right thigh. R1 had told the staff member she had spilt her coffee. The burn was noted to be irregular shaped 1st degree (A mild burn injury of the outermost layer that make up the skin. Usually heals without scarring the skin) and had three small areas. The lateral area measured 6 centimeters (cm) by 3 cm wide. The middle area was 3 cm wide x 2.5 cm long. The inner most area measure 1.5 cm x 1 cm. The report indicated the facility had installed a new coffee machine on 4/20/22. The previous coffee machine was set to dispense liquids at 145 degrees Fahrenheit, however, the coffee machine was "hot." R1's annual Minimum Data Set (MDS) dated 4/27/22, indicated R1 had severe cognitive impairment and diagnoses of Alzheimer's dementia and anxiety. The assessment indicated R1 required extensive assistance of two staff for all activities of daily living and required supervision of a mechanically altered diet while eating.	F 684	F684 Corrective Action An event was created and added in our MatrixCare software to prompt treatments and observations for any resident that sustains a burn. This event will be populated by the licensed staff that received the report or observed the burn area. The event is selected underneath the skin integrity events in MatrixCare. This event will trigger for the licensed staff to document the initial event, the description, and measurements of area, to document when family/representative were notified, to document when the physician was notified, to document when event was put on the care plan, interventions put in place, and treatment options. An email with the information was sent out to all licensed staff with the instructions on how to initiate this event for any resident. This was also discussed at the nurses meeting on 5-12-2022, nurses that did not attend the meeting received the meeting minutes in addition to the email that went out on 6-2-2022 and again on 6-6-2022 with updated hot liquid and safety evaluation form. All licensed staff have been trained to use this event for any resident that sustains a burn and to update the care plan and care sheet for the resident affected.	

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F 684	Continued From page 2 R1's Nutritional Care Area Assessment (CAA) dated 4/27/22, indicated R1 was to receive a soft diet with food cut into bite sized pieces. The CAA did not include an assessment of R1's ability to manage liquids. R1's Care Plan dated 4/29/22, identified R1 as being dependent on staff to obtain all fluids. The plan directed the staff to provide fluids but did not include any type of special instructions or adaptive equipment for hot liquids. The plan lacked direction related to burns or wound care. On 5/4/22, during continuous observation starting at 4:48 p.m. R1 was observed seated in the dining room waiting for the evening meal. -At 4:50 p.m. nursing assistant (NA)-H removed a standard plastic coffee cup from a storage drawer, added ice to the cup and then filled it with coffee. NA-H then placed the cup in front of R1. R1's cup was not observed to be equipped with any type of cover or other adaptive equipment. R1 was observed to pick up the cup and drank from it independently. -From 4:50 p.m. to 5:25 p.m. R1 picked up her coffee cup and drank from it independently. No staff members were observed to remain in the dining room while R1 drank and waited for the evening meal. On 5/5/22, during continuous observation starting at 7:02 a.m. R1 was observed seated in the dining room drinking a cup of coffee. The cup was a standard plastic coffee cup without any type of adaptive equipment. -At 7:42 a.m. R1 was served her breakfast meal consisting of scrambled eggs, a banana and toast. R1's meal was not observed to utilize any	F 684	A hot liquids and safety evaluation form was created to assess all residents on admission, readmission and change of condition for the use of hot liquids. The hot liquids assessment safety evaluation will print out with the admission paperwork and will be assessed by a RN. This assessment lists risk factors, and interventions. Based on risks identified, a referral would be made to Occupational Therapy (OT) to determine if OT needs to be ordered by the physician to assess for use of adaptive equipment or other interventions that are not listed on the form. If the resident is found to be at risk then an intervention from the list or that from the OT must be put into place and updated on the care sheet and care plan. If a resident is assessed to be unsafe for hot liquids staff will need to add ice or wait until liquid cools until temp reads at safe temperature based on assessment. If resident is at risk for burn from hot liquids this will be marked on their care sheets that the CNAs carry with them. All coffee machines will have a note placed on them as a reminder to check temperatures of hot liquids with a thermometer. Lap pads were purchased for the facility as an intervention appropriate for those residents that are marked as at risk for spilling hot liquids. In our facility weekly clinical meeting we added for topic of review Wounds, Burns, and other Skin Concerns instead of just	

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F 684	Continued From page 3 type of adaptive meal equipment. -At 8:06 a.m. R1 was observed to spill scrambled eggs on her clothing protector. -At 8:29 a.m. R1 stopped eating. She ate approximately 75% of her meal independently and drank 3/4 of the coffee. -At 8:43 a.m. R1 was wheeled to her room by NA-A and NA-B. The NA's utilized a standing mechanical lift to transfer R1 from the wheelchair into a standing position. NA-A pulled down R1's pants. R1's right thigh was observed to have a red area approximately three inches wide with three separate areas noted inside the red area. Two of the areas were noted to be covered with yellow/white slough. The third area was a fluid filled blister. -At 8:51 a.m. NA-A stated he noted the red area last week while transferring the resident after the breakfast meal. NA-A stated R1's clothing had been saturated with coffee, however, R1 had not vocalized to the staff she had spilt her coffee at the time it happened. R1 reported to NA-A she had split her coffee. NA-A stated he reported the red area to the nurse, and she had obtained a cream to be put on the area. NA-A also stated the yellow/white areas on the wound looked "awful." Review of R1's Progress Notes (PN)/nurses notes revealed the following information: - PN 4/28/22, at 9:00 a.m. R1 had a red area discovered on her right thigh. Resident stated she spilt coffee with coffee stain noted on her shirt and pants. The burn area was irregular shaped 1st degree burn and had three smaller area. The lateral area was 6 cm long and 3 cm wide. The middle area was 3 cm wide and 2.5 cm long. The inner most area was 1.5 cm x 1 cm.	F 684	listing out pressure ulcer areas to ensure that all skin concern areas are discussed. The weekly review consists of the 3 RN clinical coordinators and reviews Residents with wounds, burns, skin concerns, if area is facility acquired, what the progression of the area is, if measurements are present in progress notes, if a wound sheet is presents, if there is a facility trend noted, and if it is identified on the care plan. A Representative for the coffee machines came to facility and adjusted temps for Sophia house and therapy suites and Cushman had already been adjusted. All 3 houses coffee machines have been adjusted to the lowest setting for temperature. Current temps are reading Sophia House: coffee- 150, hot water 150 /Cushman Cottage: Coffee 130, hot water 130/ Therapy Suites: hot water: 150, Coffee-150 decaf- 158 Plan of Correction for R1 WOC nurse referral was completed for resident R1 A hot liquids safety evaluation was completed on R1 resulting in a referral to Occupational Therapy to determine if adaptive equipment or other interventions are needed. R1 has a lap pad to protect skin from the spillage of hot liquids. R1's Care Plan states she needs supervision during meals. Our current process is a staff member must remain in the dining room until all at risk residents	

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F 684	Continued From page 4 -PN 4/28/22, at 10:00 p.m. indicated the burn on the right thigh had started to blister. -PN 4/29/22, at 9:48 a.m. indicated R1 had received an order to apply Silvadene 1% (medicated cream frequently used on burns) twice a day on the right thigh. -PN 4/30/22, at 11:22 p.m. indicated the staff had placed the Silvadene to the burn. -PN 5/1/22, at 11:41 a.m. indicated Silvadene was applied to the burn and R1 still had one blister intact. -PN 5/2/22, at 2:52 p.m. indicated Silvadene was applied to the burn. One blister was still intact. -PN 5/3/22, at 10:37 a.m. Silvadene applied to burn on right thigh. - PN 5/3/22, at 9:43 p.m. Silvadene applied to burn on upper right thigh. There is a blister area above the healing area that is still intact and a blister below the healing area that is intact. -PN 5/4/22, at 8:37 a.m. Silvadene applied to burn on thigh. There is still one blister that is intact. Healing slowly. -PN 5/5/22, at 3:49 p.m. the burn area has one blister that is intact no adverse side effects. -PN 5/5/22, at 10:31 a.m. Silvadene applied to burn. There is one blister that is intact. Healing slowing with scabbing over the middle light brown in color. Review of facsimile order dated 4/29/22, from nurse practitioner (NP)-A directed the staff to apply Silvadene cream 1% twice a day for seven days to the burn on the right thigh. Review of R1's medical record lacked an event/incident report related to the burn sustained on 4/28/22. It lacked, a comprehensive skin assessment which would include measurements, visual descriptions, and/or reactions to	F 684	have exited from mealtime. This process will remain and audits will be done to ensure compliance. Corrective Action to Identify Other Residents All residents will receive an initial hot liquids safety evaluation. If the resident is found to be at risk then an intervention from the list or that from the OT must be put into place and updated on the care sheet and care plan. Based on risks identified, a referral would be made to Occupational Therapy (OT) to determine if OT needs to be ordered by the physician to assess for use of adaptive equipment or other interventions that are not listed on the form. Our current process of having a staff member remain in the dining room until all at risk residents have exited will continue for all residents in all households. This process will remain and audits will be done to ensure compliance. Corrective Action to Prevent Reoccurrence Audits will be done weekly on each household for three months starting 6/6/2022 to ensure staff are supervising the dining room until all residents have exited. Audits will be done weekly for three months on temping the coffee maker to ensure average temperatures are	

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F 684	Continued From page 5 treatments. Finally, the medical record lacked a comprehensive assessment related to R1's ability to manage hot liquids. On 5/5/22, 8:55 a.m. RN-C stated she had completed R1's wound treatment for the day. RN-C stated R1's blisters looked good, they did have slough forming over some of them and R1 had not complained of pain with the treatment. On 5/5/22, at 8:58 a.m. licensed practical nurse (LPN)-A stated R1's burn area had been red last week, however, upon her return to work on 5/4/22, the center of the wound had started to turn yellow with one blister still intact. LPN-A stated R1's burn area looked worse. On 5/5/22, at 10:47 a.m. RN-D stated the facility had not completed an incident report (events report) related to the burn because the electronic medical record system did not have an established system to generate reports related to burns. Therefore, the facility had not completed an incident report. RN-D was aware R1 had a new order for Silvadene cream after sustaining a coffee burn; however, NP-A had not observed the wound. RN-D stated the burn was evaluated daily by the wing nurses and the progress notes were to reflect the status of the burn. RN-D confirmed the medical record did not contain a comprehensive skin assessment related to the burn, a care plan had not been developed and R1's ability to manage hot liquids had not been assessed. RN-D stated the electronic medical record normally directed the staff to complete assessments after an incident (event) report was completed. However, since the facility did not have an event report for burns, no comprehensive assessment had been completed.	F 684	consistent and not running too hot. Audits will be done weekly for three months ensuring residents identified at risk of hot liquids are having their hot liquids cooled down to a safe temperature identified on the assessment. Each clinical coordinator will educate the staff on their houses regarding this plan of correction and audit results through team huddles, staff meetings, email, and one on one conversations. Results of audits will be reported at QA. The plan of correction will be emailed to each licensed staff and the director of nursing and/or clinical coordinator will meet with each licensed staff individually to educate on new process. The Administrator and Director of Nursing are responsible to ensure compliance.	

