

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL  
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: N8T4  
Facility ID: 00948

|   |  |   |  |  |   |  |
|---|--|---|--|--|---|--|
| 1. MEDICARE/MEDICAID PROVIDER NO.<br>(L1) <b>245337</b>   |  | 3. NAME AND ADDRESS OF FACILITY<br>(L3) <b>THE ESTATES AT LINDEN LLC</b><br>(L4) <b>105 WEST LINDEN STREET</b><br>(L5) <b>STILLWATER, MN</b> (L6) <b>55082</b>  |  |  | 4. TYPE OF ACTION: <u>7</u> (L8)<br><br>1. Initial                      2. Recertification<br>3. Termination              4. CHOW<br>5. Validation                 6. Complaint<br>7. On-Site Visit              9. Other<br><br>8. Full Survey After Complaint   |  |
| 2.STATE VENDOR OR MEDICAID NO.<br>(L2) <b>248627000</b>   |  | 5. EFFECTIVE DATE CHANGE OF OWNERSHIP<br>(L9) <b>03/01/2017</b>   |  |  | 7. PROVIDER/SUPPLIER CATEGORY <u>02</u> (L7)<br><b>01 Hospital      05 HHA      09 ESRD      13 PTIP      22 CLIA</b><br><b>02 SNF/NF/Dual    06 PRTF      10 NF      14 CORF</b><br><b>03 SNF/NF/Distinct   07 X-Ray      11 ICF/IID    15 ASC</b><br><b>04 SNF              08 OPT/SP    12 RHC      16 HOSPICE</b> |  |
| 6. DATE OF SURVEY <b>06/21/2017</b> (L34)                 |  | 8. ACCREDITATION STATUS: <u>    </u> (L10)<br>0 Unaccredited              1 TJC<br>2 AOA                              3 Other   |  |  | FISCAL YEAR ENDING DATE: (L35)<br><b>12/31</b>  |  |
| 11. LTC PERIOD OF CERTIFICATION<br>From (a) :<br>To (b) : |  | 10. THE FACILITY IS CERTIFIED AS:<br><b>X</b> A. In Compliance With <u>And/Or Approved Waivers Of The Following Requirements:</u><br>Program Requirements <u>    </u> 2. Technical Personnel <u>    </u> 6. Scope of Services Limit<br>Compliance Based On: <u>    </u> 3. 24 Hour RN <u>    </u> 7. Medical Director<br><u>    </u> 1. Acceptable POC <u>    </u> 4. 7-Day RN (Rural SNF) <u>    </u> 8. Patient Room Size<br><u>    </u> 5. Life Safety Code <u>    </u> 9. Beds/Room<br>B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: <b>A*</b> (L12) |  |  |   |  |
| 12.Total Facility Beds <b>67</b> (L18)                    |  | 13.Total Certified Beds <b>67</b> (L17)   |  | 14. LTC CERTIFIED BED BREAKDOWN<br>18 SNF              18/19 SNF              19 SNF              ICF              IID<br><b>67</b><br>(L37)              (L38)              (L39)              (L42)              (L43) |   |  |
| 15. FACILITY MEETS<br>1861 (e) (1) or 1861 (j) (1): (L15) |  |   |  |  |   |  |

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

|  |  |                             |   |  |                            |
|--|--|-----------------------------|---|--|----------------------------|
| 17. SURVEYOR SIGNATURE<br><br><u>Susanne Reuss, Unit Supervisor</u><br>(L19) |  | Date :<br><b>06/21/2017</b> | 18. STATE SURVEY AGENCY APPROVAL<br><br><u>Kate JohnsTon, Program Specialist</u><br>(L20) |  | Date:<br><b>09/25/2017</b> |
|--|--|-----------------------------|---|--|----------------------------|

