Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 18, 2024

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

RE: CCN: 245337
Cycle Start Date: November 1, 2024

Dear Administrator:

On November 19, 2024, we notified you a remedy was imposed. On December 9, 2024 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of November 27, 2024.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective December 4, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of November 19, 2024, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 4, 2024 due to denial of payment for new admissions. Since your facility attained substantial compliance on November 27, 2024, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 19, 2024

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

RE: CCN: 245337
Cycle Start Date: November 1, 2024

Dear Administrator:

On November 1, 2024, 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 actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 4, 2024.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 4, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 4, 2024.

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

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs

offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $12,924; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by December 4, 2024, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, The Estates At Linden Llc will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 4, 2024. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

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

ELECTRONIC PLAN OF CORRECTION (ePOC)

The purpose of the ePoC submission is to confirm your allegation of compliance and preparedness for a revisit.

Within ten (10) calendar days after your receipt of this notice, a provider should develop and submit an effective ePOC for the deficiencies cited. A revisit will determine if substantial compliance has been achieved.

A provider's ePOC must include the following:

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

DEPARTMENT CONTACT

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

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

We will also recommend to the CMS location and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 1, 2025 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file

electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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 CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245337	A. BUILDING _____ B. WING _____	C 11/01/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 10/31/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 10/28/24 - 11/1/24, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was not in compliance. The following complaints were reviewed: H53376403C (MN00105260), H53379731C (MN00099739), and H53379766C (MN00099606). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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	F 000		

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

Electronically Signed | 11/22/2024

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

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F 000	Continued From page 1 regulations has been attained.	F 000		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure freedom of	F 604	Based on observation, interview, and document review, the facility failed to	11/27/24

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F 604	Continued From page 2 movement was not restricted for 1 of 1 residents (R15) whose wheelchair was locked during mealtime in the dining room. Findings include: R15's quarterly Minimum Data Set (MDS) dated 8/14/24, indicated R15 had mild cognitive impairment and diagnoses of multiple sclerosis (a neurological disease that causes impaired walking and weakness the arms and legs), dementia with behavioral disturbance, and anxiety. R15 required total assistance with transfers, did not walk and was independent with wheelchair mobility. R15's nursing and provider orders lacked indication R15 had orders for restraints or to restrict movement when in the wheelchair. R15's care plan revised 8/12/24, indicated R15 had an alteration in socialization and at times can be disruptive during activities. Interventions included staff supervision when in an activity with R13 and encouragement to sit separately from R13. R13's annual MDS dated 10/7/24, indicated R13 had cognitive impairment and had diagnoses of dementia and diabetes. An observation on 10/28/24 at 5:09 p.m., R15 was sitting in their wheelchair in the dining room. Nursing assistant (NA)-A locked R15 wheelchair on the left side and stated "I'm going to leave the wheelchair locked". NA-A then moved a bedside table in front of R15 in preparation for dinner. NA-A and NA-B were delivering trays and assisting residents in the dining room. R13 was	F 604	ensure freedom of movement was not restricted for 1 of 1, R15 who's wheelchair was locked during mealtime in the dining room hindering resident freedom of movement. R15 was assessed by Occupational Therapy on 10/31/2024 and confirmed to be unable to unlock his breaks. Resident care plan will be updated to reflect his inability to unlock his own wheelchair breaks. Immediate education implemented on 10/31/2024 related to refraining from locking resident wheelchair breaks as such consitutes a restraint. Facility will provide all staff education on the use of wheelchair breaks as a restraint for any resident residing in facility. Additional education will also include different scenarios and examples of what classifies as a restraint at All Staff Meeting scheduled 11/26/24. Facility will review Combined Federal and State Bill of Rights at November All staff scheduled 11/26/24. Education will be provided that his document is also posted in facility for staff or residents to review at any time and copies are present for interested parties. Combined State and Federal Bill of Rights reviewed at Resident Council for resident education on 11/19/2024. Facility DON or designee will complete audits daily for one week, then three times per week for one week, then once per	