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CARRIS HEALTH CARE CENTER & THERAPY SUITES	1801 WILLMAR AVENUE SOUTHWEST WILLMAR, MN 56201

(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 684	Continued From page 6 RN-D stated she had not seen R1's burn area and she would depend upon the progress notes to reflect any changes in the wound. RN-D stated she was not aware of any changes to the burn area. On 5/5/22, at 11:13 a.m. RN-C and RN-D transferred R1 from the wheelchair to the bed via a standing mechanical lift. Once in bed, RN-D measured R1's burn area. The area was located on R1's upper right thigh just below her pantie line. RN-D measure the wound in three sections. The middle section was 6 cm x 2.25 cm and was 90%-100% covered with yellow/white slough. The portion of the wound closest to R1's groin area had a 2.25 cm x 2 cm intact fluid filled blister. The outer area of the burn measured 5.5 cm x 3 cm with a small open and slough covered areas. No significant drainage was noted. On 5/5/22, at 11:18 a.m. RN-C stated the wound appearance had changed in the last three days when the slough had started to cover the wound. On 5/5/22, at 11:25 a.m. RN-D confirmed R1's progress notes did not adequately describe the condition of R1's burn. The burn area was larger than it had been on the initial incident, no additional measurements or description of color had been recorded. In addition, R1 had not been evaluated by a physician to ensure appropriate care and treatment was being delivered for the wound. RN-D stated at minimum, the area required a weekly skin assessment. A skin/burn policy was requested, and none was provided. The Safety of Hot Liquids policy dated 2/2022,	F 684		

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F 684	Continued From page 7 directed the staff to assess all resident safety concerns and potential for injury from hot liquids upon admission, readmission and on change of condition. Appropriate precautions were to be implemented to maximize choice of beverage while minimizing the potential of injury. On 5/5/22, at 11:44 a.m. RN-A stated when an incident including a burn occurred in the facility, an event report was to be completed. However, the facility electronic medical record did not have a system for burn events, therefore, an event had not been completed. The staff members were to assess how the incident happened and develop a system for preventing future incidents. In addition, the staff members were to assess, document and care plan any treatments needed as a result of the event. RN-A confirmed R1's clinical record lacked a compressive assessment related to hot liquids and R1's current burns. RN-A added the facility did not have a policy related to burns sustained at the facility.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess safety functions of the liquid coffee	F 689	F689 Plan of Correction	6/30/22

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F 689	Continued From page 8 dispensers on 3 of 3 cottage kitchenettes (Sophia House, Cushman Cottage, and the Transitional Care Unit). This practice resulted in 1 of 1 (R1) resident who sustained coffee burns. This practice had the potential to affect all 55 residents. Findings include: A Nursing Home Incident Report (NHIR) dated 4/28/22, indicated R1 had sustained a burn on her right thigh. R1 had told the staff member she had spilt her coffee. The burn was noted to be irregular shaped 1st degree and had three small areas. The lateral area measured 6 centimeters (cm) by 3 cm wide. The middle area was 3 cm wide x 2.5 cm long. The inner most area measure 1.5 cm x 1 cm. The report indicated the facility had installed a new coffee machine on 4/20/22. The previous coffee machine was set to dispense liquids at 145 degrees Fahrenheit, however, the coffee machine was "hot." R1's annual Minimum Data Set (MDS) dated 4/27/22, indicated R1 had severe cognitive impairment and diagnoses of Alzheimer's dementia and anxiety. The assessment indicated R1 required extensive assistance of two staff for all activities of daily living and required supervision of a mechanically altered diet while eating. R1's Care Plan dated 4/29/22, identified R1 as being dependent on staff to obtain all fluids. The plan directed the staff to provide fluids.	F 689	Representative for the coffee machines came to facility and adjusted temps for Sophia house and therapy suites and Cushman had already been adjusted. All 3 houses coffee machines have been adjusted to the lowest setting for temperature. Current temps are reading Sophia House: coffee- 150, hot water 150 /Cushman Cottage: Coffee 130, hot water 130/ Therapy Suites: hot water: 150, Coffee-150 decaf- 158 A sign has been placed on all coffee makers as a reminder to ensure hot liquids are temped down with ice on those at risk. Each coffee maker also has a thermometer. Corrective Action for R1 A Hot Liquids Safety Evaluation has been completed on R1 resulting in a referral to Occupational Therapy to determine if adaptive equipment is needed or other interventions specific to R1. R1 has a lap pad to protect against spills. Corrective Action for Other Residents All residents will receive an initial Hot Liquids Safety Evaluation. Interventions will be implemented as appropriate including a referral to OT. The dining room will be monitored to ensure the safety of all residents and all hot liquids. A staff person will remain in the dining room until all residents have exited.	

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F 689	Continued From page 9 On 5/4/22, at 4:48 p.m. R1 was observed seated in the Sophia House dining room waiting for the evening meal. In the corner of the dining room, a counter was observed which contained an ice machine and a liquid coffee machine (Select Brew Excellence Compact Specialty Coffee System). A posted sign on the liquid coffee machine stated "All staff please make sure you are adding ice or cold water to every cup of coffee and hot water for tea. It is too hot. Service has been called to come and adjust water temp to 145 degrees. Until then always temp the coffee and add ice or cold water." On 5/4/22, at 4:50 p.m. nursing assistant (NA)-H removed a standard plastic coffee cup from a storage drawer, added ice to the cup and then filled it with coffee. NA-H then placed the cup in front of R1. R1's cup was not observed to be equipped with any type of cover or other adaptive equipment. R1 was observed to pick up the cup and drank from it independently. On 5/4/22, from 4:50 p.m. to 5:25 p.m. staff members were observed to assist 13 additional residents into the Sophia's dining room for the evening meal. The staff members would offer the residents their evening liquids. The residents would choose the liquids and the staff members were observed to place ice into all hot liquids and monitor the liquids with a thermometer before serving the liquids to the residents. However, no staff members were observed to remain in the dining room while R1 and other residents waited for the evening meal and drank coffee or other	F 689	Lap pads will be placed on residents based on the hot liquids safety evaluation. Corrective Action to Prevent Reoccurrence Audits will be done weekly on each household for three months starting 6/6/2022 to ensure staff are supervising the dining room until all residents have exited. Audits will be done weekly for three months on temping the coffee maker to ensure average temperatures are consistent and not running too hot. Audits will be done weekly for three months ensuring residents identified at risk of hot liquids are having their hot liquids cooled down to a safe temperature identified on the assessment. Each clinical coordinator will educate the staff on their houses regarding this plan of correction and audit results through team huddles, staff meetings, email, and one on one conversations. Results of audits will be reported at QA. The plan of correction will be emailed to each licensed staff and the director of nursing and/or clinical coordinator will meet with each licensed staff individually to educate on new process.	

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F 689	Continued From page 10 liquids. On 5/4/22, at 5:32 p.m. the Cushman dining room was noted to have a liquid coffee machine (updated Select Brew Excellence Compact Specialty Coffee System) on the counter outside of the kitchenette. The coffee machine was not observed to have any type of signage on it. On 5/4/22, at 5:36 p.m. the transitional care unit (TCU) dining room was noted to have liquid coffee machine (Select Brew NG-110 Coffee system) on a counter outside of the kitchenette. The coffee machine was not observed to have any type of additional signage on it. On 5/5/22, at 7:02 a.m. R1 was observed seated in the dining room drinking a cup of coffee. The cup was a standard plastic coffee cup without any type of adaptive equipment. On 5/5/22, from 7:02 a.m. to 8:25 a.m. the staff members were observed to assist additional residents into the dining room. The staff members would gather liquids for the residents as requested. Each time hot liquids (coffee or water for tea) were obtained for the residents; the staff members were observed to add ice to the cup and check the temperature of the liquid with a thermometer. On 5/5/22, at 8:43 a.m. R1 was wheeled to her room by NA-A and NA-B. The NA's utilized a standing mechanical lift to transfer R1 from the	F 689	The administrator and the director of nurses are responsible for compliance.	

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F 689	Continued From page 11 wheelchair into a standing position. NA-A pulled down R1's pants. R1's right thigh was observed to have a red area approximately three inches wide with three separate areas noted inside the red area. Two of the areas were noted to be covered with yellow/white slough. The third area was a fluid filled blister. On 5/5/22, at 8:51 a.m. NA-A stated he noted the red area last week while transferring the resident after the breakfast meal. NA-A stated R1's clothing had been saturated with coffee, however, R1 had not vocalized to the staff she had spilt her coffee at the time it happened. R1 reported to NA-A she had split her coffee. NA-A stated he reported the red area to the nurse, and she had obtained a cream to be put on the area. NA-A also stated the yellow/white areas on the wound looked "awful." Review of R1's progress note dated 4/28/22, at 9:00 a.m. revealed R1 had a red area discovered on her right thigh. Resident stated she spilt coffee with coffee stain noted on her shirt and pants. The burn area was irregular shaped 1st degree burn and had three smaller area. The lateral area was 6 cm long and 3 cm wide. The middle area was 3 cm wide and 2.5 cm long. The inner most area was 1.5 cm x 1 cm. On 5/5/22, at 10:20 a.m. the dietary director (DD) stated she was responsible to ensure the coffee machines were functioning properly. The DD stated the coffee pot was placed in the Sophia House dining room on 4/15/22. The facility had shifted the coffee pots in the facility due to one	F 689		

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F 689	Continued From page 12 new machine was installed on 4/15 on the Cushman Cottage. The old Cushman Cottage machine was installed on the TCU and the old TCU machine had been installed in the Sophie House. When the machines were installed or moved, the facility had not checked the temperature of the coffee. On 5/5/22, at 10:30 a.m. the temperature of the coffee machines was checked by the DD director. The TCU coffee machine was noted to be 170 degrees Fahrenheit. The Sophie House coffee machine was 152 degrees. The Cushman coffee machine was 132 degrees. The DD stated the coffee had been monitored by the coffee machine representative and the machines had been turned to the lowest temperature. The DD stated the facility did not have a system to monitor the temperature of the coffee machine on a routine basis prior to the burn. However, they were to start monitoring the coffee temperature monthly. On 5/5/22, at 10:47 a.m. RN-D confirmed R1 had sustained a burn from hot coffee. The facility had received a new coffee machine on the unit on 4/20/22, however, RN-D was not aware of how the coffee machine was being monitored. RN-D stated the staff were directed to cool the coffee from the machine with cold water or ice before serving it to the residents. The Safety of Hot Liquids policy dated 2/2022, directed the staff to assess all resident safety concerns and potential for injury from hot liquids upon admission, readmission and on change of condition. Appropriate precautions were to be implemented to maximize choice of beverage	F 689		

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F 689	Continued From page 13 while minimizing the potential of injury. On 5/5/22, at 11:44 a.m. RN-A stated when an incident including a burn occurred in the facility, an event report was to be completed. However, the facility electronic medical record did not have a system for burn events, therefore, an event had not been completed. The staff members were to assess how the incident happened and develop a system for preventing future incidents. In addition, the staff members were to assess, document and care plan any treatments needed because of the event. RN-A confirmed R1's clinical record lacked a compressive assessment related to hot liquids and R1's current burns. RN-A added none of the residents in the facility had received an assessment of their ability to manage hot liquids RN-A added the facility did not have a policy related to burns sustained at the facility. On 5/5/22, at 12:01 p.m. the administrator stated when the coffee burn was discovered, the facility put measures into place to monitor the temperature of the coffee monthly to ensure the safety of the residents. The administrator confirmed the residents were to be assessed for their ability to manage hot coffee, however, the assessments had not been done.	F 689		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 25, 2022

Administrator
Carris Health Care Center & Therapy Suites
1801 Willmar Avenue Southwest
Willmar, MN 56201

Re: State Nursing Home Licensing Orders
Event ID: Z5OZ11

Dear Administrator:

The above facility was surveyed on May 4, 2022 through May 5, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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

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.

