DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
December 21, 2023

Administrator
The Estates At Linden LLC
105 West Linden Street
Stillwater, MN 55082

RE: CCN: 245337
Cycle Start Date: November 2, 2023

Dear Administrator:

On December 19, 2023, the Minnesota Department(s) 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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 20, 2023

Administrator
The Estates At Linden LLC
105 West Linden Street
Stillwater, MN 55082

RE: CCN: 245337
Cycle Start Date: November 2, 2023

Dear Administrator:

On November 2, 2023, 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:

Pete Cole, RN Unit Supervisor
Metro Team C District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: Peter.Cole@state.mn.us
Office/Mobile: (651) 249-1724

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 February 2, 2024 (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 May 2, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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

Please note that the failure to complete the informal dispute resolution process will not delay the

dates specified for compliance or the imposition of remedies.

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
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
travis.ahrens@state.mn.us
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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245337	A. BUILDING _____ B. WING _____	C 11/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT LINDEN LLC	105 WEST LINDEN STREET STILLWATER, MN 55082

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 10/30/23 through 11/2/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 10/30/23 through 11/2/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaints were reviewed The following complaints were reviewed with no deficiency issued; H53375184C (MN85740) H53375183C (MN92212) H53376803C (MN91371) The following complaint was reviewed, H53375182C (MN85134), with an unrelated deficiency issued at F609. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are	F 000		

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

Electronically Signed | 11/28/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the	F 609		12/15/23

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F 609	Continued From page 2 incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure an allegation of resident-to-resident (R134,R135) abuse was reported to the state agency (SA) within two hours. Findings include: A Nursing Home Incident Report (NHIR) dated 7/14/23 at 12:13 p.m., indicated at 7:45 a.m., R135 entered the dining room using a four-wheeled walker. R135 approached R134 who was sitting at a table and drinking coffee and shouted, "You're not suppose to be sitting here, get your ass up." R134 replied "Yes, I am." R135 then intentionally pushed his walked into R134's leg. Review of facility Verification of Investigation undated, also indicated the incident occurred on 7/14/23 at 7:45 a.m. During an interview on 11/2/23 at 12:53 p.m., the director of nursing (DON) stated all allegations of abuse were to be reported to the SA within two hours but stated she was not involved in the investigation related to R134 and R135. During an interview on 11/2/23 at 1:52 p.m., the administrator stated allegations of abuse were to be reported to management immediately and then reported to the SA within two hours. The administrator stated she did not recall why the allegation of abuse between R134 and R135 was not reported within two hours but that "we try to	F 609	R134 and R135 are no longer residents at the facility. Facility implemented immediate interventions for safety for R134 and R13. following the occurrence of the incident and reported as soon as safely able. Facility has a Vulnerable Adult Abuse Prohibition Policy which has been reviewed as current by corporate policy committee. All staff are educated at onset of employment, annually and as needed thereafter on requirements of reporting alleged or confirmed abuse, misappropriation, mistreatment including injuries of unknown origin. IDT/Leadership staff will be educated on the Vulnerable Adult Abuse Prohibition policy/procedure and F609 to ensure understanding of regulatory reporting and policy guidance. All reports of resident-to-resident altercations will be reported to the nursing home incident reporting website within required parameter. The Administrator, DON and/or designee will be conducting audits weekly x 4 and once per month for two months any residents who have resident to resident altercations, mistreatment, abuse allegations or injuries of unknown origin to ensure compliance and monitor for potential reportable incidents. The results	

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F 609	Continued From page 3 adhere to that as closely as we can." The facility Abuse Prevention/Vulnerable Adult policy dated 8/2023, indicated abuse was the willful infliction of injury and defined willful as an individual who acted deliberately, not that they intended to inflict injury or harm. The policy also indicated resident-to-resident abuse was to be reported to the SA. The policy further indicated suspected abuse shall be reported to the SA not later than two hours after forming the suspicion of abuse.	F 609	of these audits will be shared with the facility QAPI Committee for input on the need to increase, decrease or discontinue the audits.	
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care,	F 676		12/15/23