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F 604	Continued From page 3 seated at a table behind and to the left of R15. At 5:13 p.m., NA-A brought R15's dinner tray and placed it in front of him. R15's left wheel remained locked. R15 started eating dinner. At 5:40, registered nurse (RN)-C entered and cleared R15's dinner tray and R15 remained seated at the bedside table. AT 5:47 p.m., R15 attempted to wheel back away from the bedside table and only the right side of the wheelchair moved and R15 stopped trying to move. RN-C then moved the bedside table away from R15 however did not unlock the left wheel. R15 again attempted to self-propel the wheelchair and was only able to wheel the right side. R15 was only able to move in a circle pivoting on the left wheel, as that wheel was still locked. At 5:49 p.m. R15 started to self-propel the wheelchair and again rolled in part of a circle. AT 5:51 p.m., R15 again rolled in a circle pivoting on the left wheel. NA-A and NA-B were in the dining room removing trays of other residents and assisting some back to their rooms. At 6:12 p.m., NA-B went to move R15 out of the middle of the room and stated "oh, not going anywhere with that locked" as they unlocked R15's left wheel break. At 6:15 p.m., R15 started self-propelling out of the dining room. When interviewed on 10/28/24 at 6:19 p.m., NA-B verified R15's left wheelchair wheel was locked. NA-B further stated the break was placed to help keep R15 and R13 separated during dining. NA-B stated R15 and R13 had previous physical altercations and locking R15's wheelchair prevented R15 from rolling over to R13'stable . NA- further stated R15 wonders in his chair and locking the break "made sure they were separated". When interviewed on 10/29/24 at 2:39 p.m.,	F 604	week for one week, then once monthly for three months. Results will be reviewed by QAPI for ongoing assessment and recommendation. The QAPI Committee will review the audit tools and results to determine trends and/or issues that may need further interventions. The results will determine the ongoing frequency of future audits.	

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F 604	Continued From page 4 NA-C stated R15's wheelchair should not be locked. NA-C stated R15 wouldn't know how to unlock the breaks and having them locked would be a restraint. When interviewed on 10/29/24 at 2:47 p.m., RN-C stated R15 was alert to self and was independent with wheelchair mobility. R15 had a history of being intrusive to other residents and required redirection to stay away from R13. RN-C stated staff did not lock or unlock their chair as R15 liked to move throughout the building. RN-C believed R15 did not know how to lock or unlock his wheelchair due to dementia. When interviewed on 10/31/24 at 10:06 a.m., RN-B stated staff remained in the dining room to supervise meals and residents should be able to move around how they would like to. Furthermore, wheelchair breaks should not be locked if the residents could not unlock them. If locking them was to prevent movement, it would be considered a restraint. RN-C wasn't sure if R15 could unlock their wheelchair. R15 liked to self-propel around the facility in the wheelchair and locking the breaks would be a detriment to R15. When interviewed on 10/3124 at 10:23 a.m., the Director of Nursing (DON) stated wheelchair breaks should not be locked to prevent movement of residents. DON verified that would be considered a restraint if the resident was not able to lock and unlock the breaks themselves. The facility document titled Combined Federal and State Bill of rights dated 2019 , directed staff to treat the residents with respect and dignity to ensure freedom from physical restraints imposed	F 604		

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F 604	Continued From page 5 for convenience and not required to treat a medical condition.	F 604		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to manage pain consistent with the comprehensive assessment, plan of care, and physician's orders and to ensure potential acute opioid withdrawal symptoms were assessed to prevent avoidable, significant, pain for 1 of 1 resident (R23) reviewed for pain management. This deficient practice caused actual harm for R23, who experienced unmanaged pain and withdrawal symptoms. Findings include: R23's face sheet printed 10/31/24, indicated R23 had diagnosis of chronic pain syndrome with chronic opioid use related to a motor vehicle accident (MVA). R23's quarterly minimum data set (MDS) dated 10/22/24, indicated R23 was cognitively intact with no rejection of care. The MDS further indicated R23 had pain, however, did not receive any non-pharmacological interventions for pain. R23's pain Care Area Assessment (CAA) dated	F 697	Immediate correction implemented 10/31/2024. R1 had a complete medical pharmacist record review for his pain management regime and the resident does have prescribed pain medications available. Non Pharmacological measures are in resident orders and care plan reflects monitoring for withdrawal symptoms. The Provider has been updated regarding pain medications not available for R1. R1 care plan and orders were reviewed and updated. No further action from provider was required. R1 interviewed to ensure current pain management regime is effective. Like Residents prescribed pain medications have had their medical records reviewed to assure medications are available. Each resident was interviewed to determine if the resident is receiving their pain medications timely and medications available and if so, effective. Like resident's care plan and orders have been reviewed and updated with non-pharmacological measures along	11/27/24