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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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 5/4/22- 5/5/22, 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: H54101086C (MN00083144) with a licensing order issued at TAG 830 and 1665. 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 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: THIS ONE MAY NOT BE A PERFECT FIT. Based on observation, interview and document review, the facility failed to investigate the cause of a skin injury and assess for appropriate treatment for 1 of 1 resident (R1) who sustained a burn from hot liquids served at the facility. This deficient practice resulted in actual harm for R1. Findings include:	2 830	2830 Corrective Action An event was created and added in our MatrixCare software to prompt treatments and observations for any resident that sustains a burn. This event will be populated by the licensed staff that received the report or observed the burn area. The event is selected underneath the skin integrity events in MatrixCare.	6/30/22

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CARRIS HEALTH CARE CENTER & THERAPY S	1801 WILLMAR AVENUE SOUTHWEST WILLMAR, MN 56201

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2 830	Continued From page 3 A Nursing Home Incident Report (NHIR) dated 4/28/22, indicated R1 had sustained a burn on her right thigh. R1 had told the staff member she had spilt her coffee. The burn was noted to be irregular shaped 1st degree (A mild burn injury of the outermost layer that make up the skin. Usually heals without scarring the skin) and had three small areas. The lateral area measured 6 centimeters (cm) by 3 cm wide. The middle area was 3 cm wide x 2.5 cm long. The inner most area measure 1.5 cm x 1 cm. The report indicated the facility had installed a new coffee machine on 4/20/22. The previous coffee machine was set to dispense liquids at 145 degrees Fahrenheit, however, the coffee machine was "hot." R1's annual Minimum Data Set (MDS) dated 4/27/22, indicated R1 had severe cognitive impairment and diagnoses of Alzheimer's dementia and anxiety. The assessment indicated R1 required extensive assistance of two staff for all activities of daily living and required supervision of a mechanically altered diet while eating. R1's Nutritional Care Area Assessment (CAA) dated 4/27/22, indicated R1 was to receive a soft diet with food cut into bite sized pieces. The CAA did not include an assessment of R1's ability to manage liquids. R1's Care Plan dated 4/29/22, identified R1 as being dependent on staff to obtain all fluids. The plan directed the staff to provide fluids but did not include any type of special instructions or adaptive equipment for hot liquids. The plan lacked direction related to burns or wound care. On 5/4/22, during continuous observation starting	2 830	This event will trigger for the licensed staff to document the initial event, the description, and measurements of area, to document when family/representative were notified, to document when the physician was notified, to document when event was put on the care plan, interventions put in place, and treatment options. An email with the information was sent out to all licensed staff with the instructions on how to initiate this event for any resident. This was also discussed at the nurses meeting on 5-12-2022, nurses that did not attend the meeting received the meeting minutes in addition to the email that went out on 6-2-2022 and again on 6-6-2022 with updated hot liquid and safety evaluation form. All licensed staff have been trained to use this event for any resident that sustains a burn and to update the care plan and care sheet for the resident affected. A hot liquids and safety evaluation form was created to assess all residents on admission, readmission and change of condition for the use of hot liquids. The hot liquids assessment safety evaluation will print out with the admission paperwork and will be assessed by a RN. This assessment lists risk factors, and interventions. Based on risks identified, a referral would be made to Occupational Therapy (OT) to determine if OT needs to be ordered by the physician to assess for use of adaptive equipment or other interventions that are not listed on the form. If the resident is found to be at risk	

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2 830	Continued From page 4 at 4:48 p.m. R1 was observed seated in the dining room waiting for the evening meal. -At 4:50 p.m. nursing assistant (NA)-H removed a standard plastic coffee cup from a storage drawer, added ice to the cup and then filled it with coffee. NA-H then placed the cup in front of R1. R1's cup was not observed to be equipped with any type of cover or other adaptive equipment. R1 was observed to pick up the cup and drank from it independently. -From 4:50 p.m. to 5:25 p.m. R1 picked up her coffee cup and drank from it independently. No staff members were observed to remain in the dining room while R1 drank and waited for the evening meal. On 5/5/22, during continuous observation starting at 7:02 a.m. R1 was observed seated in the dining room drinking a cup of coffee. The cup was a standard plastic coffee cup without any type of adaptive equipment. -At 7:42 a.m. R1 was served her breakfast meal consisting of scrambled eggs, a banana and toast. R1's meal was not observed to utilize any type of adaptive meal equipment. -At 8:06 a.m. R1 was observed to spill scrambled eggs on her clothing protector. -At 8:29 a.m. R1 stopped eating. She ate approximately 75% of her meal independently and drank 3/4 of the coffee. -At 8:43 a.m. R1 was wheeled to her room by NA-A and NA-B. The NA's utilized a standing mechanical lift to transfer R1 from the wheelchair into a standing position. NA-A pulled down R1's pants. R1's right thigh was observed to have a red area approximately three inches wide with three separate areas noted inside the red area. Two of the areas were noted to be covered with yellow/white slough. The third area was a fluid	2 830	then an intervention from the list or that from the OT must be put into place and updated on the care sheet and care plan. If a resident is assessed to be unsafe for hot liquids staff will need to add ice or wait until liquid cools until temp reads at safe temperature based on assessment. If resident is at risk for burn from hot liquids this will be marked on their care sheets that the CNAs carry with them. All coffee machines will have a note placed on them as a reminder to check temperatures of hot liquids with a thermometer. Lap pads were purchased for the facility as an intervention appropriate for those residents that are marked as at risk for spilling hot liquids. In our facility weekly clinical meeting we added for topic of review Wounds, Burns, and other Skin Concerns instead of just listing out pressure ulcer areas to ensure that all skin concern areas are discussed. The weekly review consists of the 3 RN clinical coordinators and reviews Residents with wounds, burns, skin concerns, if area is facility acquired, what the progression of the area is, if measurements are present in progress notes, if a wound sheet is presents, if there is a facility trend noted, and if it is identified on the care plan. A Representative for the coffee machines came to facility and adjusted temps for Sophia house and therapy suites and Cushman had already been adjusted. All 3 houses coffee machines have been	

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2 830	Continued From page 5 filled blister. -At 8:51 a.m. NA-A stated he noted the red area last week while transferring the resident after the breakfast meal. NA-A stated R1's clothing had been saturated with coffee, however, R1 had not vocalized to the staff she had spilt her coffee at the time it happened. R1 reported to NA-A she had split her coffee. NA-A stated he reported the red area to the nurse, and she had obtained a cream to be put on the area. NA-A also stated the yellow/white areas on the wound looked "awful." Review of R1's Progress Notes (PN)/nurses notes revealed the following information: - PN 4/28/22, at 9:00 a.m. R1 had a red area discovered on her right thigh. Resident stated she spilt coffee with coffee stain noted on her shirt and pants. The burn area was irregular shaped 1st degree burn and had three smaller area. The lateral area was 6 cm long and 3 cm wide. The middle area was 3 cm wide and 2.5 cm long. The inner most area was 1.5 cm x 1 cm. -PN 4/28/22, at 10:00 p.m. indicated the burn on the right thigh had started to blister. -PN 4/29/22, at 9:48 a.m. indicated R1 had received an order to apply Silvadene 1% (medicated cream frequently used on burns) twice a day on the right thigh. -PN 4/30/22, at 11:22 p.m. indicated the staff had placed the Silvadene to the burn. -PN 5/1/22, at 11:41 a.m. indicated Silvadene was applied to the burn and R1 still had one blister intact. -PN 5/2/22, at 2:52 p.m. indicated Silvadene was applied to the burn. One blister was still intact. -PN 5/3/22, at 10:37 a.m. Silvadene applied to burn on right thigh. - PN 5/3/22, at 9:43 p.m. Silvadene applied to	2 830	adjusted to the lowest setting for temperature. Current temps are reading Sophia House: coffee- 150, hot water 150 /Cushman Cottage: Coffee 130, hot water 130/ Therapy Suites: hot water: 150, Coffee-150 decaf- 158 Plan of Correction for R1 WOC nurse referral was completed for resident R1 A hot liquids safety evaluation was completed on R1 resulting in a referral to Occupational Therapy to determine if adaptive equipment or other interventions are needed. R1 has a lap pad to protect skin from the spillage of hot liquids. R1's Care Plan states she needs supervision during meals. Our current process is a staff member must remain in the dining room until all at risk residents have exited from mealtime. This process will remain and audits will be done to ensure compliance. Corrective Action to Identify Other Residents All residents will receive an initial hot liquids safety evaluation. If the resident is found to be at risk then an intervention from the list or that from the OT must be put into place and updated on the care sheet and care plan. Based on risks identified, a referral would be made to Occupational Therapy (OT) to determine if OT needs to be ordered by the physician to assess for use of adaptive equipment or other interventions that are	

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2 830	Continued From page 6 burn on upper right thigh. There is a blister area above the healing area that is still intact and a blister below the healing area that is intact. -PN 5/4/22, at 8:37 a.m. Silvadene applied to burn on thigh. There is still one blister that is intact. Healing slowly. -PN 5/5/22, at 3:49 p.m. the burn area has one blister that is intact no adverse side effects. -PN 5/5/22, at 10:31 a.m. Silvadene applied to burn. There is one blister that is intact. Healing slowing with scabbing over the middle light brown in color. Review of facsimile order dated 4/29/22, from nurse practitioner (NP)-A directed the staff to apply Silvadene cream 1% twice a day for seven days to the burn on the right thigh. Review of R1's medical record lacked an event/incident report related to the burn sustained on 4/28/22. It lacked, a comprehensive skin assessment which would include measurements, visual descriptions, and/or reactions to treatments. Finally, the medical record lacked a comprehensive assessment related to R1's ability to manage hot liquids. On 5/5/22, 8:55 a.m. RN-C stated she had completed R1's wound treatment for the day. RN-C stated R1's blisters looked good, they did have slough forming over some of them and R1 had not complained of pain with the treatment. On 5/5/22, at 8:58 a.m. licensed practical nurse (LPN)-A stated R1's burn area had been red last week, however, upon her return to work on 5/4/22, the center of the wound had started to turn yellow with one blister still intact. LPN-A stated R1's burn area looked worse.	2 830	not listed on the form. Our current process of having a staff member remain in the dining room until all at risk residents have exited will continue for all residents in all households. This process will remain and audits will be done to ensure compliance. Corrective Action to Prevent Reoccurrence Audits will be done weekly on each household for three months starting 6/6/2022 to ensure staff are supervising the dining room until all residents have exited. Audits will be done weekly for three months on temping the coffee maker to ensure average temperatures are consistent and not running too hot. Audits will be done weekly for three months ensuring residents identified at risk of hot liquids are having their hot liquids cooled down to a safe temperature identified on the assessment. Each clinical coordinator will educate the staff on their houses regarding this plan of correction and audit results through team huddles, staff meetings, email, and one on one conversations. Results of audits will be reported at QA. The plan of correction will be emailed to each licensed staff and the director of nursing and/or clinical coordinator will meet with each licensed staff individually	

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2 830	Continued From page 7 On 5/5/22, at 10:47 a.m. RN-D stated the facility had not completed an incident report (events report) related to the burn because the electronic medical record system did not have an established system to generate reports related to burns. Therefore, the facility had not completed an incident report. RN-D was aware R1 had a new order for Silvadene cream after sustaining a coffee burn; however, NP-A had not observed the wound. RN-D stated the burn was evaluated daily by the wing nurses and the progress notes were to reflect the status of the burn. RN-D confirmed the medical record did not contain a comprehensive skin assessment related to the burn, a care plan had not been developed and R1's ability to manage hot liquids had not been assessed. RN-D stated the electronic medical record normally directed the staff to complete assessments after an incident (event) report was completed. However, since the facility did not have an event report for burns, no comprehensive assessment had been completed. RN-D stated she had not seen R1's burn area and she would depend upon the progress notes to reflect any changes in the wound. RN-D stated she was not aware of any changes to the burn area. On 5/5/22, at 11:13 a.m. RN-C and RN-D transferred R1 from the wheelchair to the bed via a standing mechanical lift. Once in bed, RN-D measured R1's burn area. The area was located on R1's upper right thigh just below her pantie line. RN-D measure the wound in three sections. The middle section was 6 cm x 2.25 cm and was 90%-100% covered with yellow/white slough. The portion of the wound closest to R1's groin area had a 2.25 cm x 2 cm intact fluid filled blister. The outer area of the burn measured 5.5 cm x 3 cm with a small open and slough covered	2 830	to educate on new process. The Administrator and Director of Nursing are responsible to ensure compliance.	