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 19. DETERMINATION OF ELIGIBILITY<br><input checked="" type="checkbox"/> 1. Facility is Eligible to Participate<br><input type="checkbox"/> 2. Facility is not Eligible<br>(L21)                  |  | 20. COMPLIANCE WITH CIVIL RIGHTS ACT:  |  | 21. 1. Statement of Financial Solvency (HCFA-2572)<br>2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)<br>3. Both of the Above : <u>    </u> |  |
| 22. ORIGINAL DATE OF PARTICIPATION<br><b>07/01/1986</b><br>(L24)   |  | 23. LTC AGREEMENT BEGINNING DATE<br>(L41)  |  | 24. LTC AGREEMENT ENDING DATE<br>(L25)  |  |
| 25. LTC EXTENSION DATE: (L27)  |  | 27. ALTERNATIVE SANCTIONS<br>A. Suspension of Admissions: (L44)<br>B. Rescind Suspension Date: (L45)                                       |  |   |  |
| 26. TERMINATION ACTION: (L30)<br><u>VOLUNTARY</u> <b>00</b><br>01-Merger, Closure<br>02-Dissatisfaction W/ Reimbursement<br>03-Risk of Involuntary Termination<br>04-Other Reason for Withdrawal |  | <u>INVOLUNTARY</u><br>05-Fail to Meet Health/Safety<br>06-Fail to Meet Agreement<br><u>OTHER</u><br>07-Provider Status Change<br>00-Active |  |   |  |
| 28. TERMINATION DATE:  |  | 29. INTERMEDIARY/CARRIER NO.<br><b>01111</b><br>(L28)  |  | 30. REMARKS<br><br>Posted 09/28/2017 Co.<br><br>DETERMINATION APPROVAL  |  |
| 31. RO RECEIPT OF CMS-1539 (L32)   |  | 32. DETERMINATION OF APPROVAL DATE<br><b>06/30/2017</b> (L33)  |  |   |  |



*Protecting, Maintaining and Improving the Health of All Minnesotans*

CMS Certification Number (CCN): 245337

August 25, 2017

Mr. Eric Andersen, Administrator  
The Estates At Linden LLC  
105 West Linden Street  
Stillwater, MN 55082

Dear Mr. Andersen:

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 June 2, 2017 the above facility is certified for or recommended for:

67 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 67 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 Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

A handwritten signature in black ink that reads 'Kate Johnston'.

Kate Johnston, Program Specialist  
Program Assurance Unit  
Licensing and Certification Program  
Health Regulation Division  
Minnesota Department of Health  
kate.johnston@state.mn.us  
Telephone: (651) 201-3992 Fax: (651) 215-9697



cc: Licensing and Certification File

*An equal opportunity employer.*



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered  
August 29, 2017

Mr. Eric Andersen, Administrator  
The Estates At Linden LLC  
105 West Linden Street  
Stillwater, MN 55082

RE: Project Number S5337026 & H5337028

Dear Mr. Andersen:

On May 24, 2017, we informed you that the following enforcement remedies were being imposed:

- State Monitoring effective May 29, 2017 (42 CFR 4880.422)
- Mandatory denial of payment for new Medicare and Medicaid admissions, effective June 30, 2017. (42 CFR 488.417 (b))

Also, we notified you in our letter of May 24, 2017, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from June 30, 2017.

This was based on the deficiencies cited by the Minnesota Department of Health, Office of Health Facility Complaints on March 30, 2017 and continued non-compliance at the time of our standard survey completed on April 27, 2017. The most serious deficiencies in your facility at the time of the standard survey were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On May 19, 2017 the Minnesota Department of Health, Office of Health Facility Complaints completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an abbreviated standard survey, completed on March 30, 2017.

On June 21, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 14th the Minnesota Department of Public Safety completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 27, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 2, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our abbreviated standard survey, completed on March 30, 2017

The Estates At Linden LLC

August 29, 2017

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and the standard survey completed on April 27, 2017 as of June 2, 2017. As a result of the PCR findings, this Department is discontinuing State Monitoring effective June 2, 2017.

Furthermore, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of May 24, 2017. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective June 30, 2017, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective June 30, 2017, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective June 30, 2017, is to be rescinded.

In our letter of May 24, 2017, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 30, 2017, due to denial of payment for new admissions. Since your facility attained substantial compliance on June 2, 2017, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Feel free to contact me if you have questions.

Sincerely,



Kate JohnsTon, Program Specialist  
Program Assurance Unit  
Licensing and Certification Program  
Health Regulation Division  
Minnesota Department of Health  
kate.johnston@state.mn.us  
Telephone: (651) 201-3992 Fax: (651) 215-9697



