Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 6, 2022

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

RE: CCN: 245342
Cycle Start Date: April 7, 2022

Dear Administrator:

On June 1, 2022, 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

June 6, 2022

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

Re: Reinspection Results
Event ID: HEHY12

Dear Administrator:

On June 1, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 7, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
June 6, 2022

CMS Certification Number (CCN): 245342

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

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective May 27, 2022 the above facility is certified for:

64 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 64 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

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

Electronically delivered
April 20, 2022

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

RE: CCN: 245342
Cycle Start Date: April 7, 2022

Dear Administrator:

On April 7, 2022, 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), 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:

Sarah Grebenc, Unit Supervisor
Metro A 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: sarah.grebenc@state.mn.us
Mobile (651)238-8786

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 July 7, 2022 (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 October 7, 2022 (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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING ______ B. WING ______	04/07/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 4/4/22 to 4/7/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) 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 4/4/22 to 4/7/22, a standard recertification survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. 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.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains	F 689		5/27/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 04/27/2022

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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THE ESTATES AT GREELEY LLC	313 SOUTH GREELEY STREET STILLWATER, MN 55082

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F 689	Continued From page 1 as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide ongoing assessments of residents and their transfer ability to ensure staff used the correct lift for 1 of 2 (R12) residents reviewed for accidents. R12's face sheet (undated) indicated diagnoses which included morbid obesity, bilateral primary osteoarthritis of the knee, abnormalities of gait and mobility, muscle weakness, and convulsions. R12's annual Minimum Data Set (MDS) dated 1/25/22, indicated R12 had intact cognition and required extensive assistance of two staff with transfers. R12's care plan last revised 5/7/20, indicated R12 had a physical functioning deficit related to decreased mobility, knee pain, obesity, general muscle weakness manifested by the need for staff assist with transfers and ambulation with interventions of assist of 1 and use of SARA (sit-to-stand) lift for transfers and to monitor and report changes/decline in physical functioning and range of motion (ROM) ability. R12's care plan further included R12 was a fall risk with an intervention of "Trial starts 4/27/21: Transfer via SARA lift if strong enough, if not use MAXI (full body) lift. Bedside commode toileting recommend certified nursing assistant's (CNA)'s have all supplies ready.	F 689	Immediate Corrective Action: R12 transfer status has been re-evaluated and resident will be downgraded to mechanical lift due to inconsistencies to transfer with assist of one. Corrective Action as it applies to others: A full-house audit will be conducted for transfer status of all residents. All residents requiring less than maximum assistance will be screened by rehab services and an appropriate transfer status will be initiated. Nursing and therapy staff will be educated on facility Safe Patient Handling Policy and Procedure as it relates to lift transfers. Recurrence will be prevented by: All new admissions will be evaluated/screened by therapy, as required, for an appropriate transfer status and review with nursing within one business day. All new admissions will be audited for appropriate transfer status for four weeks then bi-monthly for two months. Therapy and nursing will collaborate on discharge transfer status to ensure nursing can provide consistent and safe transfer ability prior to resident being discharged from rehab services. Results will be shared with the facility QAPI committee for input on the need to increase, decrease or	

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	245342	A. BUILDING ______ B. WING ______	04/07/2022