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F 697	Continued From page 6 5/7/24, indicated R23 reported pain which interfered with sleep and daily activities on an almost constant basis. Further, R23 reported constant pain rated at a 10 out of 10 on a 0-10 pain scale. Additionally, the CAA indicated R23 was at risk for pain not being adequately relieved or managed with interventions for nursing to monitor pain, administer pain medications as ordered, and nursing to update provider on pain as necessary and when pain was not adequately relieved/controlled. R23's care plan with revision date 5/17/24, indicated R23 had potential for alteration of comfort related to chronic pain syndrome, right humerus, and femur fractures, and left gluteal wound with the following interventions: pain medication as ordered by medical doctor (MD) and provide non-medicinal forms of pain relief including positioning, rest, and massage. R23's goal was to have adequate relief from pain as evidenced by verbalization, and freedom from signs/symptoms of non-verbal indications of pain. R23's physician visit note dated 10/10/24, indicated R23 had been on long-term opioid pain medications since 7/25/22 due to a motor vehicle accident and R23 reported pain intensity was an 8 on a 0-10 pain scale due to a recent fall during physical therapy which resulted in a fractured hip and shoulder. Further indicated, the physician ordered Belbuca (a strong prescription pain medicine that contains an opioid Buprenorphine. It is used to manage severe pain that requires long term treatment) 600 microgram (mcg) buccal film twice a day. R23's physician orders dated 10/31/24, indicated R23 had the following orders:	F 697	with withdrawal symptoms. Each resident has the pain medications available at this time. Ad Hoc QAPI Meeting completed 10/31/2024,Facility Pain Management Policy and Provider notifiecation has been reviewed and remains current. The DON or designee will provide re-education to RN/ LPN/ TMA on the process of pain medication availability and notification to the provider if the medication is not available. RN /LPN/ TMA have been educated on non-pharmacological measures and withdrawal symptoms. If pain medication is not available, additional monitoring will be added to the orders for withdrawal symptoms. If any change of condition with pain medication not available, the provider will be notified. Education will be provided prior to the start of each shift on medication availability and notification of changes to providers. Text messages and internal electronic nonfictions have been sent to Estates At Linden RN/ LPN/ TMA, to alert them of education to be completed prior to start of next shift. Folder with education for Medication Availability and Notification of Changes policies have been made available at nursing station. The DON or designee will complete audits for 3 residents for pain medication availability and 3 RN LPN TMA will be interviewed on medication availability along with notification to the provider if the	

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	245337	A. BUILDING _____ B. WING _____	C 11/01/2024

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F 697	Continued From page 7 -Lyrica 150 milligrams (mg) three times a day with a start date of 9/18/24 and a stop date of 10/11/24. -Lyrica 175 mg three times a day with a start date on 10/11/24. -Belbuca 900 mcg buccal film twice a day with a start date on 9/18/24 and a stop date of 10/11/24. -Belbuca 600 mcg buccal film twice a day with a start date on 10/11/24. R23's medication administration record (MAR) dated October 2024, indicated R23 did not receive the Belbuca 600 mcg buccal film from 10/11/24 at 8:00 p.m. through 10/15/24 at 8:00 p.m., a total of 9 doses missed. The MAR further indicated R23 did not receive the Lyrica 175 mg from 10/11/24 at 8:00 p.m. through 10/14/24 at 12:00 p.m., a total of 9 doses missed. R23's progress note dated 10/14/24 at 3:46 p.m., indicated R23 had increased anxiety, agitation, fidgeting, and pacing. R23's progress note dated 10/14/24 at 10:12 p.m., indicated R23's pain medication wasn't available and exhibited withdrawal symptoms such as restlessness and agitation. Review of R23's progress notes from 10/10/24 through 10/15/24, revealed no indication of physician notification of missed pain medications, R23's pain status, or R23's withdrawal symptoms. During review of R23's electronic medical record (EMR) from 10/10/24 through 10/16/24 on 10/31/24, lacked indication of non-pharmacological interventions provided, physician notification, or new pharmacological orders provided in substitution.	F 697	medication is not available. This will be conducted weekly x4 and then monthly x2. Audit results will be reviewed by QAPI Committee for further recommendations. Facility will complete random quizzes with Nursing staff to ensure understanding of the Pain Management Policy, Non Pharmacological Measures along with Withdrawal symptoms.Facility will also provide education review at All Staff Meeting scheduled 11/26 via zoom or in person. Staff will be provided a copy of the training if they cannot be in attendance. Facility will review audit finding at the QAPI 11/21 and monthly and adjust audit schedules accordingly to findings going forward.	

