Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 15, 2026

Administrator
The Estates at Greeley LLC
313 SOUTH GREELEY STREET
STILLWATER, MN 55082

RE: CCN:245342

Cycle Start Date: July 2, 2026

Dear Administrator:

On July 2, 2026, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Lynn Nelson, RN Regional Operations Supervisor
Metro A District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: Lynn.nelson@state.mn.us
Office: 651-201-4392 Mobile: 651-279-5474

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by October 2, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by January 2, 2027 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.
A copy of the Department’s informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

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

DEPARTMENT OF HEALTH

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July 15, 2026

Administrator
The Estates at Greeley LLC
313 SOUTH GREELEY STREET
STILLWATER, MN 55082

Re: State Nursing Home Licensing Orders
Event ID: 231CF7-H1

Dear Administrator:

The above facility survey was completed on July 2, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted 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:

Lynn Nelson, RN Regional Operations Supervisor
Metro A District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: Lynn.nelson@state.mn.us
Office: 651-201-4392 Mobile: 651-279-5474

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

Please feel free to call me with any questions.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING B. WING	07/02/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on (6/29/26-7/2/26) during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E0000		07/24/2026
F0000	INITIAL COMMENTS On 6/29/26 through 7/2/26, a standard recertification survey (S5342020-0) was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H53423102C (27015410) ,H53423103C (2705420), H53423104C (2705430). NO deficiencies were cited. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F0000		07/24/2026
F0688 SS = D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is	F0688	The Residents task was adjusted to reflect the assigned schedule. The schedule and Task will now appear on POC for documentation for R6. Residents identified as being at risk for decline in range of motion (ROM) and mobility and residents on a current ROM program were reviewed by the interdisciplinary team. Therapy referrals were verified or updated as appropriate. Nursing staff completed review to ensure residents' care plans	08/08/2026

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245342	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/02/2026

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F0688 SS = D	Continued from page 1 unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to ensure physician-ordered passive range of motion (ROM) exercises were completed for 1 of 2 residents (R6) reviewed for range of motion. Findings include: R6's quarterly Minimum Data Set (MDS), dated 5/12/26, indicated R6 had moderate cognitive impairment. Diagnoses included cerebral infarction with hemiplegia and hemiparesis affecting the left non-dominant side following a cerebral infarction (blocked blood vessels that deprived part of the brain of oxygen and nutrients). The MDS indicated R6 was dependent on staff for mobility. The MDS also indicated a restorative nursing program had not been completed. R6's physical therapy order, dated 3/31/26, directed staff to complete passive range of motion (ROM) exercises to R6's left arm two to three times daily. The order instructed staff to review the restorative nursing program instructions which were posted on the wall in R6's room. R6's care plan, revised 2/26/26, indicated R6 had impaired mobility related to a cerebrovascular accident (CVA), left-sided hemiparesis, and a traumatic brain injury (TBI). Interventions initiated on 3/31/26 directed nursing staff to provide passive range of motion exercises to the left arm two to three times daily. The care plan also instructed staff to refer to the restorative rehabilitation handout posted on the wall and closet. R37's follow up documentation for nursing rehab passive ROM left arm 2-3 times a day *see handout on closet. indicated the following:	F0688	Continued from page 1 accurately reflect current mobility needs, interventions, and restorative nursing programming. All residents will be reviewed for mobility status, ROM needs, and restorative nursing services. Care plans will be updated to include individualized interventions for maintaining or improving mobility. Nursing staff will receive education on ROM programs and documentation, Early identification of functional decline, and Timely referral to rehabilitation services. Weekly audits of 10 resident records for 4 weeks, then monthly for 5 months. Audits will verify Appropriate assessments, evaluations and screens, Rehab services recommendations and orders, Interventions are documented in the care plan, Documentation of ROM/Restorative/Maintenance Program Activities. Findings will be reported during the Quality Assurance and Performance Improvement (QAPI) meetings, with corrective action implemented for identified deficiencies.	08/08/2026

