Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 27, 2025

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

RE: CCN: 245342

Cycle Start Date: June 12, 2025

Dear Administrator:

On August 6, 2025, 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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 9, 2025

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

RE: CCN: 245342
Cycle Start Date: June 12, 2025

Dear Administrator:

On June 12, 2025, 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:

Renee McClellan, 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: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

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 September 12, 2025 (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 December 12, 2025 (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

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 06/12/2025

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 On 6/9/25 - 6/12/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities 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.	E0000		
F0000	INITIAL COMMENTS On 6/9/25 - 6/12/25, 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. The following complaints were reviewed with NO deficiencies cited: H53426542C (MN00112150) H53426538C (MN00112153) H53426539C (MN00112152) H53426540C (MN00112149)	F0000		

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 06/12/2025

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F0000	Continued from page 1 H53426543C (MN00110336) H53426541C (MN00107936) H53424388C (MN00112911) The following complaints were reviewed: H53426510C (MN00112145) with a deficieny cited at F689. H53427027C (MN00113772) with a deficieny cited at F689. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F0000		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -	F0656	F656: Develop/Implement Comprehensive Care Plan SS=D (Dental) How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Dental services have been offered to R27. How the facility will identify other residents having the potential to be affected by the same deficient practice.	07/23/2025

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F0656 SS = D	Continued from page 2 (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: R103 R103's admission MDS dated 6/11/25, indicated R103 had moderate cognitive impairment. Diagnoses included congestive heart failure (CHF), acute respiratory failure, and localized edema. R103's physical therapy (PT) evaluation dated 6/8/25, indicated R103 was dependent on Sara lift (sit to stand	F0656	Continued from page 2 All residents have the potential to be affected. The facility sent a notice to all residents and resident representative offering dental services for those who qualify. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. Current and new residents will be informed about the facility's dental services at the time of admission via Admission Agreement, during the 48 hour care conference, quarterly care conference and as needed. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The Director of Nursing or designee will conduct 1 audit per week on all new residents X 4 weeks and 1 audit per week bi weekly for 8 weeks. The audit results will be reviewed at Quality Assurance Meeting (QAPI) monthly to determine if any trends are identified or if the deficient practice has occurred. Frequency of the audits will be adjusted based on the results and/or findings. The date that each deficiency will be corrected. 07/23/2025 F656: Develop/Implement Comprehensive Care Plan SS=D How corrective action will be accomplished for those residents found to have been affected by the deficient practice: R103 was safely transferred to bed and assessed by nurse and LPN Care Coordinator. Nursing assistant was educated on PCC tasks and using POC to determine transfer status	

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F0656 SS = D	Continued from page 3 aid) for transfers. R103's Therapy to Nursing Communication-Resident Status Update dated 6/8/25, indicated R103 required a mechanical stand lift for transfers, was full weight bearing, and used the Sara lift for assistive device. R103's care plan dated 6/6/25, indicated R103 had alteration in mobility related to diagnoses and indicated, "Assist with transfers: A-1 [assist of one person] with SARA LIFT, yellow sling[med]." R103's point of care (POC) nursing assistant (NA) task sheet printed 6/11/25, indicated, "Transferring: A-1 with SARA LIFT. Yellow sling[med]." During observation on 6/11/25 at 8:54 a.m., NA-A and NA-B into R103's room for morning cares. During peri care, a small reddened and open area was observed on R103's coccyx. Neither NA-A nor NA-B were previously aware of this skin concern and did not know if it was new. NA-A called for licensed practical nurse (LPN)-C to come assess R103's skin. LPN-C into room and looked at R103's coccyx and stated she would address it when R103 was back in bed after breakfast. NA-A and NA-B continued with morning cares and placed new brief, dressed R103 and placed a blue sling under him. The sling was attached to a Hoyer (full body lift), and R103 was transferred to a wheelchair. R103 was pushed to the dining room for breakfast. During observation on 6/11/25 at 10:40 a.m., R103 requested to go back to his room to lie down. During observation on 6/11/25 at 10:57 a.m., administrator pushed R103 back to his room, activated his call light, and left him sitting in his room in his wheelchair. During observation on 6/11/25 at 11:00 a.m., NA-A answered R103's call light and explained she needed to go find another staff to assist with the Hoyer transfer. During observation on 6/11/25 at 11:03 a.m., director of therapy services (DTS) walked to R103's room and	F0656	Continued from page 3 How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents who require transfer assistance have the potential to be affected. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. Care Planning policy was reviewed with all staff and remains current. All nursing staff have been educated how to access the resident's care plan via PCC POC in order to follow the resident's plan of care. Upon a change in transfer status, the resident's tasks will be updated and a PCC POC alert will be entered to notify the staff of a change in transfer status. Third-party nursing staff will receive notice upon shift start time to utilize PCC POC to obtain resident's plan of care. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The Director of Nursing or designee will conduct care plan audits twice per week X 4 weeks and 1 per week for 8 weeks thereafter. The audits will ensure the resident's care plan is being followed according to their PCC POC. The results will be reviewed at Quality Assurance Meeting (QAPI) monthly to determine if any trends are identified or if the deficient practice has occured. Frequency of the audits will be adjusted based on the results and/or findings. The date that each deficiency will be corrected. 07/23/2025	