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F 697	Continued From page 8 During an interview on 10/31/24 at 10:59 a.m., registered nurse (RN)-A stated R23's Belbuca 600 mcg and Lyrica 175 mg pain medications were not available. Further, RN-A stated R23 was "miserable" and a "mess" during the days the pain medications weren't provided. Additionally, RN-A stated R23 exhibited withdrawal symptoms of shakiness, irritability, and restlessness during the days the pain medications weren't provided. Also, RN-A stated R23 was allowed to go smoke after hours throughout the night while he was unable to sleep. During an interview on 10/31/24 at 11:35 a.m. R23 stated, "I felt awful, my pain was through the roof, my pain was completely out of control" and "they didn't do anything for my pain". Further, R23 verified the facility staff did not provide any non-pharmacological interventions during the time the pain medications weren't provided. During an interview on 10/31/24 at 11:43 a.m., registered nurse manager (RN-B) stated was informed by the nursing staff the pharmacy didn't send the new prescribed medications due to it was too early to fill the medications so, the medical provider was contacted on 10/16/24 regarding the missing pain medications. RN-B further stated the issue was the previous Belbuca and Lyrica medications were destroyed since R23 was given new prescriptions for the Belbuca and Lyrica. Additionally, the Belbuca prescription was sent to the wrong pharmacy and the facility had to call and have the pharmacy release the prescription so the facility pharmacy could fill and send the medication. During an interview on 10/31/24 at 1:26 p.m. the DON verified the nurses should have called the	F 697		

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F 697	Continued From page 9	F 697		

pharmacy when the medication wasn't received and should have updated the physician "right away" if the pharmacy couldn't send the medication.

During an interview on 10/31/24 at 1:30 p.m., pain specialty physician stated the facility should have notified the office as soon as the medication wasn't received so an alternative could have been given. Further, the MD indicated if an opioid medication was stopped abruptly severe withdrawal symptoms could occur as well as increased pain.

During an interview on 11/1/24 at 12:34 p.m. the administrator stated the facility administration was made aware on Monday 10/14/24 of R23 not receiving the new pain medications. Further, verified the medications were not received and given in a timely manner when the facility didn't receive the ordered medications.

During an interview on 11/1/24 at 1:33 p.m., nurse practitioner (NP) verified they did not complete a comprehensive assessment of R23's pain or withdrawal symptoms on 10/14/24.

During review of the prescribing information on Belbuca.com on 10/31/24, revealed a warning: Serious and Life-threatening risks from use of Belbuca indicated serious, life-threatening, or fatal respiratory depression may occur with use of Belbuca, especially during initiation or following a dosage increase. To reduce the risk of respiratory depression, proper dosing, and titration of Belbuca are essential. The Highlights of Prescribing Information obtained from Belbuca.com website indicated not to abruptly discontinue Belbuca in patients who may be

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F 697	Continued From page 10 physically dependent on opioids. Rapid discontinuation of opioid analgesics in patients who are physically dependent on opioids has resulted in serious withdrawal symptoms, uncontrolled pain, and suicide. Rapid discontinuation has also been associated with attempts to find other sources of opioid analgesics, which may be confused with drug-seeking for abuse. Patients may also attempt to treat their pain or withdrawal symptoms with illicit opioids, such as heroin, and other substance. The Pain Management Protocol dated 3/23/23, indicated to ensure that residents with pain or at risk for pain, have an effective pain management plan in place with individualized interventions that are consistent with the resident's goals for comfort. Treatment/Management 1. With input from the resident and/or resident representative, the provider, and staff will establish goals of pain treatment, for example, freedom from pain with minimal medication side effects, less frequent headaches, or improved functioning, mood, and sleep. 2. Nursing will evaluate for appropriate non-pharmacologic interventions to address the individual's pain. 3. Provider will order appropriate medication interventions to address individuals' pain. 4. The staff will evaluate and report how much and how often the resident utilizes PRN pain medication. a. Depending on severity and location of pain, the provider may start with PRN doses or supplement routine doses with	F 697		

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F 697	Continued From page 11 PRN doses for breakthrough pain. b. If there are more than occasional PRN analgesic utilization (and depending on the success of nonpharmacological interventions), the provider may consider changing to regular administration of at least one analgesic with another medication for PRN use, increasing the routine dose of an existing analgesic, or switching to another analgesic. 5. Staff will provide the elements of a comforting environment and appropriate physical and complementary interventions; for example, local heat or ice, repositioning, massage, and the opportunity to talk about chronic pain. 6. Resident's plan of care will reflect pain management needs. 7. For the individual who is receiving opioid analgesics, the provider may order a regimen of laxatives and other measures to prevent constipation. Monitoring 1. The staff will reassess the individual's pain and related consequences at regular intervals; monitoring will occur to ensure pain is controlled, care plan goals are met, and pain management regimen is effective. Review should include frequency and intensity of pain, ability to perform activities of daily living (ADLs), sleep pattern, mood, behavior, and participation in activities. 2. The staff will discuss significant changes in levels of comfort with the provider who will consider adjusting interventions accordingly. This may include non-pharmacological measures and adjustments of regular and PRN analgesic doses to find the best combination of effectiveness and	F 697		