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F 689	Continued From page 2 R12's nursing assistant care sheet (undated), included "trial starts: 4/27 SARA, recommended having supplies ready when toileting, (commode only). MAXI when needed." R12's nursing progress note dated 4/4/22, included "Resident is a Ax1 (assist of 1) with transfers using SARA and Ax2 (assist of 2) with MAXI lift for toileting when required." R12's physical therapy discharge summary dated 3/16/22, indicated transfer program established/trained: EZ stand (SARA lift) with assist of 1 as safety allows. During an observation on 4/6/22, at 11:00 a.m. R12 was transferred by nursing assistant (NA)-C who used the SARA 3000 (sit-to-stand lift). R12 sat in her wheelchair outside of the bathroom. NA-C put the sling behind R12's back, pushed the lift up to R12 so her shins rested against the shin pads, and connected both ends of the sling to the lift. R12 held onto the handles of the lift and NA-C used the remote to raise R12 off of the wheelchair. R12 did not bear weight on her legs. R12's knees were bent and her arms were raised above her head. Surveyor asked NA-C if R12 was able to bear weight on her legs and she responded "No, you have to be quick." NA-C pushed the lift into the bathroom and stated "it's kind of hard to push her too," and used the remote to lower R12 down onto the toilet. R12 stated she would put her light on when she was finished with the bathroom. NA-C and surveyor left the room. A few minutes later R12 put her call light on and NA-C and surveyor entered the room. NA-C used the remote to raise R12 up off the toilet and assisted R12 with peri care and pulled up her brief and pants. R12's knees were	F 689	discontinue the audit. Corrections will be monitored by: Corrections will be monitored by the Director of Nursing/Unit Nursing Managers and/or designee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING ______ B. WING ______	04/07/2022

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

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F 689	Continued From page 3	F 689		

bent and she held onto the handles with her arms above her head. NA-C pushed the lift out of the bathroom and used the remote to lower her back down into her wheelchair. Surveyor asked R12 (using her white communication board) if she was able to put weight on her legs, she stated " I don't know, I know I should try to stand up straighter but I don't know if I can." There was no bedside commode observed in R12's room.

During an interview on 4/6/22, at 11:49 a.m. the director of rehab stated in order for a resident to be approved to use the SARA lift, they needed to be able to bear 50% (percent) of their weight. He further stated the last time R12 was in therapy (a few months ago), she used the SARA lift. He also stated R12 had bad days and some behavioral issue and had gone backwards. The director of rehab stated the nursing assistants have been trained on how to transfer R12 several times. He stated R12's arms should not be above her head, when being transferred and that she needed to be coached to stand. He further stated they (rehab staff) tended to side on R12's freedom to make choices/preferences and she wanted to participate in transfers. He stated the nursing assistants should have let the nurse know if there was a change in R12's ability to bear weight during transfers. He also stated a bedside commode would be very helpful for R12 and she shouldn't be transferred if she can't hold herself up in the standing position.

During an interview on 4/6/22, at 1:17 p.m. NA-A stated she had transferred R12 a few times in the past using the SARA lift and the transfer the surveyor observed was a "typical transfer." She also stated she was supposed to let therapy know when R12 wasn't bearing weight or had trouble

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	245342	A. BUILDING ______ B. WING ______	04/07/2022

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

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F 689	Continued From page 4	F 689		

transferring with the SARA lift.

During an interview on 4/7/22, at 12:33 NA-B stated R12 used the SARA lift for transfers and R12 was not able to bear weight. NA-B further stated she felt uncomfortable transferring R12 and had reported it to the nurse in the past. However NA-B couldn't remember who she reported to or when.

During an interview on 4/7/22, at 12:40 p.m. NA-A stated R12 used the SARA lift with transfers. NA-A further stated R12 was able to stand up "within the first minute" but then was unable to hold herself up at all. NA-A stated she didn't like transferring R12 when she had to change her entire pad and clothing because took too long and she couldn't hold herself up for that long.

During an interview on 4/7/22, at 1:03 p.m. registered nurse (RN)-A stated R12 required an assist of one using the mechanical stand (SARA lift) and she "was not too sure" if R12 could bear weight.

During an interview on 4/7/22, at 1:39 p.m. the director of nursing (DON) stated there were two lifts R12 could use that had been approved by therapy (SARA & MAXI). The DON further stated R12 was able to bear weight and she thought R12 just had a "bad day yesterday" (4/6/22, when surveyor observed the transfer). The DON also stated R12 "was stressed with having new people here, she is very specific and hates the lift, she doesn't like the way it feels, it's a fear." The DON further stated, "if the NA's felt a transfer wasn't going well, they should seek out one of their co-workers to address it."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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THE ESTATES AT GREELEY LLC	**313 SOUTH GREELEY STREET** **STILLWATER, MN 55082**