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2 830	Continued From page 8 areas. No significant drainage was noted. On 5/5/22, at 11:18 a.m. RN-C stated the wound appearance had changed in the last three days when the slough had started to cover the wound. On 5/5/22, at 11:25 a.m. RN-D confirmed R1's progress notes did not adequately describe the condition of R1's burn. The burn area was larger than it had been on the initial incident, no additional measurements or description of color had been recorded. In addition, R1 had not been evaluated by a physician to ensure appropriate care and treatment was being delivered for the wound. RN-D stated at minimum, the area required a weekly skin assessment. A skin/burn policy was requested, and none was provided. The Safety of Hot Liquids policy dated 2/2022, directed the staff to assess all resident safety concerns and potential for injury from hot liquids upon admission, readmission and on change of condition. Appropriate precautions were to be implemented to maximize choice of beverage while minimizing the potential of injury. On 5/5/22, at 11:44 a.m. RN-A stated when an incident including a burn occurred in the facility, an event report was to be completed. However, the facility electronic medical record did not have a system for burn events, therefore, an event had not been completed. The staff members were to assess how the incident happened and develop a system for preventing future incidents. In addition, the staff members were to assess, document and care plan any treatments needed as a result of the event. RN-A confirmed R1's clinical record lacked a compressive assessment	2 830		

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2 830	Continued From page 9 related to hot liquids and R1's current burns. RN-A added the facility did not have a policy related to burns sustained at the facility. 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 necessaryservices to prevent or improve burn 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		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess safety functions of the liquid coffee dispensers on 3 of 3 cottage kitchenettes (Sophia House, Cushman Cottage, and the Transitional Care Unit). This practice resulted in 1 of 1 (R1) resident who sustained coffee burns. This practice had the potential to affect all 55 residents.	21665	21665 Plan of Correction Representative for the coffee machines came to facility and adjusted temps for Sophia house and therapy suites and Cushman had already been adjusted. All 3 houses coffee machines have been adjusted to the lowest setting for temperature. Current temps are reading	6/30/22

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21665	Continued From page 10 Findings include: A Nursing Home Incident Report (NHIR) dated 4/28/22, indicated R1 had sustained a burn on her right thigh. R1 had told the staff member she had spilt her coffee. The burn was noted to be irregular shaped 1st degree and had three small areas. The lateral area measured 6 centimeters (cm) by 3 cm wide. The middle area was 3 cm wide x 2.5 cm long. The inner most area measure 1.5 cm x 1 cm. The report indicated the facility had installed a new coffee machine on 4/20/22. The previous coffee machine was set to dispense liquids at 145 degrees Fahrenheit, however, the coffee machine was "hot." R1's annual Minimum Data Set (MDS) dated 4/27/22, indicated R1 had severe cognitive impairment and diagnoses of Alzheimer's dementia and anxiety. The assessment indicated R1 required extensive assistance of two staff for all activities of daily living and required supervision of a mechanically altered diet while eating. R1's Care Plan dated 4/29/22, identified R1 as being dependent on staff to obtain all fluids. The plan directed the staff to provide fluids. On 5/4/22, at 4:48 p.m. R1 was observed seated in the Sophia House dining room waiting for the evening meal. In the corner of the dining room, a counter was observed which contained an ice machine and a liquid coffee machine (Select Brew Excellence Compact Specialty Coffee System).	21665	Sophia House: coffee- 150, hot water 150 /Cushman Cottage: Coffee 130, hot water 130/ Therapy Suites: hot water: 150, Coffee-150 decaf- 158 A sign has been placed on all coffee makers as a reminder to ensure hot liquids are temped down with ice on those at risk. Each coffee maker also has a thermometer. Corrective Action for R1 A Hot Liquids Safety Evaluation has been completed on R1 resulting in a referral to Occupational Therapy to determine if adaptive equipment is needed or other interventions specific to R1. A lap pad is used for R1 to prevent hot liquid spills. Corrective Action for Other Residents All residents will receive an initial Hot Liquids Safety Evaluation. Interventions will be implemented as appropriate including a referral to OT. The dining room will be monitored to ensure the safety of all residents and all hot liquids. A staff person will remain in the dining room until all residents have exited. Lap pads will be placed on residents based on the hot liquids safety evaluation. Corrective Action to Prevent Reoccurrence Audits will be done weekly on each household for three months starting	

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21665	Continued From page 11 A posted sign on the liquid coffee machine stated "All staff please make sure you are adding ice or cold water to every cup of coffee and hot water for tea. It is too hot. Service has been called to come and adjust water temp to 145 degrees. Until then always temp the coffee and add ice or cold water." On 5/4/22, at 4:50 p.m. nursing assistant (NA)-H removed a standard plastic coffee cup from a storage drawer, added ice to the cup and then filled it with coffee. NA-H then placed the cup in front of R1. R1's cup was not observed to be equipped with any type of cover or other adaptive equipment. R1 was observed to pick up the cup and drank from it independently. On 5/4/22, from 4:50 p.m. to 5:25 p.m. staff members were observed to assist 13 additional residents into the Sophia's dining room for the evening meal. The staff members would offer the residents their evening liquids. The residents would choose the liquids and the staff members were observed to place ice into all hot liquids and monitor the liquids with a thermometer before serving the liquids to the residents. However, no staff members were observed to remain in the dining room while R1 and other residents waited for the evening meal and drank coffee or other liquids. On 5/4/22, at 5:32 p.m. the Cushman dining room was noted to have a liquid coffee machine (updated Select Brew Excellence Compact Specialty Coffee System) on the counter outside of the kitchenette. The coffee machine was not observed to have any type of signage on it.	21665	6/6/2022 to ensure staff are supervising the dining room until all residents have exited. Audits will be done weekly for three months on temping the coffee maker to ensure average temperatures are consistent and not running too hot. Audits will be done weekly for three months ensuring residents identified at risk of hot liquids are having their hot liquids cooled down to a safe temperature identified on the assessment. Each clinical coordinator will educate the staff on their houses regarding this plan of correction and audit results through team huddles, staff meetings, email, and one on one conversations. Results of audits will be reported at QA. The Administrator and Director of Nursing will ensure compliance.	

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21665	Continued From page 12 On 5/4/22, at 5:36 p.m. the transitional care unit (TCU) dining room was noted to have liquid coffee machine (Select Brew NG-110 Coffee system) on a counter outside of the kitchenette. The coffee machine was not observed to have any type of additional signage on it. On 5/5/22, at 7:02 a.m. R1 was observed seated in the dining room drinking a cup of coffee. The cup was a standard plastic coffee cup without any type of adaptive equipment. On 5/5/22, from 7:02 a.m. to 8:25 a.m. the staff members were observed to assist additional residents into the dining room. The staff members would gather liquids for the residents as requested. Each time hot liquids (coffee or water for tea) were obtained for the residents; the staff members were observed to add ice to the cup and check the temperature of the liquid with a thermometer. On 5/5/22, at 8:43 a.m. R1 was wheeled to her room by NA-A and NA-B. The NA's utilized a standing mechanical lift to transfer R1 from the wheelchair into a standing position. NA-A pulled down R1's pants. R1's right thigh was observed to have a red area approximately three inches wide with three separate areas noted inside the red area. Two of the areas were noted to be covered with yellow/white slough. The third area was a fluid filled blister. On 5/5/22, at 8:51 a.m. NA-A stated he noted the red area last week while transferring the resident	21665		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00313	A. BUILDING: _____ B. WING _____	C 05/05/2022

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21665	Continued From page 13 after the breakfast meal. NA-A stated R1's clothing had been saturated with coffee, however, R1 had not vocalized to the staff she had spilt her coffee at the time it happened. R1 reported to NA-A she had split her coffee. NA-A stated he reported the red area to the nurse, and she had obtained a cream to be put on the area. NA-A also stated the yellow/white areas on the wound looked "awful." Review of R1's progress note dated 4/28/22, at 9:00 a.m. revealed R1 had a red area discovered on her right thigh. Resident stated she spilt coffee with coffee stain noted on her shirt and pants. The burn area was irregular shaped 1st degree burn and had three smaller area. The lateral area was 6 cm long and 3 cm wide. The middle area was 3 cm wide and 2.5 cm long. The inner most area was 1.5 cm x 1 cm. On 5/5/22, at 10:20 a.m. the dietary director (DD) stated she was responsible to ensure the coffee machines were functioning properly. The DD stated the coffee pot was placed in the Sophia House dining room on 4/15/22. The facility had shifted the coffee pots in the facility due to one new machine was installed on 4/15 on the Cushman Cottage. The old Cushman Cottage machine was installed on the TCU and the old TCU machine had been installed in the Sophie House. When the machines were installed or moved, the facility had not checked the temperature of the coffee. On 5/5/22, at 10:30 a.m. the temperature of the coffee machines was checked by the DD director. The TCU coffee machine was noted to be 170 degrees Fahrenheit. The Sophie House coffee	21665		

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21665	Continued From page 14 machine was 152 degrees. The Cushman coffee machine was 132 degrees. The DD stated the coffee had been monitored by the coffee machine representative and the machines had been turned to the lowest temperature. The DD stated the facility did not have a system to monitor the temperature of the coffee machine on a routine basis prior to the burn. However, they were to start monitoring the coffee temperature monthly. On 5/5/22, at 10:47 a.m. RN-D confirmed R1 had sustained a burn from hot coffee. The facility had received a new coffee machine on the unit on 4/20/22, however, RN-D was not aware of how the coffee machine was being monitored. RN-D stated the staff were directed to cool the coffee from the machine with cold water or ice before serving it to the residents. The Safety of Hot Liquids policy dated 2/2022, directed the staff to assess all resident safety concerns and potential for injury from hot liquids upon admission, readmission and on change of condition. Appropriate precautions were to be implemented to maximize choice of beverage while minimizing the potential of injury. On 5/5/22, at 11:44 a.m. RN-A stated when an incident including a burn occurred in the facility, an event report was to be completed. However, the facility electronic medical record did not have a system for burn events, therefore, an event had not been completed. The staff members were to assess how the incident happened and develop a system for preventing future incidents. In addition, the staff members were to assess, document and care plan any treatments needed	21665		

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21665	Continued From page 15 because of the event. RN-A confirmed R1's clinical record lacked a compressive assessment related to hot liquids and R1's current burns. RN-A added none of the residents in the facility had received an assessment of their ability to manage hot liquids RN-A added the facility did not have a policy related to burns sustained at the facility. On 5/5/22, at 12:01 p.m. the administrator stated when the coffee burn was discovered, the facility put measures into place to monitor the temperature of the coffee monthly to ensure the safety of the residents. The administrator confirmed the residents were to be assessed for their ability to manage hot coffee, however, the assessments had not been done. The director of nursing (DON) or designee, could educate staff regarding the importance of a safe cofee dispensing areas. The DON or designee, could coordinate with maintenance and dietary staff to conduct periodic audits of areas residents frequent to obtain hot liquids and ensure a safe, clean, functional and homelike environment is maintained to the extent possible. Time Period for correction: Twenty-one (21) days	21665		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 11, 2022

Administrator
Centracare-Willmar
1801 Willmar Avenue Southwest
Willmar, MN 56201

Re: Reinspection Results
Event ID: Z5OZ12

Dear Administrator:

On July 5, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 5, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

Electronically delivered
May 25, 2022

Administrator
Carris Health Care Center & Therapy Suites
1801 Willmar Avenue Southwest
Willmar, MN 56201

RE: CCN: 245410
Cycle Start Date: May 5, 2022

Dear Administrator:

On May 5, 2022, 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 isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective June 9, 2022.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective June 9, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 9, 2022.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by June 9, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Carris Health Care Center & Therapy Suites will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 9, 2022. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 5, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C)

and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245410	A. BUILDING _____ B. WING _____	C 05/05/2022