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F 676	Continued From page 4 §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide a shower and accommodate a specific shower day for one of one resident (R6) who was refused showers. The facility further failed to assess why the resident was repeatedly refused his shower. Findings include: R6's quarterly Minimum Data Set (MDS), dated 9/19/23, indicated R6 was cognitively intact and admitted to the facility on 12/9/21. R6's MDS further indicated he was independent with most activities of daily living (ADLs) and required moderate assistance with bathing. R6's Medical Diagnoses List, dated 12/9/21, indicated R6 had several medical diagnoses including dementia, peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs) and squamous cell carcinoma of skin (cancer that occurs in the outermost part of the epidermis [skin surface] known as squamous cells.)	F 676	R6 shower schedule and compliance was reviewed. R6 was interviewed on preferences. Care plan was updated based on R6 preference of shower day and time. All 34 residents have the potential to be affected if the preferences are not followed as evaluated and documented on the care plan. DON/ designee reviewed current bathing preferences for all residents. Care plans have been reviewed and updated. Clinical leadership and nursing staff to be reeducated on Policies titled Quality of Life and Resident Rights DON or designee will conduct audits on all residents refusing shower. Audits will be completed multiple shifts once per day for the first 2 weeks and 3 times per week for 3 months thereafter. Shower preferences will be discussed at the resident's care conference to ensure preferences are	

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F 676	Continued From page 5 R6's care plan, dated 12/10/21, indicated R6 had potential for alteration in skin integrity related not liking to bathe or shower. The care plan, dated 6/21/22, instructed staff to continue to encourage, reapproach and reeducate R6 on the importance of weekly showers. The care plan lacked approaches to encourage R6 to shower. R6's Interdisciplinary Team (IDT) Note, dated 9/21/23, indicated R6 was refusing showers but lacked approaches that have been used to encourage R6 to shower or approaches that have been successful. R6's electronic medical record (EMR) lacked an assessment of why R6 was continuing to refuse his showers and lacked evidence of documented approaches that work with R6 or have not work with R6 to encourage showers. R6's progress notes indicated R6 had refused his weekly shower six times in the past 10 weeks on 8/21/23, 9/4/23, 9/25/23, 10/2/23, 10/9/23, and 10/16/23. A progress note dated 10/2/23 indicated R6 had refused his shower because his "shower day was Friday." During an interview and observation on 10/30/23 at 1:53 p.m., R6 stated he would rather have a shower on Fridays, so he is "clean before the weekend". Multiple signs hanging in R6's room indicated his shower day was Mondays. R6 hair and clothes appeared disheveled and dirty. During an interview on 11/2/23 at 9:28 a.m., R6 stated he would take a shower if it was on Fridays and that he had told a "few of the girls around here" but it had not changed from Mondays.	F 676	being met. Audit results will be reviewed at QAPI Committee for further recommendations.	

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F 676	Continued From page 6 During an interview on 10/1/23 at 10:43 a.m., registered nurse (RN)-A confirmed R6 did refuse his shower "most of the time" and sometimes "we just let him" or we keep asking him. During an interview on 11/2/23 at 8:50 a.m., nursing assistant (NA)-A stated she heard from other staff that R6 refused his shower a lot. She was unsure if he had asked for a different day but stated staff should offer a different day to him if he was refusing. During an interview on 11/2/23 at 9:04 a.m., social services (SS)-A stated that the nurses usually assessed for shower day preferences with a resident upon admission. SS-A stated they had not attempted to change R6's shower day after his continued refusal but could try stating she was unsure if it would decrease his refusals as they had not yet tried to offer a different day, stating "anything to help him" get a shower. During an interview on 11/2/23 at 12:30 p.m., the director of nursing (DON) stated staff should reassess a resident for bathing preferences if they are frequently refusing showers and should be assessed for why they are refusing. The DON stated refusals should be discussed, and assessed, at care conferences and those discussions should be documented in an interdisciplinary team note (IDT) note. The DON further stated she would have expected staff to let her, or the assistant director of nursing know if a resident preferred a different shower day and the change would be made. The DON further stated she would expect the nurses to ensure the showers are getting offered and completed.	F 676		

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F 676	Continued From page 7 A facility policy titled Activities of Daily Living (ADLs)/Maintain Abilities Policy, dated 3/31/23, indicated staff across all shifts should provide person-centered care and services that honor and support each resident's preferences and choices to carry out ADLs.	F 676		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to comprehensively assess, develop and implement activities for one of one resident (R10) reviewed who had a decline in condition. Finding include: R10's admission MDS dated 5/1/23, indicated R10 admitted to the facility on 6/24/23 with diagnoses of amputation (surgical removal of part of the body, such as an arm or leg), anemia (a condition in which the blood doesn't have enough healthy red blood cells), hypertension, peripheral vascular disease (circulatory condition in which narrowed blood vessels reduce blood flow to the	F 679	R10 is no longer a resident at the facility. At time of incident, resident preferences and abilities to perform activities were reviewed. Resident care plan was updated to include current abilities as resident R10 was actively declining on hospice care. Facility will follow state and federal guidelines related to meaningful activities. Facility will complete comprehensive assessments and care plan the preferences of each resident at time of admission assessment, quarterly and significant change assessments or as needed. All residents have the potential	12/15/23