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F0688 SS = D	Continued from page 2 -for 4/2026, R37 refused ROM one time, no further documentation of task completed or refused was documented. -for 5/2026, lacked indication any ROM was completed for R37 -for 6/2026, lacked indication any ROM was completed for R37 During observation and interview on 7/1/26 at 10:07 a.m., nursing assistant (NA)-A completed R6's activities of daily living (ADLs), including changing the brief and clothing, washing the face and body, applying powder and lotion, brushing the hair, and providing oral and lip care. However, NA-A did not perform the ordered passive ROM exercises, even though the instructions and photographs of the required care were posted in plain view. During the interview, NA-A stated resident care instructions were available in the care plan, Kardex, and task list within the electronic medical record (EMR). NA-A stated R6 required total assistance with all care and that if passive ROM was required, it would have been listed in the EMR. NA-A verified signs in the room, however, did not perform the task. During an interview on 7/2/26 at 11:59 a.m., NA-B stated resident care tasks were located in the Kardex/task tab of the EMR and were based on the care plan. NA-B stated the therapy department provided education and instruction regarding restorative rehabilitation. NA-B further stated the passive ROM task had not been completed because the task indicator in the EMR was not green, which indicated the task had not been performed. During an interview on 7/2/26 at 12:13 p.m., licensed practical nurse (LPN)-A stated the therapy department provided restorative rehabilitation orders and instructions, including signage and resident-specific information. LPN-A stated staff verified completion of restorative rehabilitation by reviewing the task tab in the EMR and by observing staff provide resident care. LPN-A stated it was important to follow physician orders to ensure resident care and safety. LPN-A was unable to verify in the EMR that R6's passive ROM exercises had been completed. During an interview on 7/2/26 at 12:28 p.m., the Director of Nursing (DON) stated the restorative rehabilitation process required staff to follow	F0688		08/08/2026

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F0688 SS = D	Continued from page 3 physician and therapy orders. When therapy initiated restorative rehabilitation, the task was entered into the EMR for staff to document whether it had been completed or refused. However, the DON was unable to locate documentation in the EMR indicating R6's restorative rehabilitation had been completed. The DON stated restorative rehabilitation was important to maintain a resident's baseline level of functioning after skilled therapy services had ended. During an interview on 7/2/26 at 12:55 p.m., the Director of Occupational and Physical Therapy (OT/PT) stated that when a resident met therapy goals or reached a plateau, therapy developed a restorative rehabilitation program. A restorative rehabilitation instruction sheet was completed and provided to the nurse managers. Therapy staff educated nursing staff regarding the resident's specific restorative rehabilitation orders. Information was communicated through written instructions, visual postings, and documentation within the EMR. Staff were expected to complete the ordered interventions. If questions or concerns arose, staff were instructed to submit communication forms to the therapy department. The Director of OT/PT stated therapy staff reviewed restorative care plans on admission, with new orders, quarterly, and during daily interdisciplinary meetings. A facility policy titled, "Activities of Daily Living (ADLs)/Maintain Abilities Policy," updated 3/31/23, instructed the facility to individualize each resident's care to promote quality of life by ensuring staff provided person-centered care and services. The policy further instructed the facility to provide the care and services necessary to maintain each resident's ability to perform activities of daily living unless a decline was unavoidable due to the resident's clinical condition. Residents who were unable to perform activities of daily living independently were to receive the services necessary to maintain their highest practicable level of functioning.	F0688		08/08/2026
F0740 SS = D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a	F0740	R22 was reviewed to ensure trauma-informed approaches were incorporated into assessments and care plans. Staff members involved in resident care received immediate education regarding trauma-informed care principles and individualized behavioral interventions. Nursing staff, social services, and interdisciplinary team members will complete education on trauma-informed care.	08/08/2026