cc: Licensing and Certification File

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: N8T4

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00948

|   |   |  |        |       |     |  |           |  |  |  |       |       |       |       |       |   |  |
|---|---|--|--------|-------|-----|--|-----------|--|--|--|-------|-------|-------|-------|-------|---|--|
| 1. MEDICARE/MEDICAID PROVIDER NO.<br>(L1) <b>245337</b><br><br>2.STATE VENDOR OR MEDICAID NO.<br>(L2) <b>248627000</b>  | 3. NAME AND ADDRESS OF FACILITY<br>(L3) <b>THE ESTATES AT LINDEN LLC</b><br>(L4) <b>105 WEST LINDEN STREET</b><br>(L5) <b>STILLWATER, MN</b> (L6) <b>55082</b>  | 4. TYPE OF ACTION: <u>2</u> (L8)<br><br>1. Initial                      2. Recertification<br>3. Termination              4. CHOW<br>5. Validation                6. Complaint<br>7. On-Site Visit              9. Other<br><br>8. Full Survey After Complaint |        |       |     |  |           |  |  |  |       |       |       |       |       |   |  |
| 5. EFFECTIVE DATE CHANGE OF OWNERSHIP<br>(L9) <b>04/01/2006</b><br><br>6. DATE OF SURVEY <b>04/27/2017</b> (L34)<br><br>8. ACCREDITATION STATUS: <u>    </u> (L10)<br>0 Unaccredited              1 TJC<br>2 AOA                              3 Other   | 7. PROVIDER/SUPPLIER CATEGORY <u>02</u> (L7)<br><b>01 Hospital      05 HHA      09 ESRD      13 PTIP      22 CLIA</b><br><br><b>02 SNF/NF/Dual    06 PRTF      10 NF      14 CORF</b><br><br><b>03 SNF/NF/Distinct   07 X-Ray      11 ICF/IID    15 ASC</b><br><br><b>04 SNF              08 OPT/SP    12 RHC      16 HOSPICE</b>   | FISCAL YEAR ENDING DATE: (L35)<br><br><b>12/31</b>   |        |       |     |  |           |  |  |  |       |       |       |       |       |   |  |
| 11. LTC PERIOD OF CERTIFICATION<br>From (a) :<br>To (b) :<br><br>12.Total Facility Beds <b>67</b> (L18)<br>13.Total Certified Beds <b>67</b> (L17)  | 10.THE FACILITY IS CERTIFIED AS:<br><b>X</b> A. In Compliance With <u>And/Or Approved Waivers Of The Following Requirements:</u><br>Program Requirements <u>    </u> 2. Technical Personnel <u>    </u> 6. Scope of Services Limit<br>Compliance Based On:<br><u>    </u> 1. Acceptable POC <u>    </u> 3. 24 Hour RN <u>    </u> 7. Medical Director<br><u>    </u> 4. 7-Day RN (Rural SNF) <u>    </u> 8. Patient Room Size<br><u>    </u> 5. Life Safety Code <u>    </u> 9. Beds/Room<br><br>B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: <b>A*</b> (L12) |  |        |       |     |  |           |  |  |  |       |       |       |       |       |   |  |
| 14. LTC CERTIFIED BED BREAKDOWN<br><br><table style="width:100%; border: none;"> <tr> <td style="text-align: center;">18 SNF</td> <td style="text-align: center;">18/19 SNF</td> <td style="text-align: center;">19 SNF</td> <td style="text-align: center;">ICF</td> <td style="text-align: center;">IID</td> </tr> <tr> <td></td> <td style="text-align: center;"><b>67</b></td> <td></td> <td></td> <td></td> </tr> <tr> <td style="text-align: center;">(L37)</td> <td style="text-align: center;">(L38)</td> <td style="text-align: center;">(L39)</td> <td style="text-align: center;">(L42)</td> <td style="text-align: center;">(L43)</td> </tr> </table> | 18 SNF  | 18/19 SNF  | 19 SNF | ICF   | IID |  | <b>67</b> |  |  |  | (L37) | (L38) | (L39) | (L42) | (L43) | 15. FACILITY MEETS<br>1861 (e) (1) or 1861 (j) (1): (L15) |  |
| 18 SNF  | 18/19 SNF   | 19 SNF   | ICF    | IID   |     |  |           |  |  |  |       |       |       |       |       |   |  |
|   | <b>67</b>   |  |        |       |     |  |           |  |  |  |       |       |       |       |       |   |  |
| (L37)   | (L38)   | (L39)  | (L42)  | (L43) |     |  |           |  |  |  |       |       |       |       |       |   |  |

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

|   |   |
|---|---|
| 17. SURVEYOR SIGNATURE<br><br><u>Susanne Reuss, Unit Supervisor</u><br>Date : <b>06/05/2017</b> (L19) | 18. STATE SURVEY AGENCY APPROVAL<br><br><u>Kate JohnsTon, Program Specialist</u><br>Date: <b>06/21/2017</b> (L20) |
|---|---|