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F 000	INITIAL COMMENTS On 5/4/22- 5/5/22, a standard abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was not found NOT to be in compliance with the requirements of 42 CFR Part 483, Subpart B, requirements for Long Term Care Facilities. The following complaints was found to be SUBSTANTIATED: H54101086C (MN00083144), with a deficiency cited at F684 and 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of	F 684		6/30/22

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

Electronically Signed | 06/07/2022

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 684	Continued From page 1 practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to investigate the cause of a skin injury and assess for appropriate treatment for 1 of 1 resident (R1) who sustained a burn from hot liquids served at the facility. This deficient practice resulted in actual harm for R1. Findings include: A Nursing Home Incident Report (NHIR) dated 4/28/22, indicated R1 had sustained a burn on her right thigh. R1 had told the staff member she had spilt her coffee. The burn was noted to be irregular shaped 1st degree (A mild burn injury of the outermost layer that make up the skin. Usually heals without scarring the skin) and had three small areas. The lateral area measured 6 centimeters (cm) by 3 cm wide. The middle area was 3 cm wide x 2.5 cm long. The inner most area measure 1.5 cm x 1 cm. The report indicated the facility had installed a new coffee machine on 4/20/22. The previous coffee machine was set to dispense liquids at 145 degrees Fahrenheit, however, the coffee machine was "hot." R1's annual Minimum Data Set (MDS) dated 4/27/22, indicated R1 had severe cognitive impairment and diagnoses of Alzheimer's dementia and anxiety. The assessment indicated R1 required extensive assistance of two staff for all activities of daily living and required supervision of a mechanically altered diet while eating.	F 684	F684 Corrective Action An event was created and added in our MatrixCare software to prompt treatments and observations for any resident that sustains a burn. This event will be populated by the licensed staff that received the report or observed the burn area. The event is selected underneath the skin integrity events in MatrixCare. This event will trigger for the licensed staff to document the initial event, the description, and measurements of area, to document when family/representative were notified, to document when the physician was notified, to document when event was put on the care plan, interventions put in place, and treatment options. An email with the information was sent out to all licensed staff with the instructions on how to initiate this event for any resident. This was also discussed at the nurses meeting on 5-12-2022, nurses that did not attend the meeting received the meeting minutes in addition to the email that went out on 6-2-2022 and again on 6-6-2022 with updated hot liquid and safety evaluation form. All licensed staff have been trained to use this event for any resident that sustains a burn and to update the care plan and care sheet for the resident affected.	

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F 684	Continued From page 2 R1's Nutritional Care Area Assessment (CAA) dated 4/27/22, indicated R1 was to receive a soft diet with food cut into bite sized pieces. The CAA did not include an assessment of R1's ability to manage liquids. R1's Care Plan dated 4/29/22, identified R1 as being dependent on staff to obtain all fluids. The plan directed the staff to provide fluids but did not include any type of special instructions or adaptive equipment for hot liquids. The plan lacked direction related to burns or wound care. On 5/4/22, during continuous observation starting at 4:48 p.m. R1 was observed seated in the dining room waiting for the evening meal. -At 4:50 p.m. nursing assistant (NA)-H removed a standard plastic coffee cup from a storage drawer, added ice to the cup and then filled it with coffee. NA-H then placed the cup in front of R1. R1's cup was not observed to be equipped with any type of cover or other adaptive equipment. R1 was observed to pick up the cup and drank from it independently. -From 4:50 p.m. to 5:25 p.m. R1 picked up her coffee cup and drank from it independently. No staff members were observed to remain in the dining room while R1 drank and waited for the evening meal. On 5/5/22, during continuous observation starting at 7:02 a.m. R1 was observed seated in the dining room drinking a cup of coffee. The cup was a standard plastic coffee cup without any type of adaptive equipment. -At 7:42 a.m. R1 was served her breakfast meal consisting of scrambled eggs, a banana and toast. R1's meal was not observed to utilize any	F 684	A hot liquids and safety evaluation form was created to assess all residents on admission, readmission and change of condition for the use of hot liquids. The hot liquids assessment safety evaluation will print out with the admission paperwork and will be assessed by a RN. This assessment lists risk factors, and interventions. Based on risks identified, a referral would be made to Occupational Therapy (OT) to determine if OT needs to be ordered by the physician to assess for use of adaptive equipment or other interventions that are not listed on the form. If the resident is found to be at risk then an intervention from the list or that from the OT must be put into place and updated on the care sheet and care plan. If a resident is assessed to be unsafe for hot liquids staff will need to add ice or wait until liquid cools until temp reads at safe temperature based on assessment. If resident is at risk for burn from hot liquids this will be marked on their care sheets that the CNAs carry with them. All coffee machines will have a note placed on them as a reminder to check temperatures of hot liquids with a thermometer. Lap pads were purchased for the facility as an intervention appropriate for those residents that are marked as at risk for spilling hot liquids. In our facility weekly clinical meeting we added for topic of review Wounds, Burns, and other Skin Concerns instead of just	

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F 684	Continued From page 3 type of adaptive meal equipment. -At 8:06 a.m. R1 was observed to spill scrambled eggs on her clothing protector. -At 8:29 a.m. R1 stopped eating. She ate approximately 75% of her meal independently and drank 3/4 of the coffee. -At 8:43 a.m. R1 was wheeled to her room by NA-A and NA-B. The NA's utilized a standing mechanical lift to transfer R1 from the wheelchair into a standing position. NA-A pulled down R1's pants. R1's right thigh was observed to have a red area approximately three inches wide with three separate areas noted inside the red area. Two of the areas were noted to be covered with yellow/white slough. The third area was a fluid filled blister. -At 8:51 a.m. NA-A stated he noted the red area last week while transferring the resident after the breakfast meal. NA-A stated R1's clothing had been saturated with coffee, however, R1 had not vocalized to the staff she had spilt her coffee at the time it happened. R1 reported to NA-A she had split her coffee. NA-A stated he reported the red area to the nurse, and she had obtained a cream to be put on the area. NA-A also stated the yellow/white areas on the wound looked "awful." Review of R1's Progress Notes (PN)/nurses notes revealed the following information: - PN 4/28/22, at 9:00 a.m. R1 had a red area discovered on her right thigh. Resident stated she spilt coffee with coffee stain noted on her shirt and pants. The burn area was irregular shaped 1st degree burn and had three smaller area. The lateral area was 6 cm long and 3 cm wide. The middle area was 3 cm wide and 2.5 cm long. The inner most area was 1.5 cm x 1 cm.	F 684	listing out pressure ulcer areas to ensure that all skin concern areas are discussed. The weekly review consists of the 3 RN clinical coordinators and reviews Residents with wounds, burns, skin concerns, if area is facility acquired, what the progression of the area is, if measurements are present in progress notes, if a wound sheet is presents, if there is a facility trend noted, and if it is identified on the care plan. A Representative for the coffee machines came to facility and adjusted temps for Sophia house and therapy suites and Cushman had already been adjusted. All 3 houses coffee machines have been adjusted to the lowest setting for temperature. Current temps are reading Sophia House: coffee- 150, hot water 150 /Cushman Cottage: Coffee 130, hot water 130/ Therapy Suites: hot water: 150, Coffee-150 decaf- 158 Plan of Correction for R1 WOC nurse referral was completed for resident R1 A hot liquids safety evaluation was completed on R1 resulting in a referral to Occupational Therapy to determine if adaptive equipment or other interventions are needed. R1 has a lap pad to protect skin from the spillage of hot liquids. R1's Care Plan states she needs supervision during meals. Our current process is a staff member must remain in the dining room until all at risk residents	

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F 684	Continued From page 4 -PN 4/28/22, at 10:00 p.m. indicated the burn on the right thigh had started to blister. -PN 4/29/22, at 9:48 a.m. indicated R1 had received an order to apply Silvadene 1% (medicated cream frequently used on burns) twice a day on the right thigh. -PN 4/30/22, at 11:22 p.m. indicated the staff had placed the Silvadene to the burn. -PN 5/1/22, at 11:41 a.m. indicated Silvadene was applied to the burn and R1 still had one blister intact. -PN 5/2/22, at 2:52 p.m. indicated Silvadene was applied to the burn. One blister was still intact. -PN 5/3/22, at 10:37 a.m. Silvadene applied to burn on right thigh. - PN 5/3/22, at 9:43 p.m. Silvadene applied to burn on upper right thigh. There is a blister area above the healing area that is still intact and a blister below the healing area that is intact. -PN 5/4/22, at 8:37 a.m. Silvadene applied to burn on thigh. There is still one blister that is intact. Healing slowly. -PN 5/5/22, at 3:49 p.m. the burn area has one blister that is intact no adverse side effects. -PN 5/5/22, at 10:31 a.m. Silvadene applied to burn. There is one blister that is intact. Healing slowing with scabbing over the middle light brown in color. Review of facsimile order dated 4/29/22, from nurse practitioner (NP)-A directed the staff to apply Silvadene cream 1% twice a day for seven days to the burn on the right thigh. Review of R1's medical record lacked an event/incident report related to the burn sustained on 4/28/22. It lacked, a comprehensive skin assessment which would include measurements, visual descriptions, and/or reactions to	F 684	have exited from mealtime. This process will remain and audits will be done to ensure compliance. Corrective Action to Identify Other Residents All residents will receive an initial hot liquids safety evaluation. If the resident is found to be at risk then an intervention from the list or that from the OT must be put into place and updated on the care sheet and care plan. Based on risks identified, a referral would be made to Occupational Therapy (OT) to determine if OT needs to be ordered by the physician to assess for use of adaptive equipment or other interventions that are not listed on the form. Our current process of having a staff member remain in the dining room until all at risk residents have exited will continue for all residents in all households. This process will remain and audits will be done to ensure compliance. Corrective Action to Prevent Reoccurrence Audits will be done weekly on each household for three months starting 6/6/2022 to ensure staff are supervising the dining room until all residents have exited. Audits will be done weekly for three months on temping the coffee maker to ensure average temperatures are	

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F 684	Continued From page 5 treatments. Finally, the medical record lacked a comprehensive assessment related to R1's ability to manage hot liquids. On 5/5/22, 8:55 a.m. RN-C stated she had completed R1's wound treatment for the day. RN-C stated R1's blisters looked good, they did have slough forming over some of them and R1 had not complained of pain with the treatment. On 5/5/22, at 8:58 a.m. licensed practical nurse (LPN)-A stated R1's burn area had been red last week, however, upon her return to work on 5/4/22, the center of the wound had started to turn yellow with one blister still intact. LPN-A stated R1's burn area looked worse. On 5/5/22, at 10:47 a.m. RN-D stated the facility had not completed an incident report (events report) related to the burn because the electronic medical record system did not have an established system to generate reports related to burns. Therefore, the facility had not completed an incident report. RN-D was aware R1 had a new order for Silvadene cream after sustaining a coffee burn; however, NP-A had not observed the wound. RN-D stated the burn was evaluated daily by the wing nurses and the progress notes were to reflect the status of the burn. RN-D confirmed the medical record did not contain a comprehensive skin assessment related to the burn, a care plan had not been developed and R1's ability to manage hot liquids had not been assessed. RN-D stated the electronic medical record normally directed the staff to complete assessments after an incident (event) report was completed. However, since the facility did not have an event report for burns, no comprehensive assessment had been completed.	F 684	consistent and not running too hot. Audits will be done weekly for three months ensuring residents identified at risk of hot liquids are having their hot liquids cooled down to a safe temperature identified on the assessment. Each clinical coordinator will educate the staff on their houses regarding this plan of correction and audit results through team huddles, staff meetings, email, and one on one conversations. Results of audits will be reported at QA. The plan of correction will be emailed to each licensed staff and the director of nursing and/or clinical coordinator will meet with each licensed staff individually to educate on new process. The Administrator and Director of Nursing are responsible to ensure compliance.	