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F0740 SS = D	Continued from page 4 resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to identify and appropriately monitor target behaviors for 1 of 1 residents (R22) reviewed for mood and behavior. Findings include: R22's admission Minimum Data Set (MDS) dated 6/22/26, identified intact cognition, moderately severe depression, no exhibited behaviors, and received antidepressant medications. R22's diagnosis included major depressive disorder and spinal stenosis (narrowing of spaces in spine putting pressure on spinal cord and nerves causing pain and weakness). R22's care plan dated 6/11/26, indicated R22 had potential for adverse drug reactions (ADRs) related to daily use of psychotropic medications. R22's care plan further identified alteration in mood and behavior related to diagnoses, adjustment to placement, and loss of independence. The care plan instructed staff to monitor target behaviors and ADRs as ordered. R22's PHQ-9 assessment (screening tool used to diagnose and monitor severity of depression with a scale from 0 to 27) dated 6/10/26, identified a score of 19-moderately severe depression. R22's provider orders dated 6/9/26, indicated, "Target Behavior Monitoring: A._____, B._____, C._____: Non-Pharmacological, Document # of those Interventions used: 0: N/A, 1: Redirection, 2: Ambulate, 3: Offer Activity, 4: Essential Oil, 5: Reposition, 6: Toileting, 7: Provide 1:1, 8: Offer food/fluids, 9: Offer pain relief every shift if Target Behavior was observed. Select chart other and enter findings including effectiveness of interventions in the Nursing Progress Notes." R22's treatment administration record (TAR) for 6/10/26 through 6/30/26, indicated, "Target Behavior Monitoring: A._____, B._____, C._____: … Select chart other and enter findings including effectiveness of interventions in the Nursing Progress Notes." The task was documented as completed every shift except for one evening shift, and no target behaviors were identified. Interventions were documented as provided on seven occasions.	F0740	Continued from page 4 Residents will have behavior monitoring related to diagnosis assessed upon admission. Behavior Monitoring will be adjusted according to individual behaviors and needs as reviewed by IDT. Behavioral health care plans will be reviewed quarterly and with any significant change. The Social Services Director or designee will audit five behavioral health records weekly for four weeks, then monthly for five months. Audits will verify Trauma-informed assessment completion, Individualized interventions, and Staff documentation reflecting trauma-informed practices. Results will be reviewed during QAPI meetings, and additional education will be provided as needed.	08/08/2026

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F0740 SS = D	Continued from page 5 R22's Informed Consent for Required Medications dated 6/12/26, identified R22 was taking antidepressants and antipsychotics for depression and insomnia. R22's progress notes 6/9/26 through 6/29/26, lacked evidence of identification or occurrence of any behaviors. During observation and interview on 6/29/26 at 12:26 p.m., R22 was in room in wheelchair. R22 stated feeling very depressed due to her loss of normal abilities. R22 stated she did not like having to rely on others for assistance and that her weakness had caused increased instability and chance of falling. R22 could not remember anyone discussing her depressed mood or behaviors, and felt like she had lost interest in a lot of her prior activities. During interview on 6/30/26 at 12:43 p.m., registered nurse (RN)-A stated behavior monitoring was documented on the TAR where the specific target behavior was identified. RN-A stated staff should document the behavior observed and any interventions provided. RN-A stated R22 often attempted to self-transfer and self-toilet and considered those target behaviors. RN-A reviewed R22's TAR and agreed R22's target behaviors were not identified and was not really sure what she should be monitoring for R22. RN-A stated she would just watch for anything out of the ordinary and document it in a progress note. During interview on 6/30/26 at 2:26 p.m., director of nursing (DON) stated target behaviors should be identified and monitored to assess medication effectiveness. DON stated R22's target behaviors should have been identified so staff understood what specifically to watch for, and that since she was taking an antidepressant, a general behavior of increased depression at a minimum should have been monitored. During interview on 7/1/26 at 11:47 a.m., consultant pharmacist (CP) stated would agree target behaviors should be identified for monitoring. CP further stated R22's order to monitor target behaviors failed to identify the specific medication nor its generic category and therefore, did not provide any instruction for actual behavior monitoring. CP stated the importance of behavior monitoring was to assess effectiveness of the medication and whether adjustments and or interventions were required.	F0740		08/08/2026

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F0740 SS = D	Continued from page 6 Facility policy on behavior monitoring was requested but not provided.	F0740		08/08/2026
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the	F0880	The Infection Preventionist conducted an immediate review of infection prevention practices related to the cited deficiency. Staff received re-education on infection prevention policies, including hand hygiene, PPE use, and transmission-based precautions as applicable. Infection prevention policies were reviewed and remain current. Nursing staff will be re-educated on infection prevention policy/practices. Weekly infection prevention audits will be completed for four weeks, then monthly for four months. Audits will include Hand hygiene compliance, Appropriate PPE usage, and Isolation precaution compliance. Audit findings will be reported to the QAPI Committee, and corrective actions will be implemented immediately for identified deficiencie s.	08/08/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245342	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/02/2026