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

|  |  |   |
|--|--|---|
| 19. DETERMINATION OF ELIGIBILITY<br><br><u>    </u> 1. Facility is Eligible to Participate<br><u>    </u> 2. Facility is not Eligible<br>(L21) | 20. COMPLIANCE WITH CIVIL RIGHTS ACT:<br><br>_____   | 21. 1. Statement of Financial Solvency (HCFA-2572)<br>2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)<br>3. Both of the Above : _____ |
| 22. ORIGINAL DATE OF PARTICIPATION<br><b>07/01/1986</b><br>(L24)   | 23. LTC AGREEMENT BEGINNING DATE<br>(L41)  | 24. LTC AGREEMENT ENDING DATE<br>(L25)  |
| 25. LTC EXTENSION DATE:<br>(L27)   | 27. ALTERNATIVE SANCTIONS<br>A. Suspension of Admissions: (L44)<br><br>B. Rescind Suspension Date: (L45) |   |
| 28. TERMINATION DATE:  | 29. INTERMEDIARY/CARRIER NO.<br><br><b>00454</b><br>(L28)  | 30. REMARKS<br><br>Posted 06/26/2017 Co.<br><br>DETERMINATION APPROVAL  |
| 31. RO RECEIPT OF CMS-1539<br>(L32)  | 32. DETERMINATION OF APPROVAL DATE<br>(L33)  |   |



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered  
May 24, 2017

Mr. Eric Andersen, Administrator  
The Estates At Linden LLC  
105 West Linden Street  
Stillwater, MN 55082

RE: Project Number S5337026 & H5337029

Dear Mr. Andersen:

**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.**

On April 27, 2016, the Minnesota Department of Health completed a standard survey. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required. A copy of the Statement of Deficiencies (CMS-2567 and/or Form A) is available electronically.

However, compliance with the deficiencies issued pursuant to the March 30, 2017 abbreviated standard survey has not yet been verified. The most serious health deficiencies in your facility at the time of the abbreviated standard survey were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective June 30, 2017. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective June 30, 2017. They will also notify the State Medicaid Agency that they must

The Estates At Linden LLC

May 24, 2017

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also deny payment for new Medicaid admissions effective June 30, 2017. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, The Estates At Linden Llc is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective June 30, 2017. 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. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

## **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:

[Tamika.Brown@cms.hhs.gov](mailto:Tamika.Brown@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) 565-9462

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 Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at [Tamika.Brown@cms.hhs.gov](mailto:Tamika.Brown@cms.hhs.gov).

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 30, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

#### **INFORMAL DISPUTE RESOLUTION**

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: [http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\\_idr.cfm](http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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:

<http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm>

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:



The Estates At Linden LLC

May 24, 2017

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Mr. Tom Linhoff, Fire Safety Supervisor  
Health Care Fire Inspections  
Minnesota Department of Public Safety  
State Fire Marshal Division  
445 Minnesota Street, Suite 145  
St. Paul, Minnesota 55101-5145  
Email: tom.linhoff@state.mn.us  
Telephone: (651) 430-3012  
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Kate Johnston". The signature is fluid and cursive, with a long horizontal flourish extending to the right.

Kate JohnsTon, Program Specialist  
Program Assurance Unit  
Licensing and Certification Program  
Health Regulation Division  
Minnesota Department of Health  
Email: kate.johnston@state.mn.us  
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered  
May 24, 2017

Mr. Eric Andersen, Administrator  
The Estates At Linden LLC  
105 West Linden Street  
Stillwater, MN 55082

RE: Project Number S5337026 & H5337029

Dear Mr. Andersen:

On April 18, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by the Minnesota Department of Health, Office of Health Facility Complaints for an abbreviated standard survey, completed on March 30, 2017. This abbreviated standard survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On April 27, 2017, the Minnesota Department of Health and on April 25, 2017, the Minnesota Department of Public Safety completed a standard survey 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 program. The standard survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required. A copy of the Statement of Deficiencies (CMS-2567 and/or Form A) is available electronically. In addition at the time of the standard survey, an investigation of complaint number H5337029 was conducted and found to be unsubstantiated.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

- State Monitoring effective May 29, 2017. (42 CFR 488.422)

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

The Estates At Linden LLC

May 24, 2017

Page 2

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective June 30, 2017. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective June 30, 2017. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 30, 2017. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, The Estates At Linden Llc is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective June 30, 2017. 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. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

The CMS Region V Office will notify you of their determination regarding our recommendations and appeal rights.