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F0656 SS = D	Continued from page 4 asked what he needed. R103 stated he wanted to go back to bed. DTS did not offer to assist and continued walking down the hallway. During observation on 6/11/25 at 11:10 a.m., R103 was still sitting in his wheelchair waiting to be transferred to bed. NA-A stopped at R103's doorway and stated that she was still looking for someone to help with the transfer. During observation on 6/11/25 at 11:28 a.m., NA-A and NA-B in R103's room, blue sling attached to the Hoyer lift and R103 was transferred back to bed. During interview on 6/11/25 at 11:30 a.m., NA-B stated each resident had a care plan that staff were supposed to refer to at the beginning of each shift to know how to care for the residents. NA-B stated transfer status was included on the care plan and that R103 required a two person Hoyer lift for transfers. During observation on 6/11/25 at 11:36 a.m., LPN-C and LPN-B into R103's room to assess and treat R103's coccyx skin concern. LPN-C stated was not aware of the skin issue previously and described it as a new wound, "looks like a blister that just popped." LPN-C cleaned and dressed the wound. LPN-B stated they would notify the wound nurse and develop a wound care plan. During interview on 6/11/25 at 11:55 a.m., LPN-C stated resident transfer status was in point click care (PCC) and thought R103 required a Hoyer lift for transfers. During interview on 6/11/25 at 12:00 p.m., NA-B looked in POC and confirmed R103's transfer status was assist of one with a Sara lift and did not require a two-person assist with a Hoyer lift. NA-B further stated sometimes there were changes to a resident's status and POC and the care plan were not updated timely. NA-B stated she got report at the beginning of her shift and did not confirm any information in POC. During interview on 6/11/25 at 12:11 p.m., NA-A stated she would get report from the previous shift in the	F0656		

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F0656 SS = D	Continued from page 5 morning and expected to be informed of any transfer status changes. NA-A further stated staff could refer to POC as well and that the information in PCC should be accurate and up to date. NA-A looked in POC and confirmed R103's transfer status was assist of one with a Sara lift and did not require a two-person assist with a Hoyer lift. NA-A stated if R103 only required one person to assist with a transfer, he would not have had to wait and sit on his new coccyx wound over 40 minutes to be transferred back to bed after breakfast. During interview on 6/11/25 at 12:18 p.m., registered nurse (RN)-A stated resident's transfer status was kept current in POC and the care plan in PCC and would staff to refer to POC and the care plan at the beginning of each shift and would expect staff to follow the care plan. During interview on 6/11/25 at 12:25 p.m., director of nursing (DON) stated would expect the tasks and care plan to be kept current and staff to refer to POC and PCC for transfer status and other care instructions. DON stated would expect staff to follow the care plan. Facility policy for Care Planning dated 11/2024, identified care plan interventions were derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The comprehensive person-centered care plan would be consistent with the resident's rights to identify problem areas and their causes and develop interventions that are targeted and meaningful to the resident. The resident has the right and is encouraged to participate in the development of his or her care plan. The care plan shall be used in developing the resident's daily care routines and will be utilized by staff personnel for the purposes of providing care or services to the resident. The plan of care will be utilized to provide care to the resident. The care plan is to be modified and updated as the condition and care needs of the resident changes. Facility policy for Safe Handling Program dated 3/2020, indicated, "All resident care will be provided in a safe, appropriate, and timely manner in accordance with the individual resident's care plan." Based on observation, interview and document review, the facility failed to comprehensively assess and initiate a plan of care for dental interventions for 1	F0656		