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

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F0880 SS = D	Continued from page 7 least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure staff used enhanced barrier precautions (EBP) for 1 of 1 residents (R6) reviewed who required EBP. Findings include: R6's quarterly Minimum Data Set (MDS), dated 5/12/26, indicated R6 had moderate cognitive impairment. Diagnoses included cerebral infarction with hemiplegia and hemiparesis affecting the left non-dominant side following a cerebral infarction (blocked blood vessels that deprived part of the brain of oxygen and nutrients). The MDS indicated R6 was dependent on staff for mobility and activities of daily living. R6's provider order, dated 2/10/26, instructed staff to follow enhanced barrier precautions (EBP) related to the gastrostomy tube (G-tube). R6's care plan dated 2/13/26, identified a problem related to the need for EBP due to the G-tube. Interventions included staff following EBP, using appropriate communication regarding EBP, explaining the reasons for EBP, and donning and	F0880		08/08/2026

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F0880 SS = D	Continued from page 8 doffing personal protective equipment (PPE), including gloves and a gown, before providing high-contact care. High-contact care included, but was not limited to, dressing, grooming, bathing, transferring, providing personal hygiene, changing linens, changing briefs, and assisting with toileting. During observation on 7/1/26 at 10:07 a.m., nursing assistant (NA)-A entered R6's room with a stand lift. After washing her hands and putting on gloves, she began providing personal care. NA-A cleaned and changed R6, applied powder under the breasts and armpits, assisted with dressing, and washed R6's face using a clean washcloth. NA-A removed her gloves after completing care in bed, washed her hands, without donning gloves, and transferred R6 to her wheelchair using an stand lift with the assistance of one staff member. While R6 was seated in the wheelchair, NA-A brushed R6's hair, applied lip balm, applied lotion to R6's legs, and put on R6's shoes. Although multiple high-contact care activities were performed, NA-A did not wear a gown. Gloves were worn only while care was provided in bed. There was a sign that stated Enhanced Barrier Precautions and PPE hanging on R6's door. During an interview on 7/1/26 at 10:30 a.m., NA-A stated resident care tasks were located in the electronic medical record (EMR) under the task tab and the information was based on the resident's care plan. NA-A stated EBP was only used when staff had contact with the G-tube during feedings. She stated the infection prevention process was to keep the G-tube site covered and notify the nurse if any issues were observed. NA-A verified there was a sign and PPE on the door. She stated that gown and gloves should have been worn during high-contact cares. During an interview on 7/2/26 at 9:25 a.m., licensed practical nurse (LPN)-C stated the EBP supplies and instructions were posted on the resident's door. LPN-C stated staff were expected to use the required PPE during all high-contact care activities. LPN-C stated EBP was important to help prevent the spread of infection. During an interview on 7/2/26 at 9:38 a.m., the Director of Nursing (DON) stated EBP was initiated when a resident met the applicable guidelines. The DON stated EBP was documented in the resident's EMR banner and that signage and the necessary PPE supplies were posted outside the resident's room. The DON stated staff were expected to wear the appropriate PPE whenever high-contact care	F0880		08/08/2026

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F0880 SS = D	Continued from page 9 was provided. The DON stated EBP was important to protect vulnerable residents and prevent the spread of infection. During an interview on 7/2/26 at 9:53 a.m., registered nurse (RN)-A stated EBP was to be followed. RN-A stated the sign posted on the resident's door identified the required PPE and that staff were expected to wear both gowns and gloves during all high-contact care activities. A policy titled, "Enhanced Barrier Precautions," revised 4/1/24, instructed staff to implement enhanced barrier precautions to prevent the transmission of multidrug-resistant organisms (MDROs). The policy defined enhanced barrier precautions as the use of gowns and gloves during high-contact resident care activities for residents known to be colonized or infected with an MDRO, as well as residents at increased risk of MDRO acquisition, such as those with wounds or indwelling medical devices. The policy further instructed that all staff were to receive training on enhanced barrier precautions upon hire and at least annually and were expected to comply with all designated precautions.	F0880		08/08/2026

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 6/29/26 through 7/2/26, a standard licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed: H53423102C (27015410), H53423103C	20000		08/07/2026

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

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20000	Continued from page 1 (2705420), H53423104C (2705430). NO licensing orders were issued. 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 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. 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.	20000		08/07/2026
20895	Rehab - Range of Motion CFR(s): MN Rule 4658.0525 Subp. 2.B Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that:	20895	The Residents task was adjusted to reflect the assigned schedule. The schedule and Task will now appear on POC for documentation for R6. Residents identified as being at risk for decline in range of motion (ROM) and mobility and residents on a current ROM program were reviewed by the interdisciplinary team. Therapy referrals were verified or updated as appropriate. Nursing staff completed review to ensure residents' care plans accurately reflect current mobility needs, interventions, and restorative nursing programming.	08/08/2026