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.

A copy of the Statement of Deficiencies (CMS-2567) and the Post Certification Revisit Form (CMS-2567B) from this visit are enclosed.

## DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor  
Minnesota Department of Health  
P.O. Box 64900  
St. Paul, Minnesota 55164-0900  
susanne.reuss@state.mn.us  
Telephone: (651) 201-3793  
Fax: 651-215-9697

## ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Include electronic acknowledgement signature of provider and date.

If an acceptable PoC 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 remedy be imposed:

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

#### **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 their respective deficiencies (if any) is acceptable.

#### **VERIFICATION OF SUBSTANTIAL COMPLIANCE**

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

#### **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 June 30, 2017 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 30, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

#### **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:

[Tamika.Brown@cms.hhs.gov](mailto:Tamika.Brown@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) 565-9462

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 Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at [Tamika.Brown@cms.hhs.gov](mailto:Tamika.Brown@cms.hhs.gov).

#### **INFORMAL DISPUTE RESOLUTION**

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: [http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\\_idr.cfm](http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm)

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day

The Estates At Linden LLC

May 24, 2017

Page 6

period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:

<http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm>

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:

Mr. Tom Linhoff, Fire Safety Supervisor  
Health Care Fire Inspections  
Minnesota Department of Public Safety  
State Fire Marshal Division  
445 Minnesota Street, Suite 145  
St. Paul, Minnesota 55101-5145  
Email: tom.linhoff@state.mn.us  
Telephone: (651) 430-3012  
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,



Kate JohnsTon, Program Specialist  
Program Assurance Unit  
Licensing and Certification Program  
Health Regulation Division  
Minnesota Department of Health  
Email: kate.johnston@state.mn.us  
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES


F9337025

PRINTED: 06/05/2017  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>245337</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01 - MAIN BUILDING 01</b><br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>04/25/2017</b> |
|--|---|---|---|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>THE ESTATES AT LINDEN LLC</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>105 WEST LINDEN STREET<br/>STILLWATER, MN 55082</b> |
|--|---|

| (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 |
|--------------------|--|---------------|---|----------------------|
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|       |   |       |   |  |
|-------|---|-------|---|--|
| K 000 | <p><b>INITIAL COMMENTS</b></p> <p><b>FIRE SAFETY</b></p> <p>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.</p> <p>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.</p> <p>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Golden Livingcenter Linden was found not in compliance with the requirements for participation in Medicare/Medicaid of 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.</p> <p>Please return the plan of correction for the Fire Safety Deficiencies (K-tags) to:<br/>HEALTHCARE FIRE INSPECTIONS<br/>STATE FIRE MARSHAL DIVISION<br/>445 MINNESOTA STREET, SUITE 145<br/>ST. PAUL, MN 55101-5145</p> <p>Or by email to:<br/>Marian.Whitney@state.mn.us And<br/>Angela.Kappenman@state.mn.us</p> | K 000 |  |  |
|-------|---|-------|---|--|

|  |       |                                |
|--|-------|--------------------------------|
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE<br><br>Electronically Signed | TITLE | (X6) DATE<br><b>06/02/2017</b> |
|--|-------|--------------------------------|

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.