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F 679	Continued From page 8 limbs), diabetes, dementia, and anxiety. R10's significant change Minimum Data Set (MDS) dated 6/7/23, indicated R10 had moderate cognitive impairment and had enrolled in hospice. R10's "Preference for Customary Routine and Activities" indicated listening to music, keep up with the news, do things with groups of people, go outside to get fresh air, and participation in religious services was listed as very important to her. R10's quarterly MDS dated 9/5/23, indicated R10 had severe cognitive impairment, needed setup with transfers and needed assistance with oral hygiene and dressing. The MDS section "Preference for Customary Routine and Activities" was not completed. R10's activities care plan dated 4/27/23, indicated "Resident is independent with activity choices. She enjoys dancing, singing, being with her siblings [she is a twin], quilting, talking on the phone, and going out for dinner. She is of Catholic faith. She is not interested in much being here. She is eager to leave." R10's care plan goal indicated, "Resident will express satisfaction through positive statements". R10's activities care plan included two interventions. The first intervention dated 4/27/23 indicated, "Invite her to Catholic services on Tuesdays" and, the second intervention dated 7/20/23, indicated "Issue monthly activity calendar. Offer to assist as needed." The activities care plan lacked documentation about R10's change in condition and being signed onto hospice. The care plan focus, goals and interventions were not revised to reflect R10's cognitive decline, medical condition, or her enrollment into a hospice program.	F 679	for being affected if their assessments are not completed. Facility will provide education on F679 State Operations Manual to Therapeutic Recreation and Nursing staff. Therapeutic Recreation Director or designee will complete admission, quarterly, significant change assessments based on RAI manual requirements. Care plan will be updated to reflect those preferences including changes to abilities and hospice services. Therapeutic Recreation Staff will document residents offered but declined or refused activities. Facility will audit 4 residents with Admission, Quarterly or Significant Change assessments completed to ensure Therapeutic Recreation care plan in place and current weekly x4 weeks and monthly for two months. Audit will also include observation of resident daily routine including being offered to attend activities of preference or individual offerings in room. Audits will be present to QAPI committee for further recommendations.	

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F 679	Continued From page 9 During observation on 10/30/23 at 12:58 p.m. staff brought R10's lunch tray, set up the meal and R10 didn't sit up in bed. At 1:24 p.m., R10 was laying down in bed, the lunch tray remained at bed side and resident had not eaten any of her meal. During observation on 10/30/23 at 1:51 p.m., R10 was laying in bed, calling out for help, her call light was at the end of the bed, not within reach. Later, at 3:19 p.m., R10 was observed sleeping in bed. During observation on 10/31/23 at 8:19 a.m., R10 was laying in bed in a hospital gown without staff interaction,with no TV, or music on in her room. During observation on 10/31/23 at 12:13 p.m., R10 was sleeping in bed wearing a hospital gown, with no TV, or music on in her room. During observation on 10/31/23 at 12:42 p.m., R10 was in bed, wearing a hospital gown, with no TV, or music on in her room.. During observation on 10/31/23 at 12:50 p.m., R10 was in bed sleeping wearing a hospital gown. R10 woke up when her name was called a second time, answered yes/no questions. R10's side of her room didn't have a TV and the drape dividing the room was pulled obstructing R10 view of the roommate's TV or the room window. During observation on 11/1/23 at 7:23 a.m., R10 was awake in bed, disoriented to time and place, and was only able to answer yes or no to questions. During this observation, no newspaper, magazines, books, or radio were	F 679		