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F 684	Continued From page 6 RN-D stated she had not seen R1's burn area and she would depend upon the progress notes to reflect any changes in the wound. RN-D stated she was not aware of any changes to the burn area. On 5/5/22, at 11:13 a.m. RN-C and RN-D transferred R1 from the wheelchair to the bed via a standing mechanical lift. Once in bed, RN-D measured R1's burn area. The area was located on R1's upper right thigh just below her pantie line. RN-D measure the wound in three sections. The middle section was 6 cm x 2.25 cm and was 90%-100% covered with yellow/white slough. The portion of the wound closest to R1's groin area had a 2.25 cm x 2 cm intact fluid filled blister. The outer area of the burn measured 5.5 cm x 3 cm with a small open and slough covered areas. No significant drainage was noted. On 5/5/22, at 11:18 a.m. RN-C stated the wound appearance had changed in the last three days when the slough had started to cover the wound. On 5/5/22, at 11:25 a.m. RN-D confirmed R1's progress notes did not adequately describe the condition of R1's burn. The burn area was larger than it had been on the initial incident, no additional measurements or description of color had been recorded. In addition, R1 had not been evaluated by a physician to ensure appropriate care and treatment was being delivered for the wound. RN-D stated at minimum, the area required a weekly skin assessment. A skin/burn policy was requested, and none was provided. The Safety of Hot Liquids policy dated 2/2022,	F 684		

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F 684	Continued From page 7 directed the staff to assess all resident safety concerns and potential for injury from hot liquids upon admission, readmission and on change of condition. Appropriate precautions were to be implemented to maximize choice of beverage while minimizing the potential of injury. On 5/5/22, at 11:44 a.m. RN-A stated when an incident including a burn occurred in the facility, an event report was to be completed. However, the facility electronic medical record did not have a system for burn events, therefore, an event had not been completed. The staff members were to assess how the incident happened and develop a system for preventing future incidents. In addition, the staff members were to assess, document and care plan any treatments needed as a result of the event. RN-A confirmed R1's clinical record lacked a compressive assessment related to hot liquids and R1's current burns. RN-A added the facility did not have a policy related to burns sustained at the facility.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess safety functions of the liquid coffee	F 689	F689 Plan of Correction	6/30/22

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F 689	Continued From page 8 dispensers on 3 of 3 cottage kitchenettes (Sophia House, Cushman Cottage, and the Transitional Care Unit). This practice resulted in 1 of 1 (R1) resident who sustained coffee burns. This practice had the potential to affect all 55 residents. Findings include: A Nursing Home Incident Report (NHIR) dated 4/28/22, indicated R1 had sustained a burn on her right thigh. R1 had told the staff member she had spilt her coffee. The burn was noted to be irregular shaped 1st degree and had three small areas. The lateral area measured 6 centimeters (cm) by 3 cm wide. The middle area was 3 cm wide x 2.5 cm long. The inner most area measure 1.5 cm x 1 cm. The report indicated the facility had installed a new coffee machine on 4/20/22. The previous coffee machine was set to dispense liquids at 145 degrees Fahrenheit, however, the coffee machine was "hot." R1's annual Minimum Data Set (MDS) dated 4/27/22, indicated R1 had severe cognitive impairment and diagnoses of Alzheimer's dementia and anxiety. The assessment indicated R1 required extensive assistance of two staff for all activities of daily living and required supervision of a mechanically altered diet while eating. R1's Care Plan dated 4/29/22, identified R1 as being dependent on staff to obtain all fluids. The plan directed the staff to provide fluids.	F 689	Representative for the coffee machines came to facility and adjusted temps for Sophia house and therapy suites and Cushman had already been adjusted. All 3 houses coffee machines have been adjusted to the lowest setting for temperature. Current temps are reading Sophia House: coffee- 150, hot water 150 /Cushman Cottage: Coffee 130, hot water 130/ Therapy Suites: hot water: 150, Coffee-150 decaf- 158 A sign has been placed on all coffee makers as a reminder to ensure hot liquids are temped down with ice on those at risk. Each coffee maker also has a thermometer. Corrective Action for R1 A Hot Liquids Safety Evaluation has been completed on R1 resulting in a referral to Occupational Therapy to determine if adaptive equipment is needed or other interventions specific to R1. R1 has a lap pad to protect against spills. Corrective Action for Other Residents All residents will receive an initial Hot Liquids Safety Evaluation. Interventions will be implemented as appropriate including a referral to OT. The dining room will be monitored to ensure the safety of all residents and all hot liquids. A staff person will remain in the dining room until all residents have exited.	

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F 689	Continued From page 9 On 5/4/22, at 4:48 p.m. R1 was observed seated in the Sophia House dining room waiting for the evening meal. In the corner of the dining room, a counter was observed which contained an ice machine and a liquid coffee machine (Select Brew Excellence Compact Specialty Coffee System). A posted sign on the liquid coffee machine stated "All staff please make sure you are adding ice or cold water to every cup of coffee and hot water for tea. It is too hot. Service has been called to come and adjust water temp to 145 degrees. Until then always temp the coffee and add ice or cold water." On 5/4/22, at 4:50 p.m. nursing assistant (NA)-H removed a standard plastic coffee cup from a storage drawer, added ice to the cup and then filled it with coffee. NA-H then placed the cup in front of R1. R1's cup was not observed to be equipped with any type of cover or other adaptive equipment. R1 was observed to pick up the cup and drank from it independently. On 5/4/22, from 4:50 p.m. to 5:25 p.m. staff members were observed to assist 13 additional residents into the Sophia's dining room for the evening meal. The staff members would offer the residents their evening liquids. The residents would choose the liquids and the staff members were observed to place ice into all hot liquids and monitor the liquids with a thermometer before serving the liquids to the residents. However, no staff members were observed to remain in the dining room while R1 and other residents waited for the evening meal and drank coffee or other	F 689	Lap pads will be placed on residents based on the hot liquids safety evaluation. Corrective Action to Prevent Reoccurrence Audits will be done weekly on each household for three months starting 6/6/2022 to ensure staff are supervising the dining room until all residents have exited. Audits will be done weekly for three months on temping the coffee maker to ensure average temperatures are consistent and not running too hot. Audits will be done weekly for three months ensuring residents identified at risk of hot liquids are having their hot liquids cooled down to a safe temperature identified on the assessment. Each clinical coordinator will educate the staff on their houses regarding this plan of correction and audit results through team huddles, staff meetings, email, and one on one conversations. Results of audits will be reported at QA. The plan of correction will be emailed to each licensed staff and the director of nursing and/or clinical coordinator will meet with each licensed staff individually to educate on new process.	

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F 689	Continued From page 10 liquids. On 5/4/22, at 5:32 p.m. the Cushman dining room was noted to have a liquid coffee machine (updated Select Brew Excellence Compact Specialty Coffee System) on the counter outside of the kitchenette. The coffee machine was not observed to have any type of signage on it. On 5/4/22, at 5:36 p.m. the transitional care unit (TCU) dining room was noted to have liquid coffee machine (Select Brew NG-110 Coffee system) on a counter outside of the kitchenette. The coffee machine was not observed to have any type of additional signage on it. On 5/5/22, at 7:02 a.m. R1 was observed seated in the dining room drinking a cup of coffee. The cup was a standard plastic coffee cup without any type of adaptive equipment. On 5/5/22, from 7:02 a.m. to 8:25 a.m. the staff members were observed to assist additional residents into the dining room. The staff members would gather liquids for the residents as requested. Each time hot liquids (coffee or water for tea) were obtained for the residents; the staff members were observed to add ice to the cup and check the temperature of the liquid with a thermometer. On 5/5/22, at 8:43 a.m. R1 was wheeled to her room by NA-A and NA-B. The NA's utilized a standing mechanical lift to transfer R1 from the	F 689	The administrator and the director of nurses are responsible for compliance.	

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F 689	Continued From page 11 wheelchair into a standing position. NA-A pulled down R1's pants. R1's right thigh was observed to have a red area approximately three inches wide with three separate areas noted inside the red area. Two of the areas were noted to be covered with yellow/white slough. The third area was a fluid filled blister. On 5/5/22, at 8:51 a.m. NA-A stated he noted the red area last week while transferring the resident after the breakfast meal. NA-A stated R1's clothing had been saturated with coffee, however, R1 had not vocalized to the staff she had spilt her coffee at the time it happened. R1 reported to NA-A she had split her coffee. NA-A stated he reported the red area to the nurse, and she had obtained a cream to be put on the area. NA-A also stated the yellow/white areas on the wound looked "awful." Review of R1's progress note dated 4/28/22, at 9:00 a.m. revealed R1 had a red area discovered on her right thigh. Resident stated she spilt coffee with coffee stain noted on her shirt and pants. The burn area was irregular shaped 1st degree burn and had three smaller area. The lateral area was 6 cm long and 3 cm wide. The middle area was 3 cm wide and 2.5 cm long. The inner most area was 1.5 cm x 1 cm. On 5/5/22, at 10:20 a.m. the dietary director (DD) stated she was responsible to ensure the coffee machines were functioning properly. The DD stated the coffee pot was placed in the Sophia House dining room on 4/15/22. The facility had shifted the coffee pots in the facility due to one	F 689		

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F 689	Continued From page 12 new machine was installed on 4/15 on the Cushman Cottage. The old Cushman Cottage machine was installed on the TCU and the old TCU machine had been installed in the Sophie House. When the machines were installed or moved, the facility had not checked the temperature of the coffee. On 5/5/22, at 10:30 a.m. the temperature of the coffee machines was checked by the DD director. The TCU coffee machine was noted to be 170 degrees Fahrenheit. The Sophie House coffee machine was 152 degrees. The Cushman coffee machine was 132 degrees. The DD stated the coffee had been monitored by the coffee machine representative and the machines had been turned to the lowest temperature. The DD stated the facility did not have a system to monitor the temperature of the coffee machine on a routine basis prior to the burn. However, they were to start monitoring the coffee temperature monthly. On 5/5/22, at 10:47 a.m. RN-D confirmed R1 had sustained a burn from hot coffee. The facility had received a new coffee machine on the unit on 4/20/22, however, RN-D was not aware of how the coffee machine was being monitored. RN-D stated the staff were directed to cool the coffee from the machine with cold water or ice before serving it to the residents. The Safety of Hot Liquids policy dated 2/2022, directed the staff to assess all resident safety concerns and potential for injury from hot liquids upon admission, readmission and on change of condition. Appropriate precautions were to be implemented to maximize choice of beverage	F 689		

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F 689	Continued From page 13 while minimizing the potential of injury. On 5/5/22, at 11:44 a.m. RN-A stated when an incident including a burn occurred in the facility, an event report was to be completed. However, the facility electronic medical record did not have a system for burn events, therefore, an event had not been completed. The staff members were to assess how the incident happened and develop a system for preventing future incidents. In addition, the staff members were to assess, document and care plan any treatments needed because of the event. RN-A confirmed R1's clinical record lacked a compressive assessment related to hot liquids and R1's current burns. RN-A added none of the residents in the facility had received an assessment of their ability to manage hot liquids RN-A added the facility did not have a policy related to burns sustained at the facility. On 5/5/22, at 12:01 p.m. the administrator stated when the coffee burn was discovered, the facility put measures into place to monitor the temperature of the coffee monthly to ensure the safety of the residents. The administrator confirmed the residents were to be assessed for their ability to manage hot coffee, however, the assessments had not been done.	F 689		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 25, 2022

Administrator
Carris Health Care Center & Therapy Suites
1801 Willmar Avenue Southwest
Willmar, MN 56201

Re: State Nursing Home Licensing Orders
Event ID: Z5OZ11

Dear Administrator:

The above facility was surveyed on May 4, 2022 through May 5, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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

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.