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F0656 SS = D	Continued from page 6 of 1 resident (R27) who had tooth concerns. Additionally, the facility failed to ensure care was provided in accordance with a resident's care plan for 1 of 1 residents (R103) reviewed for transfer status. R27's quarterly Minimum Data Set (MDS) dated 3/18/25, identified she had intact cognition and no behaviors. R27 had no problems with dentures and no mouth or facial pain. R27 was independent with oral hygiene, diagnoses included malnutrition and dysphagia (difficulty swallowing). R27's hospital History and Physical (H&P) dated 9/16/24, identified she reported difficulty eating due to poor dentition with multiple upper and lower teeth missing. R27's admission Oral/Dental Evaluation dated 9/20/24 and quarterly Oral/Dental Evaluation dated 3/18/25, identified there were several missing teeth on the upper and lower jaw but lacked comments for care plan interventions. R27's nutrition care plan dated 9/22/24, identified mechanically altered diet d/t (due to) difficulty chewing and dysphagia. R27's care plan lacked a focus area, goal and interventions related to dental care related to poor dentition. R27's progress note dated 9/24/25 at 17:12 (5:12 p.m.), identified she reported difficulty eating foods due to lack of teeth. R27 deferred to family member (FM)-B for most decision making. R27's Care Conference forms dated 12/20/24 and 3/18/25, in the section for last dental exam date and comments were left blank. R27's care conferences lacked a discussion related obtaining dental care related to poor dentition. During an observation and interview on 6/9/25 at 12:51 p.m., R27 was sitting in her recliner with a small tube of Anbesol (gel for oral pain) on her bedside table. R27 stated she did not use the Anbesol often, only when she had tooth pain. R27 opened her mouth to show a front tooth with only a small sliver of the tooth remaining, many missing teeth and molars. R27's	F0656		

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F0656 SS = D	Continued from page 7 remaining teeth were grey in color. During an interview on 6/10/25 at 1:57 p.m., nursing assistant (NA)-G stated R27 had missing teeth and was independent with brushing her teeth. NA-G thought R27 had mentioned tooth pain in the past and social services would help set up dental services. During an interview on 6/10/25 at 2:03 p.m., social services (SS)-A stated she would help set up residents with dental services if needed. Usually it was addressed upon admit, at care conferences, or to a move to the long-term care unit, however, SS-A was not able to find documentation that dental interventions had been discussed with the resident or family. During an interview on 6/12/25 at 8:23 a.m., FM-A stated he would like to see if R27 could get fitted for dentures and was interested in learning more about dental care. FM-A stated he was unsure what the facility could offer for dental services and it had not been addressed at care conferences yet. During an interview on 6/12/25 at 12:03 p.m., licensed practical nurse (LPN)-B stated the Oral Evaluation results should have carried over to the care plan. Additionally, issues that required intervention should be added to the care plan. During an interview on 6/12/24 at 12:26 p.m., the director of nursing (DON) stated at admission residents were informed about dental services that were available and it was also brought up at care conferences. The DON reviewed R27's care conferences and care plan and agreed dental services were not included in the care plan. The DON stated care plans should address concerns from assessments (evaluations).	F0656		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F0689	F689: Free of Accident Hazards/Supervision/Devices SS=D How corrective action will be accomplished for those residents found to have been affected by the deficient practice: R4 was immediately assessed by nurse and then transferred into bed using maxi lift.	07/23/2025