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20895	Continued from page 2 B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review the facility failed to ensure physician-ordered passive range of motion (ROM) exercises were completed for 1 of 2 residents (R6) reviewed for range of motion. Findings include: R6's quarterly Minimum Data Set (MDS), dated 5/12/26, indicated R6 had moderate cognitive impairment. Diagnoses included cerebral infarction with hemiplegia and hemiparesis affecting the left non-dominant side following a cerebral infarction (blocked blood vessels that deprived part of the brain of oxygen and nutrients). The MDS indicated R6 was dependent on staff for mobility. The MDS also indicated a restorative nursing program had not been completed. R6's physical therapy order, dated 3/31/26, directed staff to complete passive range of motion (ROM) exercises to R6's left arm two to three times daily. The order instructed staff to review the restorative nursing program instructions which were posted on the wall in R6's room. R6's care plan, revised 2/26/26, indicated R6 had impaired mobility related to a cerebrovascular accident (CVA), left-sided hemiparesis, and a traumatic brain injury (TBI). Interventions initiated on 3/31/26 directed nursing staff to provide passive range of motion exercises to the left arm two to three times daily. The care plan also instructed staff to refer to the restorative rehabilitation handout posted on the wall and closet. R37's follow up documentation for nursing rehab passive ROM left arm 2-3 times a day *see handout on closet. indicated the following: -for 4/2026, R37 refused ROM one time, no further documentation of task completed or refused was documented. -for 5/2026, lacked indication any ROM was completed for R37 -for 6/2026, lacked indication any ROM was	20895	Continued from page 2 All residents will be reviewed for mobility status, ROM needs, and restorative nursing services. Care plans will be updated to include individualized interventions for maintaining or improving mobility. Nursing staff will receive education on ROM programs and documentation, Early identification of functional decline, and Timely referral to rehabilitation services. Weekly audits of 10 resident records for 4 weeks, then monthly for 5 months. Audits will verify Appropriate assessments, evaluations and screens, Rehab services recommendations and orders, Interventions are documented in the care plan, Documentation of ROM/Restorative/Maintenance Program Activities. Findings will be reported during the Quality Assurance and Performance Improvement (QAPI) meetings, with corrective action implemented for identified deficiencies.	08/08/2026

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20895	Continued from page 3 completed for R37 During observation and interview on 7/1/26 at 10:07 a.m., nursing assistant (NA)-A completed R6's activities of daily living (ADLs), including changing the brief and clothing, washing the face and body, applying powder and lotion, brushing the hair, and providing oral and lip care. However, NA-A did not perform the ordered passive ROM exercises, even though the instructions and photographs of the required care were posted in plain view. During the interview, NA-A stated resident care instructions were available in the care plan, Kardex, and task list within the electronic medical record (EMR). NA-A stated R6 required total assistance with all care and that if passive ROM was required, it would have been listed in the EMR. NA-A verified signs in the room, however, did not perform the task. During an interview on 7/2/26 at 11:59 a.m., NA-B stated resident care tasks were located in the Kardex/task tab of the EMR and were based on the care plan. NA-B stated the therapy department provided education and instruction regarding restorative rehabilitation. NA-B further stated the passive ROM task had not been completed because the task indicator in the EMR was not green, which indicated the task had not been performed. During an interview on 7/2/26 at 12:13 p.m., licensed practical nurse (LPN)-A stated the therapy department provided restorative rehabilitation orders and instructions, including signage and resident-specific information. LPN-A stated staff verified completion of restorative rehabilitation by reviewing the task tab in the EMR and by observing staff provide resident care. LPN-A stated it was important to follow physician orders to ensure resident care and safety. LPN-A was unable to verify in the EMR that R6's passive ROM exercises had been completed. During an interview on 7/2/26 at 12:28 p.m., the Director of Nursing (DON) stated the restorative rehabilitation process required staff to follow physician and therapy orders. When therapy initiated restorative rehabilitation, the task was entered into the EMR for staff to document whether it had been completed or refused. However, the DON was unable to locate documentation in the EMR indicating R6's restorative rehabilitation had been completed. The DON stated restorative rehabilitation was important to maintain a resident's baseline level of functioning after skilled therapy services had ended.	20895		08/08/2026