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
	00313	A. BUILDING: _____ B. WING _____	C 05/05/2022

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CARRIS HEALTH CARE CENTER & THERAPY S	1801 WILLMAR AVENUE SOUTHWEST WILLMAR, MN 56201

(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 5/4/22- 5/5/22, 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: H54101086C (MN00083144) with a licensing order issued at TAG 830 and 1665. 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 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: THIS ONE MAY NOT BE A PERFECT FIT. Based on observation, interview and document review, the facility failed to investigate the cause of a skin injury and assess for appropriate treatment for 1 of 1 resident (R1) who sustained a burn from hot liquids served at the facility. This deficient practice resulted in actual harm for R1. Findings include:	2 830	2830 Corrective Action An event was created and added in our MatrixCare software to prompt treatments and observations for any resident that sustains a burn. This event will be populated by the licensed staff that received the report or observed the burn area. The event is selected underneath the skin integrity events in MatrixCare.	6/30/22

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2 830	Continued From page 3 A Nursing Home Incident Report (NHIR) dated 4/28/22, indicated R1 had sustained a burn on her right thigh. R1 had told the staff member she had spilt her coffee. The burn was noted to be irregular shaped 1st degree (A mild burn injury of the outermost layer that make up the skin. Usually heals without scarring the skin) and had three small areas. The lateral area measured 6 centimeters (cm) by 3 cm wide. The middle area was 3 cm wide x 2.5 cm long. The inner most area measure 1.5 cm x 1 cm. The report indicated the facility had installed a new coffee machine on 4/20/22. The previous coffee machine was set to dispense liquids at 145 degrees Fahrenheit, however, the coffee machine was "hot." R1's annual Minimum Data Set (MDS) dated 4/27/22, indicated R1 had severe cognitive impairment and diagnoses of Alzheimer's dementia and anxiety. The assessment indicated R1 required extensive assistance of two staff for all activities of daily living and required supervision of a mechanically altered diet while eating. R1's Nutritional Care Area Assessment (CAA) dated 4/27/22, indicated R1 was to receive a soft diet with food cut into bite sized pieces. The CAA did not include an assessment of R1's ability to manage liquids. R1's Care Plan dated 4/29/22, identified R1 as being dependent on staff to obtain all fluids. The plan directed the staff to provide fluids but did not include any type of special instructions or adaptive equipment for hot liquids. The plan lacked direction related to burns or wound care. On 5/4/22, during continuous observation starting	2 830	This event will trigger for the licensed staff to document the initial event, the description, and measurements of area, to document when family/representative were notified, to document when the physician was notified, to document when event was put on the care plan, interventions put in place, and treatment options. An email with the information was sent out to all licensed staff with the instructions on how to initiate this event for any resident. This was also discussed at the nurses meeting on 5-12-2022, nurses that did not attend the meeting received the meeting minutes in addition to the email that went out on 6-2-2022 and again on 6-6-2022 with updated hot liquid and safety evaluation form. All licensed staff have been trained to use this event for any resident that sustains a burn and to update the care plan and care sheet for the resident affected. A hot liquids and safety evaluation form was created to assess all residents on admission, readmission and change of condition for the use of hot liquids. The hot liquids assessment safety evaluation will print out with the admission paperwork and will be assessed by a RN. This assessment lists risk factors, and interventions. Based on risks identified, a referral would be made to Occupational Therapy (OT) to determine if OT needs to be ordered by the physician to assess for use of adaptive equipment or other interventions that are not listed on the form. If the resident is found to be at risk	

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2 830	Continued From page 4 at 4:48 p.m. R1 was observed seated in the dining room waiting for the evening meal. -At 4:50 p.m. nursing assistant (NA)-H removed a standard plastic coffee cup from a storage drawer, added ice to the cup and then filled it with coffee. NA-H then placed the cup in front of R1. R1's cup was not observed to be equipped with any type of cover or other adaptive equipment. R1 was observed to pick up the cup and drank from it independently. -From 4:50 p.m. to 5:25 p.m. R1 picked up her coffee cup and drank from it independently. No staff members were observed to remain in the dining room while R1 drank and waited for the evening meal. On 5/5/22, during continuous observation starting at 7:02 a.m. R1 was observed seated in the dining room drinking a cup of coffee. The cup was a standard plastic coffee cup without any type of adaptive equipment. -At 7:42 a.m. R1 was served her breakfast meal consisting of scrambled eggs, a banana and toast. R1's meal was not observed to utilize any type of adaptive meal equipment. -At 8:06 a.m. R1 was observed to spill scrambled eggs on her clothing protector. -At 8:29 a.m. R1 stopped eating. She ate approximately 75% of her meal independently and drank 3/4 of the coffee. -At 8:43 a.m. R1 was wheeled to her room by NA-A and NA-B. The NA's utilized a standing mechanical lift to transfer R1 from the wheelchair into a standing position. NA-A pulled down R1's pants. R1's right thigh was observed to have a red area approximately three inches wide with three separate areas noted inside the red area. Two of the areas were noted to be covered with yellow/white slough. The third area was a fluid	2 830	then an intervention from the list or that from the OT must be put into place and updated on the care sheet and care plan. If a resident is assessed to be unsafe for hot liquids staff will need to add ice or wait until liquid cools until temp reads at safe temperature based on assessment. If resident is at risk for burn from hot liquids this will be marked on their care sheets that the CNAs carry with them. All coffee machines will have a note placed on them as a reminder to check temperatures of hot liquids with a thermometer. Lap pads were purchased for the facility as an intervention appropriate for those residents that are marked as at risk for spilling hot liquids. In our facility weekly clinical meeting we added for topic of review Wounds, Burns, and other Skin Concerns instead of just listing out pressure ulcer areas to ensure that all skin concern areas are discussed. The weekly review consists of the 3 RN clinical coordinators and reviews Residents with wounds, burns, skin concerns, if area is facility acquired, what the progression of the area is, if measurements are present in progress notes, if a wound sheet is presents, if there is a facility trend noted, and if it is identified on the care plan. A Representative for the coffee machines came to facility and adjusted temps for Sophia house and therapy suites and Cushman had already been adjusted. All 3 houses coffee machines have been	

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2 830	Continued From page 5 filled blister. -At 8:51 a.m. NA-A stated he noted the red area last week while transferring the resident after the breakfast meal. NA-A stated R1's clothing had been saturated with coffee, however, R1 had not vocalized to the staff she had spilt her coffee at the time it happened. R1 reported to NA-A she had split her coffee. NA-A stated he reported the red area to the nurse, and she had obtained a cream to be put on the area. NA-A also stated the yellow/white areas on the wound looked "awful." Review of R1's Progress Notes (PN)/nurses notes revealed the following information: - PN 4/28/22, at 9:00 a.m. R1 had a red area discovered on her right thigh. Resident stated she spilt coffee with coffee stain noted on her shirt and pants. The burn area was irregular shaped 1st degree burn and had three smaller area. The lateral area was 6 cm long and 3 cm wide. The middle area was 3 cm wide and 2.5 cm long. The inner most area was 1.5 cm x 1 cm. -PN 4/28/22, at 10:00 p.m. indicated the burn on the right thigh had started to blister. -PN 4/29/22, at 9:48 a.m. indicated R1 had received an order to apply Silvadene 1% (medicated cream frequently used on burns) twice a day on the right thigh. -PN 4/30/22, at 11:22 p.m. indicated the staff had placed the Silvadene to the burn. -PN 5/1/22, at 11:41 a.m. indicated Silvadene was applied to the burn and R1 still had one blister intact. -PN 5/2/22, at 2:52 p.m. indicated Silvadene was applied to the burn. One blister was still intact. -PN 5/3/22, at 10:37 a.m. Silvadene applied to burn on right thigh. - PN 5/3/22, at 9:43 p.m. Silvadene applied to	2 830	adjusted to the lowest setting for temperature. Current temps are reading Sophia House: coffee- 150, hot water 150 /Cushman Cottage: Coffee 130, hot water 130/ Therapy Suites: hot water: 150, Coffee-150 decaf- 158 Plan of Correction for R1 WOC nurse referral was completed for resident R1 A hot liquids safety evaluation was completed on R1 resulting in a referral to Occupational Therapy to determine if adaptive equipment or other interventions are needed. R1 has a lap pad to protect skin from the spillage of hot liquids. R1's Care Plan states she needs supervision during meals. Our current process is a staff member must remain in the dining room until all at risk residents have exited from mealtime. This process will remain and audits will be done to ensure compliance. Corrective Action to Identify Other Residents All residents will receive an initial hot liquids safety evaluation. If the resident is found to be at risk then an intervention from the list or that from the OT must be put into place and updated on the care sheet and care plan. Based on risks identified, a referral would be made to Occupational Therapy (OT) to determine if OT needs to be ordered by the physician to assess for use of adaptive equipment or other interventions that are	

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2 830	Continued From page 6 burn on upper right thigh. There is a blister area above the healing area that is still intact and a blister below the healing area that is intact. -PN 5/4/22, at 8:37 a.m. Silvadene applied to burn on thigh. There is still one blister that is intact. Healing slowly. -PN 5/5/22, at 3:49 p.m. the burn area has one blister that is intact no adverse side effects. -PN 5/5/22, at 10:31 a.m. Silvadene applied to burn. There is one blister that is intact. Healing slowing with scabbing over the middle light brown in color. Review of facsimile order dated 4/29/22, from nurse practitioner (NP)-A directed the staff to apply Silvadene cream 1% twice a day for seven days to the burn on the right thigh. Review of R1's medical record lacked an event/incident report related to the burn sustained on 4/28/22. It lacked, a comprehensive skin assessment which would include measurements, visual descriptions, and/or reactions to treatments. Finally, the medical record lacked a comprehensive assessment related to R1's ability to manage hot liquids. On 5/5/22, 8:55 a.m. RN-C stated she had completed R1's wound treatment for the day. RN-C stated R1's blisters looked good, they did have slough forming over some of them and R1 had not complained of pain with the treatment. On 5/5/22, at 8:58 a.m. licensed practical nurse (LPN)-A stated R1's burn area had been red last week, however, upon her return to work on 5/4/22, the center of the wound had started to turn yellow with one blister still intact. LPN-A stated R1's burn area looked worse.	2 830	not listed on the form. Our current process of having a staff member remain in the dining room until all at risk residents have exited will continue for all residents in all households. This process will remain and audits will be done to ensure compliance. Corrective Action to Prevent Reoccurrence Audits will be done weekly on each household for three months starting 6/6/2022 to ensure staff are supervising the dining room until all residents have exited. Audits will be done weekly for three months on temping the coffee maker to ensure average temperatures are consistent and not running too hot. Audits will be done weekly for three months ensuring residents identified at risk of hot liquids are having their hot liquids cooled down to a safe temperature identified on the assessment. Each clinical coordinator will educate the staff on their houses regarding this plan of correction and audit results through team huddles, staff meetings, email, and one on one conversations. Results of audits will be reported at QA. The plan of correction will be emailed to each licensed staff and the director of nursing and/or clinical coordinator will meet with each licensed staff individually	

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2 830	Continued From page 7 On 5/5/22, at 10:47 a.m. RN-D stated the facility had not completed an incident report (events report) related to the burn because the electronic medical record system did not have an established system to generate reports related to burns. Therefore, the facility had not completed an incident report. RN-D was aware R1 had a new order for Silvadene cream after sustaining a coffee burn; however, NP-A had not observed the wound. RN-D stated the burn was evaluated daily by the wing nurses and the progress notes were to reflect the status of the burn. RN-D confirmed the medical record did not contain a comprehensive skin assessment related to the burn, a care plan had not been developed and R1's ability to manage hot liquids had not been assessed. RN-D stated the electronic medical record normally directed the staff to complete assessments after an incident (event) report was completed. However, since the facility did not have an event report for burns, no comprehensive assessment had been completed. RN-D stated she had not seen R1's burn area and she would depend upon the progress notes to reflect any changes in the wound. RN-D stated she was not aware of any changes to the burn area. On 5/5/22, at 11:13 a.m. RN-C and RN-D transferred R1 from the wheelchair to the bed via a standing mechanical lift. Once in bed, RN-D measured R1's burn area. The area was located on R1's upper right thigh just below her pantie line. RN-D measure the wound in three sections. The middle section was 6 cm x 2.25 cm and was 90%-100% covered with yellow/white slough. The portion of the wound closest to R1's groin area had a 2.25 cm x 2 cm intact fluid filled blister. The outer area of the burn measured 5.5 cm x 3 cm with a small open and slough covered	2 830	to educate on new process. The Administrator and Director of Nursing are responsible to ensure compliance.	