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F0689 SS = D	Continued from page 8 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure care planned interventions to reduce fall risk were implemented for 2 of 2 residents (R4 and R2) reviewed for falls. Findings include: R4's quarterly Minimum Data Set (MDS) dated 5/9/25 identified R4 had intact cognition and no behaviors; had limited range of motion on one side of upper and lower extremity. R4 was dependent on a helper to do all the effort to transfer from chair to bed (or bed to chair). Sit to stand was not attempted due to medical condition or safety concerns. R4's care plan dated 6/9/25, identified she was at risk for falls due to impaired mobility and required assist of two staff for transfers using the MAXI lift (full body lift) r/t (related to) diagnoses of vascular dementia, non-traumatic intracerebral hemorrhage (type of stroke), and right sided weakness. R4's Follow Up Question Report dated 4/12/25 through 6/11/25, identified assist of two staff was required to transfer R4 using the MAXI lift with an XL sling size. During an interview on 6/9/25 at 4:08 p.m., R4 stated she had a fall earlier, because the nursing assistant attempted to transfer her using a standing lift and not the MAXI lift. R4 stated that did not work because the right side of her body was weak, and she fell without getting injured. During an interview on 6/9/25 at 7:32 p.m.,, nursing assistant (NA)-F stated she was called into R4's room earlier today by NA-H, because R4 had fallen. When NA-F entered R4's room, R4 was on the ground. NA-H stated she went to get the nurse to assess the situation. During an interview on 6/9/25 at 8:47 p.m., NA-F stated	F0689	Continued from page 8 How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. Facility educated nursing staff on the Safe Patient Handling Program and Care Planning policy. Educated staff on the importance of prioritizing resident safety over resident preferences. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. Safe Patient Handling Program and Care Planning policies have been reviewed with all staff and remain current. Upon a change in transfer status, the resident's tasks will be updated and a PCC POC alert will be entered to notify the staff of a change in transfer status. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The Director of Nursing or designee will conduct lift audits on 5 residents per week X 4 weeks and 5 residents per week bi weekly for 8 weeks. The audit results will be reviewed at Quality Assurance Meeting (QAPI) monthly to determine if any trends are identified or if the deficient practice has occurred. Frequency of the audits will be adjusted based on the results and/or findings. The date that each deficiency will be corrected. 07/23/2025 F689: Free of Accident Hazards/Supervision/Devices SS=D How corrective action will be accomplished for those residents found to have been affected by the deficient practice:	

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F0689 SS = D	Continued from page 9 she attempted to transfer R4 with a standing lift instead of the MAXI lift, due to R4's request. When R4 started to stand up with the lift, her right leg buckled and she started to drop. NA-F lowered R4 to the floor and asked NA-H for help. NA-H left the room to get assistance, a nurse came in to assess R4's status, and then NA-H and NA-F assisted off the floor R4 using the full body lift. NA-F stated she should not have transferred R4 differently than what the care plan identified, however, R4 was in a hurry and requested the standing lift instead of the full body lift. During an observation and interview on 6/11/25 at 10:10 a.m., NA-A and NA-B assisted R4 with a transfer from bed to wheelchair using the MAXI lift. NA-A and NA-B stated residents should be transferred using the care planned devices. During an interview on 6/10/25 at 11:09 a.m., the director of therapy services (DTS) stated R4 used to tolerate the standing lift, however, due to the progression of weakness from her stroke was switched over to the MAXI lift. The DTS stated R4 could bear some weight but the MAXI lift should be used for all transfers. During an interview on 6/11/25 at 1:10 p.m., licensed practical nurse (LPN)-E stated she was called to R4's room on 6/9/25, due to report of a fall. When LPN-E got to the room R4 was on the ground. LPN-E stated NA-H said she attempted a transfer using the standing lift instead of the MAXI lift, however, R4's leg gave out so NA-H lowered R4 to the ground. LPN-E assessed R4's vital signs and range of motion and determined it was acceptable to continue the transfer using the full body lift. R2's quarterly MDS dated 5/27/25, identified she had severely impaired cognition and no behaviors. Required substantial/maximal assistance putting on/taking off footwear, and supervision or touching assistance for sit to stand and for walking up to 50 feet. Diagnoses included heart failure, repeated falls, chronic pain, and palliative care. R2 had two falls without injury and one fall with minor injury since the previous MDS. R2's care plan dated 2/26/25, identified risk for falls related to heart failure, mild cognitive impairment, advanced age and end-stage disease processes on hospice	F0689	Continued from page 9 Appropriate footwear was placed on R2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. The facility's Care Planning policy was reviewed with all staff and remains current. All nursing staff have been educated how to access the resident's care plan via PCC POC in order to follow the resident's plan of care. Third-party nursing staff will receive welcome letter upon shift start, which informs them to utilize PCC POC to obtain resident's plan of care. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The Director of Nursing or designee will conduct weekly audits on 5 residents for 4 weeks and bi-weekly audits on 5 residents for 8 weeks thereafter to ensure nursing staff are following the residents plan of care according to PCC POC. The audit results will be reviewed at Quality Assurance Meeting (QAPI) monthly to determine if any trends are identified or if the deficient practice has occured. Frequency of the audits will be adjusted based on the results and/or findings. The date that each deficiency will be corrected. 07/23/2025	