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F 679	Continued From page 10 noted in R10's room. During interview on 11/01/23 at 12:41 p.m., R10's daughter stated R10 enjoyed being with other people, liked to listen to music, listened to the news, liked to attend religious services and played bingo. R10's daughter stated, R10 was no longer able to use her cellular phone as a distraction. During interview on 11/2/23 at 8:57 a.m., the therapeutic recreation director (TRD) stated, upon admission all residents are assessed, asked about their preferences, a MDS assessment is done, and a care plan is developed. TRD stated, the care plans were reviewed quarterly and changed accordingly to reflect changes in condition or changes in residents' interests. TRD stated for the last two months, R10 had spent more time in her room, hasn't attended Catholic services and hasn't participated in activities R10 enjoyed before, and most recently refused to go to music on Halloween day. TRD stated, the staff continued to invite R10 to attend activities, offered books, trivia questions and TV guide. TRD stated, R10's refusal to participate in activities was not documented, therefore there was not documentation R10 was invited to attend to activities. TRD verified R10's activities care plan had not been updated to include significant cognitive and physical decline, as well as the lack of documentation of R10's enrollment on hospice on June 2023. During interview on 11/2/23 at 12:10 p.m., the director of nursing (DON) stated she expected the activity director to assess residents quarterly, with significant changes and reevaluate their	F 679		

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F 679	Continued From page 11 interests, activities and update their care plans. The DON also stated, the care plans should include a variety of interventions and if a resident was enrolled on hospice, the activities care plan should incorporate the services provided by the hospice program. A facility policy on recreational activities was requested; however, none was received.	F 679		
F 684 SS=D	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 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 report to the provider timely, and appropriately respond to, significantly high blood pressure after a medication change for one of one resident (R2) reviewed for quality of care. Findings include: The Mayo Clinic article, What is a Hypertensive Crisis, dated 8/3/22, defined a hypertensive (high blood pressure) emergency as blood pressure higher than 180 millimeters of mercurcy (mm Hg)/120 mm Hg which requires emergency medical help. The Mayo Clinic further indicated	F 684	R2□s Blood pressures and medications were reviewed Medical Provider notified of R2 high blood pressure, Consulting Pharmacist was alerted and asked to review blood pressures and current medication regimen. The consulting Pharmacist reviewed and made recommendations which were reviewed by the Medical Provider and new orders were obtained. High/Low threshold added to resident Electronic Medical Record (EMR) All residents' blood pressures were	12/15/23

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F 684	Continued From page 12 untreated, high blood pressure increases the risk of heart attack, stroke and other serious health problems. The American Heart Association article, Why High Blood Pressure is a "Silent Killer", dated 5/31/23, indicated that most of the time, there are no physical symptoms of high blood pressure, and it is known as the "silent killer." The American Heart Association indicates ignoring high blood pressure and waiting for symptoms to alert that something is wrong is "taking a dangerous chance with your life." R2's Minimum Data Set (MDS), dated 9/9/23, indicated R2 was cognitively intact and required extensive assist with most activities of daily living but was able to eat and use his wheelchair for locomotion independently. R2's Medical Diagnoses list, dated 1/18/23, indicated R2 was admitted to the facility with a primary diagnosis of acute on chronic kidney failure and had a secondary diagnosis of hemiplegia (paralysis on one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles) following a cerebral infarction (stroke). R2's physician orders indicated R2 had an order for amlodipine (used to treat high blood pressure) 10 milligrams (mg) daily, dated 1/20/23 and hydralazine (also used to treat high blood pressure) 25 mg three times a day, dated 10/23/23. The order lacked blood pressure parameters on when to notify the physcian. R2's care plan and treament record also lacked	F 684	reviewed, base low/high vitals sign thresholds were added to each resident's EMR. Staff will be educated on the following: Facility's policy, titled "Change in Condition" American Heart Association Blood Pressure Categories Facility will set low/high threshold for vital signs upon initial admission, quarterly, annual and significant change assessments and as needed. Monitoring for abnormal vitals signs outside of the resident's set threshold will be reviewed daily by DON or designee and Primary Medical Provider will be updated per policy. DON or designee will audit once per day for the first 2 weeks and 3 times per week for 3 months thereafter. Audit results will be reviewed by QAPI committee for further recommendations.	