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20895	Continued from page 4 During an interview on 7/2/26 at 12:55 p.m., the Director of Occupational and Physical Therapy (OT/PT) stated that when a resident met therapy goals or reached a plateau, therapy developed a restorative rehabilitation program. A restorative rehabilitation instruction sheet was completed and provided to the nurse managers. Therapy staff educated nursing staff regarding the resident's specific restorative rehabilitation orders. Information was communicated through written instructions, visual postings, and documentation within the EMR. Staff were expected to complete the ordered interventions. If questions or concerns arose, staff were instructed to submit communication forms to the therapy department. The Director of OT/PT stated therapy staff reviewed restorative care plans on admission, with new orders, quarterly, and during daily interdisciplinary meetings. A facility policy titled, "Activities of Daily Living (ADLs)/Maintain Abilities Policy," updated 3/31/23, instructed the facility to individualize each resident's care to promote quality of life by ensuring staff provided person-centered care and services. The policy further instructed the facility to provide the care and services necessary to maintain each resident's ability to perform activities of daily living unless a decline was unavoidable due to the resident's clinical condition. Residents who were unable to perform activities of daily living independently were to receive the services necessary to maintain their highest practicable level of functioning. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for limited range of motion/ambulation to assure they are receiving the necessary treatment/services to prevent further limitation in range of motion. The director of nursing or designee, could conduct random audits of the delivery of care to ensure appropriate care and services are implemented. The results of the audits could be brought to the quality assurance committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20895		08/08/2026
21390	Infection Control CFR(s): MN Rule 4658.0800 Subp. 4 A-I Subp. 4. Policies and procedures. The infection	21390	corrected.	08/08/2026

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21390	Continued from page 5 control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure staff used enhanced barrier precautions (EBP) for 1 of 1 residents (R6) reviewed who required EBP. Findings include: R6's quarterly Minimum Data Set (MDS), dated 5/12/26, indicated R6 had moderate cognitive impairment. Diagnoses included cerebral infarction with hemiplegia and hemiparesis affecting the left non-dominant side following a cerebral infarction (blocked blood vessels that deprived part of the brain of oxygen and nutrients). The MDS indicated R6 was dependent on staff for mobility and activities of daily living. R6's provider order, dated 2/10/26, instructed staff	21390		08/08/2026

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21390	Continued from page 6 to follow enhanced barrier precautions (EBP) related to the gastrostomy tube (G-tube). R6's care plan dated 2/13/26, identified a problem related to the need for EBP due to the G-tube. Interventions included staff following EBP, using appropriate communication regarding EBP, explaining the reasons for EBP, and donning and doffing personal protective equipment (PPE), including gloves and a gown, before providing high-contact care. High-contact care included, but was not limited to, dressing, grooming, bathing, transferring, providing personal hygiene, changing linens, changing briefs, and assisting with toileting. During observation on 7/1/26 at 10:07 a.m., nursing assistant (NA)-A entered R6's room with a stand lift. After washing her hands and putting on gloves, she began providing personal care. NA-A cleaned and changed R6, applied powder under the breasts and armpits, assisted with dressing, and washed R6's face using a clean washcloth. NA-A removed her gloves after completing care in bed, washed her hands, without donning gloves, and transferred R6 to her wheelchair using an stand lift with the assistance of one staff member. While R6 was seated in the wheelchair, NA-A brushed R6's hair, applied lip balm, applied lotion to R6's legs, and put on R6's shoes. Although multiple high-contact care activities were performed, NA-A did not wear a gown. Gloves were worn only while care was provided in bed. There was a sign that stated Enhanced Barrier Precautions and PPE hanging on R6's door. During an interview on 7/1/26 at 10:30 a.m., NA-A stated resident care tasks were located in the electronic medical record (EMR) under the task tab and the information was based on the resident's care plan. NA-A stated EBP was only used when staff had contact with the G-tube during feedings. She stated the infection prevention process was to keep the G-tube site covered and notify the nurse if any issues were observed. NA-A verified there was a sign and PPE on the door. She stated that gown and gloves should have been worn during high-contact cares. During an interview on 7/2/26 at 9:25 a.m., licensed practical nurse (LPN)-C stated the EBP supplies and instructions were posted on the resident's door. LPN-C stated staff were expected to use the required PPE during all high-contact care activities. LPN-C stated EBP was important to help prevent the spread of infection.	21390		08/08/2026