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F0689 SS = D	Continued from page 10 care. Interventions were in place dated 4/11/25, to ensure resident always has appropriate footwear (gripper socks at HS/hour of sleep), and dated 6/10/25, to offer toileting upon rising, before and after meals, at HS, around 0100 to 0200 (1:00 a.m. to 2:00 a.m.) and PRN (as needed). Vulnerable Adult Maltreatment Report dated 4/8/25, identified R4's care planned interventions for falls were not implemented. During an observation on 6/10/25 at 2:52 p.m., R2 was in bed with tan socks on with no grip on the bottom. R2 did not have appropriate footwear on as care planned. During an interview on 6/10/25 at 3:24 p.m., NA-C R2 was a fall risk and should always have non-slip footwear on. NA-C observed the tan socks R2 had on and stated those were slippery and he would put gripper socks on now. During an interview on 6/10/25 at 3:25 p.m., LPN-A stated R2 was at risk of falls because she was impulsive and on-slip footwear should always be in place. During an observation at 6/11/25 at 8:25 a.m., R2 was in the dining room. At 9:15 a.m., NA-F took R2 out of the dining room and back to her room. Once in the room NA-F put shoes on R2's feet over her socks and gripper socks and brought her down to the commons area to watch TV. R2 was not offered to toilet after meals as care planned. During intermittent observations on 6/11/25 from 9:15 a.m., through 11:58 a.m., R2 remained in the commons are watching TV. At 11:58 a.m., family member (FM)-B came to visit and brought R2 back to her room and assisted R2 into a recliner in her room to have lunch together. During an observation on 6/11/25 at 12:27 p.m., NA-F entered R2's room, FM-B asked R2 if there was anything she needed from NA-F such as the bathroom. NA-F had not offered to toilet R2 before lunch as care planned. NA-F stated the bathroom should have been offered to R2 before and after meals.	F0689		

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F0689 SS = D	Continued from page 11 R2's Follow Up Question Report dated 6/11/25, identified toilet support was provided at 2:45 a.m., and 9:59 p.m. There was no documentation during the day shift of toileting before and after meals. During an interview on 6/11/25 at 12:03 p.m., registered nurse (RN)-A stated care planned interventions for falls should be carried out to prevent falls and injuries. During an interview on 6/11/25 at 12:56 p.m., the director of nursing (DON) stated fall interventions should be implemented as per the care plan. The facility policy Falls Prevention and Management dated 2/2024, identified care plans would be updated to reflect fall interventions. The facility policy Care planning dated 11/2024, identified the care plan would be used in developing the resident's daily care routines and would be utilized by staff personnel for the purposes of providing care or services to the resident.	F0689		
F0700 SS = D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are	F0700	F700 Bedrails How corrective action will be accomplished for those residents found to have been affected by the deficient practice: R35's grab bars have been removed. Resident was re-assessed and appropriate size grab bars were installed on R35's bed. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents with grab bars have the potential to be affected. A house-wide audit has been completed and revisions have been made as necessary. Education on the facility's grab bar process will be given to nursing staff and IDT.	07/23/2025