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F 684	Continued From page 13 blood pressure parameters on when to notify the physcian. R2's blood pressure list in the electronic medical record (EMR) indicated R2 had the following blood pressures: 173/103 on 10/24/23, 165/104 on 10/27/23, 185/137 and 166/104 on 10/28/23, 183/119 on 10/29/23, 163/107 on 10/30/23, 194/106 on 10/31/23 and 177/107 on 11/1/23. During an interview on 10/23/23 at 6:02 p.m., R2 stated he was often dizzy when he stood up and went outside to smoke multiple times a day. During an interview on 11/1/23 at 10:35 a.m., registered nurse (RN)-A stated she would notify the provider if a resident's blood pressure was over 180. RN-A stated she did not notify the provider yesterday when R2 had a blood pressure of 194/106 but had notified the provider this morning for the first time due to R2's blood pressure of 177/107. During an interview on 11/1/23 at 12:27 p.m., nurse practitioner (NP)-A stated she had increased R2's Hydralazine from 25mg two times a day to 3 times a day on 10/23/23. The NP stated she was not concerned about R2's high blood pressure because he was not having any symptoms. NP-A failed to indicate what symptoms should be monitored for signs of hypertension. NP-A stated R2 was good at letting staff know if he wasn't feeling well but was unaware that he had been feeling dizzy. During an interview on 11/2/23 at 9:09 a.m., the consulting pharmacist (CP) confirmed that R2's blood pressure increased after increasing his Hydralazine, stating this concerned her because	F 684		

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F 684	Continued From page 14 hydralazine could cause rebound hypertension. The CP stated she would have been concerned with R2's blood pressure readings and would have reached out to the provider right away regardless if R2 was experiencing physical symptoms or not. The CP stated she would "definitely" consider adding another blood pressure medication and would continue to closely monitor R2's blood pressure until it was "stable" to prevent it from impacting R2's renal function and cardiovascular status. The CP stated, "the providers need to make some changes or closely monitor this patient" (R2). During an interview on 11/2/23 at 12:25 p.m., the director of nursing DON stated she would have expected the staff to reach out to the provider with R2's high blood pressure reading or at least reach out to the provider to ask for parameters of when to be notified of abnormal blood pressure readings. The DON stated she had reached out to the medical director on 11/1/23 who had discontinued R2's blood pressure checks and had recommended no changes to his medication despite his ongoing elevated blood pressure. The DON further stated she had received a fax from the CP that morning (at approximately 10:00 a.m.) concerned about R2's high blood pressure, which suggested to taper off R2's hydralazine and start an angiotensin-converting-enzyme inhibitor (ACE inhibitors, a class of medication used primarily for the treatment of high blood pressure and heart failure) due to the CP's concerns of "significantly high" blood pressures. A facility policy on vital signs and provider notification was requested but not provided. A facility policy, undated titled Change in Resident	F 684		

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F 684	Continued From page 15 Condition or Status indicated the facility will promptly notify the physician or healthcare provider of a change in the resident's medical condition or status.	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel	F 690		12/15/23

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F 690	Continued From page 16 receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to reassess a newly incontinent resident after foley catheter removal for a toileting program for one of one resident (R5) reviewed for bowel and bladder. Findings include: R5's admission Minimum Data Set (MDS) dated 8/18/23, indicated R5 was admitted to the facility on 8/11/23, did not have a catheter in place and was not on a toileting program. R5's significant change MDS dated 9/7/23, indicated R5 was cognitively intact, now had a foley catheter and was not on a toileting program. R5's Bladder Evaluations on 8/18/23 and 9/6/23, both indicated R5 was "continent on most occasions but rarely incontinent due to impaired mobility" and that R5 was an assist of 1 with toileting. R5's Foley Catheter Evaluation, dated 9/6/23, indicated "resident continues with need for a foley catheter." R5's Admission/Initial Data Collection, dated 8/11/23, indicated R5 was both "always continent" and "occasionally incontinent" of bladder. R5's progress note, dated 8/18/23, indicated R5 was sent to the emergency department for pain in his lower back, and bright red blood in his urine. A foley catheter was placed at the hospital on	F 690	R5 Bladder/ Bowel Incontinence, Catheter reviewed R5 Foley catheter was removed on 9/7/23. New bladder assessment completed for resident since removal of foley catheter. All like residents reviewed. All residents who have a catheter have the potential to be affected. Nursing staff will be educated on the initiation and completion of new 3 day bowel and bladder assessment to be completed after removal of catheters and a new bladder evaluation form. Staff will be required to review and understand the facility's Assessment Grid. DON/Designee will complete Audits once per day for the first 2 weeks and 3 times per week for 3 months thereafter. Audit results will be reviewed by QAPI committee for further recommendations.	