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F 689	Continued From page 5 The manufacturer's instructions for use for the Sara 3000 lift dated 6/2018, indicated (under the heading Patient/Resident Assessment), we recommend that facilities establish regular assessment routine's. Caregivers should assess each resident/patient according to the following criteria prior to use: patient/resident is able to partially bear weight on at least one leg. If the patient does not meet these criteria an alternative equipment/system shall be used. The facility's policy titled Safe Resident Handling indicated, it is the policy of Monarch Healthcare Management that when residents receiving care require assistance from facility employee to move (e.g. transferring, lifting, repositioning), that assistance is provided in a manner that is safe to both the resident and employee.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**04/07/2022**

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

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 04/07/2022. At the time of this survey, The Estates at Greeley 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. 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 2(111) construction. In 1988, an addition was constructed to the west side of the building that was determined to be of Type II(111)construction. In 1997, an addition was constructed to the north and south sides of the building that was determined to be of Type V(111)construction. Because the original building and the additions meet the construction type allowed for existing buildings, the facility was surveyed as one building as Type V(111) construction. The facility has a capacity of 64 beds and had a census of 50 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.

Electronically delivered
April 20, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: HEHY11

Dear Administrator:

The above facility was surveyed on April 4, 2022 through April 7, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Sarah Grebenc, Unit Supervisor
Metro A 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: sarah.grebenc@state.mn.us
Mobile (651)238-8786

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

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00947	A. BUILDING: ______ B. WING ______	04/07/2022

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

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2 000	Initial Comments	2 000		

Initial Comments

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

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

INITIAL COMMENTS:
On 4/4/22 to 4/7/22, a standard licensing survey was conducted completed at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. The following licensing orders were issued: 0830.

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2 000	Continued From page 1 Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		

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2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide ongoing assessments of residents and their transfer ability to ensure staff used the correct lift for 1 of 2 (R12) residents reviewed for accidents. R12's face sheet (undated) indicated diagnoses which included morbid obesity, bilateral primary osteoarthritis of the knee, abnormalities of gait and mobility, muscle weakness, and convulsions. R12's annual Minimum Data Set (MDS) dated 1/25/22, indicated R12 had intact cognition and	2 830	corrected	5/27/22

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required extensive assistance of two staff with transfers.

R12's care plan last revised 5/7/20, indicated R12 had a physical functioning deficit related to decreased mobility, knee pain, obesity, general muscle weakness manifested by the need for staff assist with transfers and ambulation with interventions of assist of 1 and use of SARA (sit-to-stand) lift for transfers and to monitor and report changes/decline in physical functioning and range of motion (ROM) ability. R12's care plan further included R12 was a fall risk with an intervention of "Trial starts 4/27/21: Transfer via SARA lift if strong enough, if not use MAXI (full body) lift. Bedside commode toileting recommend certified nursing assistant's (CNA)'s have all supplies ready.

R12's nursing assistant care sheet (undated), included "trial starts: 4/27 SARA, recommended having supplies ready when toileting, (commode only). MAXI when needed."

R12's nursing progress note dated 4/4/22, included "Resident is a Ax1 (assist of 1) with transfers using SARA and Ax2 (assist of 2) with MAXI lift for toileting when required."

R12's physical therapy discharge summary dated 3/16/22, indicated transfer program established/trained: EZ stand (SARA lift) with assist of 1 as safety allows.