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2 830	Continued From page 8 areas. No significant drainage was noted. On 5/5/22, at 11:18 a.m. RN-C stated the wound appearance had changed in the last three days when the slough had started to cover the wound. On 5/5/22, at 11:25 a.m. RN-D confirmed R1's progress notes did not adequately describe the condition of R1's burn. The burn area was larger than it had been on the initial incident, no additional measurements or description of color had been recorded. In addition, R1 had not been evaluated by a physician to ensure appropriate care and treatment was being delivered for the wound. RN-D stated at minimum, the area required a weekly skin assessment. A skin/burn policy was requested, and none was provided. The Safety of Hot Liquids policy dated 2/2022, directed the staff to assess all resident safety concerns and potential for injury from hot liquids upon admission, readmission and on change of condition. Appropriate precautions were to be implemented to maximize choice of beverage while minimizing the potential of injury. On 5/5/22, at 11:44 a.m. RN-A stated when an incident including a burn occurred in the facility, an event report was to be completed. However, the facility electronic medical record did not have a system for burn events, therefore, an event had not been completed. The staff members were to assess how the incident happened and develop a system for preventing future incidents. In addition, the staff members were to assess, document and care plan any treatments needed as a result of the event. RN-A confirmed R1's clinical record lacked a compressive assessment	2 830		

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2 830	Continued From page 9 related to hot liquids and R1's current burns. RN-A added the facility did not have a policy related to burns sustained at the facility. 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 necessaryservices to prevent or improve burn 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		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess safety functions of the liquid coffee dispensers on 3 of 3 cottage kitchenettes (Sophia House, Cushman Cottage, and the Transitional Care Unit). This practice resulted in 1 of 1 (R1) resident who sustained coffee burns. This practice had the potential to affect all 55 residents.	21665	21665 Plan of Correction Representative for the coffee machines came to facility and adjusted temps for Sophia house and therapy suites and Cushman had already been adjusted. All 3 houses coffee machines have been adjusted to the lowest setting for temperature. Current temps are reading	6/30/22

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21665	Continued From page 10 Findings include: A Nursing Home Incident Report (NHIR) dated 4/28/22, indicated R1 had sustained a burn on her right thigh. R1 had told the staff member she had spilt her coffee. The burn was noted to be irregular shaped 1st degree and had three small areas. The lateral area measured 6 centimeters (cm) by 3 cm wide. The middle area was 3 cm wide x 2.5 cm long. The inner most area measure 1.5 cm x 1 cm. The report indicated the facility had installed a new coffee machine on 4/20/22. The previous coffee machine was set to dispense liquids at 145 degrees Fahrenheit, however, the coffee machine was "hot." R1's annual Minimum Data Set (MDS) dated 4/27/22, indicated R1 had severe cognitive impairment and diagnoses of Alzheimer's dementia and anxiety. The assessment indicated R1 required extensive assistance of two staff for all activities of daily living and required supervision of a mechanically altered diet while eating. R1's Care Plan dated 4/29/22, identified R1 as being dependent on staff to obtain all fluids. The plan directed the staff to provide fluids. On 5/4/22, at 4:48 p.m. R1 was observed seated in the Sophia House dining room waiting for the evening meal. In the corner of the dining room, a counter was observed which contained an ice machine and a liquid coffee machine (Select Brew Excellence Compact Specialty Coffee System).	21665	Sophia House: coffee- 150, hot water 150 /Cushman Cottage: Coffee 130, hot water 130/ Therapy Suites: hot water: 150, Coffee-150 decaf- 158 A sign has been placed on all coffee makers as a reminder to ensure hot liquids are temped down with ice on those at risk. Each coffee maker also has a thermometer. Corrective Action for R1 A Hot Liquids Safety Evaluation has been completed on R1 resulting in a referral to Occupational Therapy to determine if adaptive equipment is needed or other interventions specific to R1. A lap pad is used for R1 to prevent hot liquid spills. Corrective Action for Other Residents All residents will receive an initial Hot Liquids Safety Evaluation. Interventions will be implemented as appropriate including a referral to OT. The dining room will be monitored to ensure the safety of all residents and all hot liquids. A staff person will remain in the dining room until all residents have exited. Lap pads will be placed on residents based on the hot liquids safety evaluation. Corrective Action to Prevent Reoccurrence Audits will be done weekly on each household for three months starting	

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21665	Continued From page 11 A posted sign on the liquid coffee machine stated "All staff please make sure you are adding ice or cold water to every cup of coffee and hot water for tea. It is too hot. Service has been called to come and adjust water temp to 145 degrees. Until then always temp the coffee and add ice or cold water." On 5/4/22, at 4:50 p.m. nursing assistant (NA)-H removed a standard plastic coffee cup from a storage drawer, added ice to the cup and then filled it with coffee. NA-H then placed the cup in front of R1. R1's cup was not observed to be equipped with any type of cover or other adaptive equipment. R1 was observed to pick up the cup and drank from it independently. On 5/4/22, from 4:50 p.m. to 5:25 p.m. staff members were observed to assist 13 additional residents into the Sophia's dining room for the evening meal. The staff members would offer the residents their evening liquids. The residents would choose the liquids and the staff members were observed to place ice into all hot liquids and monitor the liquids with a thermometer before serving the liquids to the residents. However, no staff members were observed to remain in the dining room while R1 and other residents waited for the evening meal and drank coffee or other liquids. On 5/4/22, at 5:32 p.m. the Cushman dining room was noted to have a liquid coffee machine (updated Select Brew Excellence Compact Specialty Coffee System) on the counter outside of the kitchenette. The coffee machine was not observed to have any type of signage on it.	21665	6/6/2022 to ensure staff are supervising the dining room until all residents have exited. Audits will be done weekly for three months on temping the coffee maker to ensure average temperatures are consistent and not running too hot. Audits will be done weekly for three months ensuring residents identified at risk of hot liquids are having their hot liquids cooled down to a safe temperature identified on the assessment. Each clinical coordinator will educate the staff on their houses regarding this plan of correction and audit results through team huddles, staff meetings, email, and one on one conversations. Results of audits will be reported at QA. The Administrator and Director of Nursing will ensure compliance.	

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21665	Continued From page 12 On 5/4/22, at 5:36 p.m. the transitional care unit (TCU) dining room was noted to have liquid coffee machine (Select Brew NG-110 Coffee system) on a counter outside of the kitchenette. The coffee machine was not observed to have any type of additional signage on it. On 5/5/22, at 7:02 a.m. R1 was observed seated in the dining room drinking a cup of coffee. The cup was a standard plastic coffee cup without any type of adaptive equipment. On 5/5/22, from 7:02 a.m. to 8:25 a.m. the staff members were observed to assist additional residents into the dining room. The staff members would gather liquids for the residents as requested. Each time hot liquids (coffee or water for tea) were obtained for the residents; the staff members were observed to add ice to the cup and check the temperature of the liquid with a thermometer. On 5/5/22, at 8:43 a.m. R1 was wheeled to her room by NA-A and NA-B. The NA's utilized a standing mechanical lift to transfer R1 from the wheelchair into a standing position. NA-A pulled down R1's pants. R1's right thigh was observed to have a red area approximately three inches wide with three separate areas noted inside the red area. Two of the areas were noted to be covered with yellow/white slough. The third area was a fluid filled blister. On 5/5/22, at 8:51 a.m. NA-A stated he noted the red area last week while transferring the resident	21665		

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21665	Continued From page 13 after the breakfast meal. NA-A stated R1's clothing had been saturated with coffee, however, R1 had not vocalized to the staff she had spilt her coffee at the time it happened. R1 reported to NA-A she had split her coffee. NA-A stated he reported the red area to the nurse, and she had obtained a cream to be put on the area. NA-A also stated the yellow/white areas on the wound looked "awful." Review of R1's progress note dated 4/28/22, at 9:00 a.m. revealed R1 had a red area discovered on her right thigh. Resident stated she spilt coffee with coffee stain noted on her shirt and pants. The burn area was irregular shaped 1st degree burn and had three smaller area. The lateral area was 6 cm long and 3 cm wide. The middle area was 3 cm wide and 2.5 cm long. The inner most area was 1.5 cm x 1 cm. On 5/5/22, at 10:20 a.m. the dietary director (DD) stated she was responsible to ensure the coffee machines were functioning properly. The DD stated the coffee pot was placed in the Sophia House dining room on 4/15/22. The facility had shifted the coffee pots in the facility due to one new machine was installed on 4/15 on the Cushman Cottage. The old Cushman Cottage machine was installed on the TCU and the old TCU machine had been installed in the Sophie House. When the machines were installed or moved, the facility had not checked the temperature of the coffee. On 5/5/22, at 10:30 a.m. the temperature of the coffee machines was checked by the DD director. The TCU coffee machine was noted to be 170 degrees Fahrenheit. The Sophie House coffee	21665		

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21665	Continued From page 14 machine was 152 degrees. The Cushman coffee machine was 132 degrees. The DD stated the coffee had been monitored by the coffee machine representative and the machines had been turned to the lowest temperature. The DD stated the facility did not have a system to monitor the temperature of the coffee machine on a routine basis prior to the burn. However, they were to start monitoring the coffee temperature monthly. On 5/5/22, at 10:47 a.m. RN-D confirmed R1 had sustained a burn from hot coffee. The facility had received a new coffee machine on the unit on 4/20/22, however, RN-D was not aware of how the coffee machine was being monitored. RN-D stated the staff were directed to cool the coffee from the machine with cold water or ice before serving it to the residents. The Safety of Hot Liquids policy dated 2/2022, directed the staff to assess all resident safety concerns and potential for injury from hot liquids upon admission, readmission and on change of condition. Appropriate precautions were to be implemented to maximize choice of beverage while minimizing the potential of injury. On 5/5/22, at 11:44 a.m. RN-A stated when an incident including a burn occurred in the facility, an event report was to be completed. However, the facility electronic medical record did not have a system for burn events, therefore, an event had not been completed. The staff members were to assess how the incident happened and develop a system for preventing future incidents. In addition, the staff members were to assess, document and care plan any treatments needed	21665		

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21665	Continued From page 15 because of the event. RN-A confirmed R1's clinical record lacked a compressive assessment related to hot liquids and R1's current burns. RN-A added none of the residents in the facility had received an assessment of their ability to manage hot liquids RN-A added the facility did not have a policy related to burns sustained at the facility. On 5/5/22, at 12:01 p.m. the administrator stated when the coffee burn was discovered, the facility put measures into place to monitor the temperature of the coffee monthly to ensure the safety of the residents. The administrator confirmed the residents were to be assessed for their ability to manage hot coffee, however, the assessments had not been done. The director of nursing (DON) or designee, could educate staff regarding the importance of a safe cofee dispensing areas. The DON or designee, could coordinate with maintenance and dietary staff to conduct periodic audits of areas residents frequent to obtain hot liquids and ensure a safe, clean, functional and homelike environment is maintained to the extent possible. Time Period for correction: Twenty-one (21) days	21665		