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F 690	Continued From page 17 8/20/23. A Urology After Visit Summary (AVS) note, dated 9/8/23, indicated R5's catheter was removed at the urology clinic 9/8/23. R5's care plan, dated 8/15/23, indicated R5 had an "alteration in elimination as evidenced by indwelling foley catheter due to blood clot causing urinary retention. Resident has a history of hematuria and a diagnosis of benign prostatic hyperplasia" (also called prostate enlargement, is a noncancerous increase in size of the prostate gland). Interventions included assist of 1 with toileting, monitoring foley output and change foley as ordered. R5's electronic medical record lacked evidence R5's bladder status was reassessed after foley catheter removal on 9/8/23. During an interview on 11/1/23 at 9:05 a.m., R5 stated his biggest concern was for his need for incontinent briefs, stating he was continent of bladder prior to admission to the facility. R5 stated he could sense the urge to urinate but felt he was always leaking urine and had to change his brief about five times a day. During an interview on 10/1/23 at 10:43 a.m., registered nurse (RN)-A stated there were no residents currently on a toileting program that she was aware of. However, RN-A stated staff were to check on R5 and ask if needed to use the toilet or have a brief change due to him being "incontinent lately." During an interview on 11/2/23 at 8:50 a.m., nursing assistant (NA)-A stated staff checked on	F 690		

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F 690	Continued From page 18 R5 to make sure he was clean and dry. NA stated R5 was not on a regimented toileting schedule and R5 would let staff "know when he was wet." During an interview on 11/2/23 at 12:30 p.m., the director of nursing (DON) stated bowel and bladder assessments should be done within three days of admission and with significant changes. The DON confirmed R5 was not on a toileting program. The DON further stated it would be expected for a new bowel and bladder assessment to be completed when a foley catheter was removed. The DON stated R5 was recently started on a diuretic (also known as a water pill which increase the flow of urine) and could possibly benefit from a toileting program and should be assessed for a toileting program. A facility policy on bowel and bladder assessments was requested but not received.	F 690		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		12/15/23

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F 812	Continued From page 19 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure food was labeled with an expiration date. The facility also failed to ensure food was prepared in a clean and sanitary environment. In addition, the facility failed to ensure the dishwasher temperatures were logged daily, and the chemical sanitization solution was at the correct concentration to ensure proper sanitization to prevent foodborne illness. This had the potential to affect all 34 residents in the facility. Findings include: Food Storage During an initial kitchen observation on 10/30/23 at 12:31 p.m., the following items were observed in the main kitchen: Refrigerator: -two half dozen bags of hard-boiled eggs, dated 10/13/23. Dry Storage: -canned peaches in a 1-quart plastic tub with no label or date to indicate when they were opened. -multiple individual ranch and French dressing packets with no expiration date. Freezer: -frozen sausage links in a plastic bag with no date to indicate when they were opened or when they expire.	F 812	Full kitchen and food storage area audit completed, and all items are confirmed to be non-expired and labeled per food storage policy. Food Storage Policy reviewed and confirmed as current. Dish Temperature Policy reviewed and confirmed as current. Testing completed with appropriate test strips indicated appropriate PPM range 50-100. Facility ensured non expired test strips were on hand and available to test dishwasher PPM. Ductwork and ceiling was repaired to ensure no potential for sanitary surface or food contamination. The facility will provide education to all staff including food storage policy and Dish Temperature Policy. This has the potential to impact all 34 residents. Temperature and disinfectant log was updated to include required PPM ranges for dish disinfectant and temperatures will be maintained twice daily. Dietary Manager will notify Maintenance Director of out-of-range readings. Maintenance Director will escalate to Dishwasher Sanitization Company as appropriate. Education will be provided to all culinary staff on food storage policies and dishwasher testing practices.	

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F 812	Continued From page 20 During an observation 11/2/23 at 9:45 a.m., the following items were observed: Dry Storage: -Five 6-pound (lb) cans of crushed pineapple and six 6 lb cans of diced pears with no expiration date. -Two bags of dried cheddar cheese mix and three bags of dried cream soup mix with no expiration date. -Two bags of refried pinto beans with an expiration date of 9/23. During an interview on 11/2/23 at 9:45 a.m., the dietary manager (DM) stated food removed from their original containers should be labeled with a date to indicate when they were opened and/or when they expire to avoid serving expired food to residents and potentially causing foodborne illnesses. Food Served/Prepped in a Sanitary Environment During an observation on 11/2/23 at 9:28 a.m., in the main kitchen food prep area by the stove, the ceiling was noted to have multiple cracks and flaking ceiling material and paint spanning the entire area above the food prep counter with two large chunks broken off and balancing and propped above the duct work over the stove area. A vent in the duct above the stove and near the food prep area was also coated around the edges and blades with black, fur-like dirt. The DM stated the vent should have been cleaned and the ceiling should be repaired to avoid contaminating food. During an observation on 11/2/23 at 9:28 a.m., six dozen muffins were cooling on the food prep	F 812	Audits of temperature and disinfectant log will be completed by Dietary Manage or designee twice per week for two months. Audits of food storage areas will be completed by Dietary Manager or designee twice weekly for two months. Audit results will be reviewed by QAPI Committee for further recommendations.	