During an observation on 4/6/22, at 11:00 a.m. R12 was transferred by nursing assistant (NA)-C who used the SARA 3000 (sit-to-stand lift). R12 sat in her wheelchair outside of the bathroom. NA-C put the sling behind R12's back, pushed the lift up to R12 so her shins rested against the

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shin pads, and connected both ends of the sling to the lift. R12 held onto the handles of the lift and NA-C used the remote to raise R12 off of the wheelchair. R12 did not bear weight on her legs. R12's knees were bent and her arms were raised above her head. Surveyor asked NA-C if R12 was able to bear weight on her legs and she responded "No, you have to be quick." NA-C pushed the lift into the bathroom and stated "it's kind of hard to push her too," and used the remote to lower R12 down onto the toilet. R12 stated she would put her light on when she was finished with the bathroom. NA-C and surveyor left the room. A few minutes later R12 put her call light on and NA-C and surveyor entered the room. NA-C used the remote to raise R12 up off the toilet and assisted R12 with peri care and pulled up her brief and pants. R12's knees were bent and she held onto the handles with her arms above her head. NA-C pushed the lift out of the bathroom and used the remote to lower her back down into her wheelchair. Surveyor asked R12 (using her white communication board) if she was able to put weight on her legs, she stated " I don't know, I know I should try to stand up straighter but I don't know if I can." There was no bedside commode observed in R12's room.

During an interview on 4/6/22, at 11:49 a.m. the director of rehab stated in order for a resident to be approved to use the SARA lift, they needed to be able to bear 50% (percent) of their weight. He further stated the last time R12 was in therapy (a few months ago), she used the SARA lift. He also stated R12 had bad days and some behavioral issue and had gone backwards. The director of rehab stated the nursing assistants have been trained on how to transfer R12 several times. He stated R12's arms should not be above her head, when being transferred and that she needed to

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be coached to stand. He further stated they (rehab staff) tended to side on R12's freedom to make choices/preferences and she wanted to participate in transfers. He stated the nursing assistants should have let the nurse know if there was a change in R12's ability to bear weight during transfers. He also stated a bedside commode would be very helpful for R12 and she shouldn't be transferred if she can't hold herself up in the standing position.

During an interview on 4/6/22, at 1:17 p.m. NA-A stated she had transferred R12 a few times in the past using the SARA lift and the transfer the surveyor observed was a "typical transfer." She also stated she was supposed to let therapy know when R12 wasn't bearing weight or had trouble transferring with the SARA lift.

During an interview on 4/7/22, at 12:33 NA-B stated R12 used the SARA lift for transfers and R12 was not able to bear weight. NA-B further stated she felt uncomfortable transferring R12 and had reported it to the nurse in the past. However NA-B couldn't remember who she reported to or when.

During an interview on 4/7/22, at 12:40 p.m. NA-A stated R12 used the SARA lift with transfers. NA-A further stated R12 was able to stand up "within the first minute" but then was unable to hold herself up at all. NA-A stated she didn't like transferring R12 when she had to change her entire pad and clothing because took too long and she couldn't hold herself up for that long.

During an interview on 4/7/22, at 1:03 p.m. registered nurse (RN)-A stated R12 required an assist of one using the mechanical stand (SARA lift) and she "was not too sure" if R12 could bear

Minnesota Department of Health

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weight.

During an interview on 4/7/22, at 1:39 p.m. the director of nursing (DON) stated there were two lifts R12 could use that had been approved by therapy (SARA & MAXI). The DON further stated R12 was able to bear weight and she thought R12 just had a "bad day yesterday" (4/6/22, when surveyor observed the transfer). The DON also stated R12 "was stressed with having new people here, she is very specific and hates the lift, she doesn't like the way it feels, it's a fear." The DON further stated, "if the NA's felt a transfer wasn't going well, they should seek out one of their co-workers to address it."

The manufacturer's instructions for use for the Sara 3000 lift dated 6/2018, indicated (under the heading Patient/Resident Assessment), we recommend that facilities establish regular assessment routine's. Caregivers should assess each resident/patient according to the following criteria prior to use: patient/resident is able to partially bear weight on at least one leg. If the patient does not meet these criteria an alternative equipment/system shall be used.

The facility's policy titled Safe Resident Handling indicated, it is the policy of Monarch Healthcare Management that when residents receiving care require assistance from facility employee to move (e.g. transferring, lifting, repositioning), that assistance is provided in a manner that is safe to both the resident and employee.

SUGGESTED METHOD OF CORRECTION:
The director of nursing or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventions are being

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2 830	Continued From page 7 implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		