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F0700 SS = D	Continued from page 12 appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the appropriate mobility device was installed and in good working condition for 1 of 1 resident (R35) reviewed for bed rails. Findings include: R35's admission Minimum Data Set (MDS) dated 4/1/25, indicated R35 had mild cognitive impairment, was dependent on staff for bed mobility, and did not use bed rails. R35's diagnoses included embolus of pulmonary artery, and fracture of multiple ribs. R35's care plan dated 3/28/25 indicated R35 had alteration in mobility related to diagnoses and required assistance with movement in bed and in and out of bed. R35's Bed Mobility Device Evaluation dated 3/28/25, indicated R35 and R35's emergency contact requested a bed mobility device. The evaluation indicated R35 was assessed for grab bars for bed mobility and transfer assistance. R35's Therapy to Nurse Communication dated 3/27/25, indicated R35 was approved for grab bars "if patient requests." R35's Therapy to Nurse Communication dated 4/22/25, indicated R35 was approved for grab bars "if patient requests." R35's progress note dated 3/27/25, indicated, "Apply grab bars to bed to assist w/[with] bed mobility." During observation on 6/9/25 at 1:32 p.m., R35's bed had bilateral half bed rails on bed. One bed rail was	F0700	Continued from page 12 What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. Prior to the application of grab bars, the bed mobility assessment will be completed by nursing or designee. The assessment will help determine the residents ability to properly use the aided device and that the device's dimensions is appropriate for the residents level of bed mobility. All current and new grab bars installed will be inspected by Maintenance Director or desginee weekly to ensure proper functioning. Education has been provided to staff on how to enter a "TELS" order in PCC for any device malfunctions. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Director of Nursing or designee will conduct grab bar audit weekly X 4 weeks for 1 month and bi-weekly for 8 weeks thereafter. The audits will monitor. Audit results will be review at Quality Assurance Meeting (QAPI) monthly to determine if any trends are identified. Frequency of the audits will be adjusted based on the results and/or findings. The date that each deficiency will be corrected. 07/23/2025	

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F0700 SS = D	Continued from page 13 raised on the side of the bed against the wall. The bed rail on the outer side of the bed was not up but very loose and would move several inches side to side when touched. During observation on 6/10/25 at 10:41 a.m., R35's bed still had bilateral half bed rails, and the outer one was still very loose. The bed rails measured 31 inches long by 19 inches high. During interview and observation on 6/10/25 at 11:32 a.m., R35 stated he did not request bed rails and did not like the outer one to be raised since it prevented him from getting in and out of bed. R35 stated the outer one had been wobbly for a while and he did not use the rails for bed mobility. During interview on 6/10/25 at 11:35 a.m., registered nurse (RN)-B stated upon admission, a nurse assessed a resident and see if grab bars would help with mobility and transfers. Also, a resident could just request them, or physical therapy (PT) could recommend them. If appropriate, a request would be sent to maintenance for installation. RN-B further stated after installation, PT would assess the resident to ensure they were safe to use grab bars. During interview on 6/10/25 at 11:40 a.m., director of therapy services (DTS) stated during PT evaluation, it could be determined that a resident would benefit from the use of grab bars for bed mobility so a therapy to nurse communication would be used to notify nursing for the need for grab bar installation. DTS further stated PT would assess a resident after the grab bars were installed to ensure the resident was safe to use them. DTS did not think the facility used any other type of bed rail other than grab bars. DTS stated grab bar use would be monitored for appropriateness during therapy sessions, and if a grab bar was deemed no longer appropriate or not functioning correctly, would expect a work order placed to maintenance for repair or removal. During interview on 6/10/25 at 12:39 p.m., maintenance (M)-A stated he installed assist bars after receiving a work for from either PT or nursing. M-A stated only certain rails were compatible with certain beds and thought the facility only used the smaller grab bars. M-A further stated there should be a weekly visual	F0700		