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	245337	A. BUILDING _____ B. WING _____	C 11/02/2023

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F 812	Continued From page 21 counter. The ceiling above them remained cracked and peeling, with large pieces balanced on top of the duct work. During an interview on 11/2/23 at 10:09 a.m., the maintenance director (MTD) stated he was unaware of the pealing and cracked ceiling in the kitchen food prep area, and upon inspection agreed it would be a concern for possible food contamination. The MTD also stated the vents above the food prep area were supposed to be cleaned at least monthly to ensure they don't have dirt buildup and also contaminate food. Dishwasher Review of the facility dishwasher and sanitation solution log dated "October" indicated the dishwasher temperatures and sanitation solutions were tested 12 times out of the 52 times they should have been tested between 10/1/23 and 10/26/23 (two times per day). The log also indicated the following results: 10/4/23, PM -Dish PPM (sanitation parts per million) 0 -Wash temp:115 -Rinse temp:120 10/7/23, PM -Dish PPM: 0 -Wash temp:110 -Rinse temp:115 10/8/23, PM -Dish PPM: 0 -Wash temp:115 -Rinse temp:120	F 812		

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F 812	Continued From page 22 10/16/23, PM -Dish PPM: 100 -Wash temp:110 -Rinse temp:115 10/18/23, AM -Dish PPM: 100 -Wash temp:116 -Rinse temp:124 During an interview on 10/30/23 at 12:55 p.m., the cook (CK) stated the dishwasher was a low-temp dishwasher and they used test strips to test the sanitation solution for proper concentration. The test strips for the spray sanitation solution had an expiration date of 7/15/20, and the dishwasher test strips had an expiration date of 7/1/23. During an interview and observation on 10/30/23 at 12:55 p.m., the DM stated the dishwasher and sanitation solutions should have been checked and logged twice each day. The DM also verified the test strips were expired and should not have been used. The DM further stated there was no temperature requirement for the low-temp dishwasher, but it was preferred if the wash temp was over 120 degrees Fahrenheit (F) and the rinse temp was at least 124 degrees F. The DM then tested the dishwasher sanitization level using an expired test strip and the reading was 60 ppm. The DM stated he was unsure what the required PPM should be to ensure proper sanitization of the dishes. During an interview and observation on 11/2/23 at 9:39 a.m., the DM used a new, unexpired test strip to test the dishwasher ppm: the result was 25ppm. The DM again stated he did not know	F 812		

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F 812	Continued From page 23 what the ppm was supposed to be to ensure proper sanitization of the dishes. During an interview on 11/2/23 at 12:18 p.m., the dishwasher sanitization company representative (ELR) arrived at the facility to inspect the dishwasher and sanitization solutions. The ELR stated the test strip should have read between 50-100 ppm to ensure proper sanitization. The ELR further stated the wash temp should be over 115 degrees F and combined with the proper ppm, would ensure the dishes were sanitized properly. The ELR also stated he believed staff were not testing the sanitization solution at the proper intervals, causing low readings and educated them on how to test the solution accurately. During an interview on 11/2/23 at 1:55 p.m., the administrator stated she would have expected to have been notified if there were any concerns related to the dishwasher and/or sanitizing solution and was unaware of any problems. The facility Food Receiving and Storage policy dated 10/17, indicated staff were to maintain clean food storage areas at all times. Dry foods removed from their original packaging and stored in bins were to be labeled and dated with a "use by" date. All foods stored in the refrigerator and freezer were also to be labeled with a "use by" date. The facility Sanitization policy dated 10/08, indicated all kitchens were to be kept clean, free from litter and rubbish and all counters, shelves and equipment was to be kept clean, maintained in good repair and free from breaks, corrosions, open seams, cracks and chipped areas.	F 812		

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F 812	Continued From page 24 Low-temperature dishwashers (chemical sanitization) was to have a wash temperature of 120 degrees F and a final rinse with 50ppm hypocholorite (chlorine) for at least 10 seconds.	F 812		
F 880 SS=F	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 §483.70(e) 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	F 880		12/15/23