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(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
21390	Continued from page 7 During an interview on 7/2/26 at 9:38 a.m., the Director of Nursing (DON) stated EBP was initiated when a resident met the applicable guidelines. The DON stated EBP was documented in the resident's EMR banner and that signage and the necessary PPE supplies were posted outside the resident's room. The DON stated staff were expected to wear the appropriate PPE whenever high-contact care was provided. The DON stated EBP was important to protect vulnerable residents and prevent the spread of infection. During an interview on 7/2/26 at 9:53 a.m., registered nurse (RN)-A stated EBP was to be followed. RN-A stated the sign posted on the resident's door identified the required PPE and that staff were expected to wear both gowns and gloves during all high-contact care activities. A policy titled, "Enhanced Barrier Precautions," revised 4/1/24, instructed staff to implement enhanced barrier precautions to prevent the transmission of multidrug-resistant organisms (MDROs). The policy defined enhanced barrier precautions as the use of gowns and gloves during high-contact resident care activities for residents known to be colonized or infected with an MDRO, as well as residents at increased risk of MDRO acquisition, such as those with wounds or indwelling medical devices. The policy further instructed that all staff were to receive training on enhanced barrier precautions upon hire and at least annually and were expected to comply with all designated precautions. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON), ICP, or designee could review facility policies/procedures regarding isolation and or/enhanced barrier precautions for the resident and provide staff education regarding the policies and educate staff on appropriate PPE wear. They could also do environmental rounds, audits, and re-education anytime isolation precautions are placed. The ICP should have formal training to be completed according to regulation and head the above measures. The ICP, DON and/or designee could take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time, until the QAPI committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		08/08/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING **01 - MAIN BUILD...** B. WING	**07/02/2026**

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K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on July 2, 2026, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, The Estates at Greeley LLC, was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K0000		07/24/2026

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245342	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **07/02/2026**

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K0000 Bldg. 01	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Building Info: Greeley Healthcare Center is a 1-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1964 and was determined to be of Type II (111) construction. In 1988, an addition was constructed to the west side of the building that was determined to be of Type II(111)construction. In 1997, an addition was constructed to the north and south sides of the building that was determined to be of Type V(111)construction. Because the original building and the additions meet the construction type allowed for existing buildings, the facility was surveyed as one building as Type V(111) construction. The facility has a capacity of 64 beds and had a census of 49 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K0000		07/24/2026

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K0918 SS = F Bldg. 01	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the Emergency Power Supply System (EPSS) per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4, and NFPA 110 (2010 edition) section 8.3.7.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 7/2/2026, at 9:20 AM, it was revealed by a review of available documentation, the facility was not testing the batteries for the Emergency Generators for specific gravity or conductance.	K0918	The facility immediately reviewed the essential electrical system maintenance and testing records. Any overdue inspections, maintenance, or testing were scheduled and completed by qualified personnel. Documentation was updated and retained in accordance with NFPA 99 and NFPA 110 requirements. A preventive maintenance calendar has been implemented to ensure all required inspections and testing are completed within required timeframes. The Maintenance Director will maintain a tracking log for all emergency power supply system inspections, generator testing, transfer switch testing, and related documentation. Staff responsible for maintenance activities will receive education regarding NFPA documentation and testing requirements. The Maintenance Director will review maintenance logs monthly to verify compliance. Quarterly audits of electrical system testing documentation will be conducted. Audit findings will be presented during the facility's QAPI/Safety Committee meetings, with corrective action initiated immediately for any identified deficiencies.	07/24/2026

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K0918 SS = F Bldg. 01	Continued from page 3 An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K0918		07/24/2026

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 17, 2026

Administrator
THE ESTATES AT GREELEY LLC
313 SOUTH GREELEY STREET
STILLWATER, MN 55082

RE: CCN: 245342
Cycle Start Date: July 2, 2026

Dear Administrator:

On August 13, 2026, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 17, 2026

Administrator
THE ESTATES AT GREELEY LLC
313 SOUTH GREELEY STREET
STILLWATER, MN 55082

Re: Reinspection Results
Event ID: 231CF7-H2

Dear Administrator:

On August 13, 2026 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 2, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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