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F0700 SS = D	Continued from page 14 inspection of all installed assist bars to ensure good working condition. M-A stated he did not currently document any type of weekly inspection. During observation and interview on 6/10/25 at 12:50 p.m., M-A into R35's room and confirmed R35's bed had half bed rails and not grab bars. M-A further confirmed the one side of the bed rail was very loose and wobbled from side to side when touched. M-A stated would have expected to receive a work order on this so that he could repair it. M-A could not explain why the side rails were placed on R35's bed instead of grab bars other than there must not have been any grab bars available at the time of the request. M-A could not provide any documentation regarding the instillation or maintenance evaluation of the bed rails and could not confirm these bed rails were even compatible with R35's bed. During interview on 6/10/25 at 12:54 p.m., RN-A stated upon admission, residents were assessed for grab bars and if recommended by PT, they would be installed on the resident's bed. RN-A further stated nursing also completed an assessment upon admission and quarterly to ensure grab bars were used appropriately and safe to bed mobility. RN-A stated the facility only used the smaller assist bars for grab bars and half bed rails were never used. During interview on 6/10/25 at 12:55 p.m. licensed practical nurse (LPN)-B stated the facility only used grab bars which were smaller than regular bed rails. LPN-B stated would expect staff to notify maintenance immediately if one was loose or not working. During interview on 6/10/25 at 1:23 p.m., director of nursing (DON) stated grab bars were used for bed mobility and transfer assistance in and out of bed and that half side rails were not used as they could restrict a resident's transfer ability. DON stated would expect installed assist rails be appropriate for the resident and in good working condition. DON further stated expectation maintenance would ensure any installed assist rails were compatible with the bed. A facility policy regarding bed rails was requested but not provided.	F0700		

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K0000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on June 10, 2025, 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		

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

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K0000	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: 1. 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	K0000		

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K0000	Continued from page 2 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 50 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K0000		
K0293 SS = F	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to properly maintain illuminated exit signage per NFPA 101 (2012 edition), section(s) 7.10.1.5.1, 7.10.6.2 and 19.2.10 This deficient finding could have an widespread impact on the residents within the facility. Findings include: On 06/10/2025 at 10:12am, it was revealed by observation that there was no Exit sings at the main entrance, the North Wing and the West Wing. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0293	How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Exit signs have been purchased for identified areas and will be professionally installed per Fire Marshal's recommendations. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. Exit signs have been installed in the identified areas. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Facility will conduct monthly audits to ensure exit signs are at all exits and working properly in accordance with the fire safety regulations. The Maintenance Director or designee will conduct 1 audit per month to ensure exit signs are located in the appropriate areas and are functioning properly. The audit results will be reviewed at Quality Assurance	07/23/2025

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 06/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K0293 SS = F		K0293	Continued from page 3 Meeting (QAPI) monthly to determine if any trends are identified or if the deficient practice has occured. Frequency of the audits will be adjusted based on the results and/or findings. The date that each deficiency will be corrected. 07/23/2025	
K0353 SS = A	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain spacing between storage and the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, Section 9.7.5, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 5.2.1.2, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, Sections 8.6.5.3.2 and 8.15.9. This deficient finding could an isolated impact on the residents within the facility. Findings include:	K0353		07/09/2025

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 06/10/2025

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K0353 SS = A	Continued from page 4 On 06/10/2025, at 10:05 AM, it was revealed by observation that storage materials had been placed within 18" of the sprinkler system within Culinary Services. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0353		
K0923 SS = D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected	K0923	How corrective action will be accomplished for those residents found to have been affected by the deficient practice: The O2 Concentrator was removed from the affected resident's room and placed in the appropriate storage area. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents using an oxygen concentrator have the potential to be affected. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. Maintenance Director or designated will complete random assessment of the facility to assure compliance with requirements to properly store O2 Concentrators. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The Maintenance Director or designee will conduct weekly ra audits for 4 weeks and bi-weekly audits for 8 weeks thereafter. The audit results will be reviewed at Quality Assurance Meeting (QAPI) monthly to determine if any trends are identified or if the deficient practice has occured. Frequency of the audits will be adjusted based on the results and/or findings.	07/23/2025

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K0923 SS = D	Continued from page 5 from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain proper medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.6.5. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 06/10/2025 at 10:17am, it was revealed by observation that room 233, there was an oxygen concentrator being stored within this room. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0923	Continued from page 5 The date that each deficiency will be corrected. 07/23/2025	