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F 880	Continued From page 25 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 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 a risk assessment and a water management program was developed and maintained to help reduce the risk of Legionnaire's Disease (Legionella)	F 880	Facility has implemented infection control practices related to Facility Water Management Program. Facility Risk Assessment completed on 10/30/2023. Facility Legionella Water Management	

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F 880	Continued From page 26 bacterial growth and subsequent contamination in the facility's water supply and/or storage. These findings had potential to affect all 34 residents, staff and visitors within the nursing home. Findings include: Review of the Centers for Disease Control and Prevention (CDC) website titled "Legionella. . .Prevention and Control, dated 03/25/21, revealed, "The key to preventing Legionnaires' disease is to reduce the risk of Legionella growth and spread. Building owners and managers can do this by maintaining building water systems and implementing controls for Legionella. . .Key Elements. . .Seven key elements of a Legionella water management program are to. . . Establish a water management program team. . . Describe the building water systems using text and flow diagrams. . . Identify areas where Legionella could grow and spread. . . Decide where control measures should be applied and how to monitor them. . . Establish ways to intervene when control limits are not met. . . Make sure the program is running as designed (verification) and is effective (validation). . .Document and communicate all the activities. . .Principles. . . In general, the principles of effective water management include. . .Maintaining water temperatures outside the ideal range for Legionella growth. . .Preventing water stagnation. . .Ensuring adequate disinfection. . .Maintaining devices to prevent sediment, scale, corrosion, and biofilm, all of which provide a habitat and nutrients for Legionella. . .Once established, water management programs require regular monitoring of key areas for potentially hazardous conditions and the use of predetermined responses to respond when control measures are not met."	F 880	Program Policy reviewed as current. Facility confirmed visual and temperature logs are completed per CDC guidance and documented in TELS maintenance computer system. Out of range results have potential to impact all 34 residents, staff and visitors. Facility Risk Assessment completed 10/30/2023 using CDC Legionella Environmental Assessment Form. Legionella Action Plan completed. Education to be provided to All Staff On Facility Water Management Plan. Legionella Team updated to include facility Medical Director. The Maintenance Director will escalate any out of range readings to facility administrator for necessary action. Visual and temperature guides were created and housed in TELS computer systems for documentation of water flushes and temperature logs. Facility will complete Water testing annually through IWC Innovations. All Legionella Tool Kit resources for health care facilities and ASHRAE guidance will be implemented as appropriate. Water Management Program will be reviewed by Water Management team and at next QAPI Meeting for further recommendations. Plan will be reviewed annually or during any occurrences of out of range readings. Facility Maintenance Director or designee will complete audits weekly for 4 weeks and once monthly for 4 months.	

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F 880	Continued From page 27 During interview on 11/1/23 at 11:50 a.m., the maintenance director (MD) stated "since the first floor is empty, I flush the first-floor toilets and open the faucets once a week." MD stated this task was not documented and was not able to provide documentation of a water management program upon request. During interview on 11/2/23 at 12:34 p.m., the administrator stated a water management program was not developed and verified a Legionella risk assessment had not been completed prior to 10/30/23. A facility water management program and Legionella risk assessment was requested and was not provided. Review of the policy titled "Legionella Water Management Program" dated 6/13/23, indicated Monarch Healthcare Management had developed and implemented water management programs in large or complex building water systems to reduce the risk of legionellosis. The policy interpretation and implementation, identified three key elements: * "Each facility must conduct a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens could grow and spread in the facility water system." * "Implementation of a water management program that considers the ASHRAE industry standard and the CDC toolkit, and includes control measures such as physical controls, temperature management, disinfectant level control, visual inspections, and environmental testing for pathogens."	F 880		

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F 880	Continued From page 28 * "Specify testing protocols and acceptable ranges for control measures and document the results of testing and corrective actions taken when control limits are not maintained."	F 880		

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	245337	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/02/2023**

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K 000	INITIAL COMMENTS The Minnesota Department of Public Safety conducted an annual Life Safety recertification survey, State Fire Marshal Division, on 11/02/2023. At the time of this survey, The Estates at Linden was found 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, the Health Care Facilities Code. This 2 story building was determined to be of Type II(222) construction and was constructed in 1950 and an addition in 1969. It has no basement and is fully fire sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 51 beds and had a census of 35 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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.