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F 697	Continued From page 12 tolerable side effects. 3. The staff and physician will monitor for adverse effects of pain medications such as gastrointestinal bleeding from nonsteroidal anti-inflammatory drugs (NSAIDs), and anorexia, confusion, lethargy, severe constipation, or ileus related to opioids.	F 697		

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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 10/30/2024. At the time of this survey, The Estates At Linden 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.	K 000		

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

Electronically Signed | 11/22/2024

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 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. This 2 story building was determined to be of Type II(222) construction and was constructed in 1950 and an addition in 1969. It has no basement and is fully fire sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 51 beds and had a census of 35 at the time of the survey.	K 000		

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K 000	Continued From page 2 The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 331 SS=F	Interior Wall and Ceiling Finish CFR(s): NFPA 101 Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). _____ This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provided interior finish materials that meets the NFPA Life Safety Code 101 2012 edition sections 19.3.3.1, 19.3.3.2, and 10.2.3. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 10/30/2024, between 9:00 AM and 12:00 PM, observation revealed that the facility has wood paneling located in the Central Supply room area on all walls. At the time of the inspection it could not be verified by documentation or that it was treated with a fire retardant finish. NOTE: The entire facility needs to be checked for this deficiency.	K 331	Based on observation and staff interview, the facility failed to provide interior finish materials that meets the NFPA Life Safety Code 101 2012 edition sections 19.3.3.2 and 10.2.3. This deficient condition could have a widespread impact on the residents wtihin the facility. The Facility has wood paneling located in the central supply room area on all walls. At the time of the inspection, it could not be verified by documentation or that it was treated with a fire-retardant finish. The Central Supply room paneled walls have been painted with Sherwin Williams Fire Retardant Firex F55120. Completion of	11/15/24

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K 331	Continued From page 3 An interview with the Maintenance Director and Administrator verified these deficient findings at the time of discovery.	K 331	this task occurred on 11/15/24 by Maintenance Director. Per recommendation, Maintenance Director will check facility for wall and ceiling finish that does not meet NFPA Life Safety Code 101 2012 edition sections 19.3.3.2 and 10.2.3. Findings will be reviewed at next scheduled Safety Committee meeting scheduled December 2024. The Maintenance Director will audit once per month for three months. Findings will be reviewed at Safety Committee meeting scheduled in December, 2024 and QAPI going forward as needed based on findings.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per	K 914		11/21/24

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K 914	Continued From page 4 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct the electrical testing and maintenance per NFPA 99 Standards for Health Care Facilities 2012 edition, sections 6.3.3.2, 6.3.4.1.3, and 6.3.4.2.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings Include: On 10/30/2024, between 9:00 AM and 12:00 PM, it was revealed by a review of available documentation that the facility was unable to provide documentation showing that the facility has properly tested all electrical receptacles in the resident rooms. An interview with the Maintenance Director, and Administrator verified this deficient finding at the time of discovery.	K 914	Annual Receptacle Testing completed with proper receptable labeling and outlet tension listed for each in ounces on 11/05/2024 Documentation of the annual receptacle testing now includes the actual tension readings in ounces. Documentation also identifies each specific receptacle which was performed on 11/05/2024. Maintenance Director will conduct annual receptacle checks using format including properly labeled outlets including tension readings in ounces. Findings discussed at facility QAPI meeting 11/21/2024 and will be reviewed at Safety Committee Meeting scheduled December 2024.	
K 927 SS=D	Gas Equipment - Transfilling Cylinders CFR(s): NFPA 101 Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care	K 927		11/20/24

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K 927	Continued From page 5 rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain oxygen transfilling rooms per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.5.2.3.1 (1). This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 10/30/2024 between 09:00 AM and 12:00 PM, it was revealed by observation that the oxygen transfill room on the 1st floor had open penetrations about the drop in ceiling around piping and head of wall. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 927	The penetrations above the drop ceiling in the oxygen transfer room have been sealed with 3M Fire Bloc on 11/20/2024. The Maintenance Director will Audit for potential penetrants in facility once per month for three months. Findings will be reviewed at Safety Committee scheduled in December and QAPI as needed based on findings.	