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                     |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>245337</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01 - MAIN BUILDING 01</b><br><br>B. WING _____                     | (X3) DATE SURVEY COMPLETED<br><br><b>04/25/2017</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>THE ESTATES AT LINDEN LLC</b> |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>105 WEST LINDEN STREET<br/>STILLWATER, MN 55082</b>                 |   |
| (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                                |
| K 000  | Continued From page 1  | K 000   |   |   |
| K 363<br>SS=C  | <p><b>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:</b></p> <ol style="list-style-type: none"> <li>1. A description of what has been, or will be, done to correct the deficiency.</li> <li>2. The actual, or proposed, completion date.</li> <li>3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.</li> </ol> <p>This 2 story building was determined to be of Type II(222) construction. 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 67 beds and had a census of 40 at the time of the survey.</p> <p>The requirement at 42 CFR, Subpart 483.70(a) is <b>NOT MET</b> as evidenced by:</p> <p><b>NFPA 101 Corridor - Doors</b></p> <p><b>Corridor - Doors</b><br/><b>2012 EXISTING</b><br/>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed.</p> | K 363   |   | 5/5/17  |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>THE ESTATES AT LINDEN LLC</b> |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>105 WEST LINDEN STREET<br/>STILLWATER, MN 55082</b>   |   |
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| K 363  | <p>Continued From page 2</p> <p>There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is not met as evidenced by: Based on observations and interview, the facility has failed to maintain smoke/fire barrier doors in accordance with LSC 19.3.7.5. This deficient practice could affect all patients.</p> <p>Findings include:</p> <p>On facility tour between 08:30 AM and 11:30 AM on 04/25/2017, observation revealed:</p> <p>The following doors did not close and positively latch:</p> <p>1) Room 21<br/>2) Room 117</p> | K 363   | <p>The Estates at Linden has prepared this plan of correction, as a result of an annual survey completed 04/25/2017. The Estates at Linden has prepared and submitted this plan of correction at this time solely because of the requirements under state and federal law that mandate submission of a plan of correction within ten (10) calendar days following receipt of this statement of deficiencies as a condition to participate in the Title 18 and Title 19 programs. The submission of this Plan of Correction within this time frame should in no way be considered or construed as agreement with the</p> |   |

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>THE ESTATES AT LINDEN LLC</b> |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>105 WEST LINDEN STREET<br/>STILLWATER, MN 55082</b>   |                      |   |
| (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 |   |
| K 363  | Continued From page 3<br>3) Room 118<br><br>This deficient practice was verified by the facility staff (EA), at the time of discovery. | K 363   | allegation of non-compliance or admission by The Estates at Linden that a deficiency exists. However, evidencing The Estates at Linden's good faith, the facility offers the following plan of correction and will achieve substantial compliance in the following areas addressed by 05/05/2017. This plan of correction should serve as the allegation of compliance.<br><br>K363, S/S = C<br>NFPA 101 Corridor – Doors<br><br>The doors identified during the tour on 4/25/17 have been addressed. The Maintenance Director sanded down a section of the door and door frame to ensure that the room 21, room 117, and room 118 doors shut with minimal force applied. Administrator tested the identified doors and confirmed the work was completed by the Maintenance Director. |                      |   |



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered  
May 24, 2017

Mr. Eric Andersen, Administrator  
The Estates At Linden LLC  
105 West Linden Street  
Stillwater, MN 55082

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5337026 & H5337029

Dear Mr. Andersen:

The above facility was surveyed on April 24, 2017 through April 27, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes and to investigate complaint number H5337029. 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 <http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm> . 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

The Estates At Linden LLC

May 24, 2017

Page 2

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 Susanne Reuss, Unit Supervisor at (651) 201-3793 or susanne.reuss@state.mn.us.

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,

A handwritten signature in black ink, appearing to read "Kate Johnston". The signature is fluid and cursive, with a long horizontal flourish extending to the right.

Kate JohnsTon, Program Specialist  
Program Assurance Unit  
Licensing and Certification Program  
Health Regulation Division  
Minnesota Department of Health  
Email: kate.johnston@state.mn.us  
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

Minnesota Department of Health

|  |  |   |   |
|--|--|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>00948</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>04/27/2017</b> |
|--|--|---|---|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>THE ESTATES AT LINDEN LLC</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>105 WEST LINDEN STREET</b><br><b>STILLWATER, MN 55082</b> |
|--|---|

| (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) COMPLETE DATE |
|--------------------|---|---------------|---|--------------------|
| 2 000              | <p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS:<br/>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: &lt;<a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>&gt; The State licensing orders are delineated on the attached Minnesota</p> | 2 000         | 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. |                    |

|   |       |           |
|---|-------|-----------|
| Minnesota Department of Health<br>LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|-------|-----------|

Minnesota Department of Health

|  |  |   |   |
|--|--|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>00948</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>04/27/2017</b> |
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>THE ESTATES AT LINDEN LLC</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>105 WEST LINDEN STREET<br/>STILLWATER, MN 55082</b> |
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| 2 000              | <p>Continued From page 1</p> <p>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.</p> <p>On April 24,25,26 and 27, 2017, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.</p> <p>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.</p> <p>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 surveyors findings are the Suggested Method of Correction and Time period for Correction.</p> <p>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.</p> | 2 000         | <p>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 which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.</p> |                    |

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| 2 000              | Continued From page 2<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.<br><br>In addition, a complaint investigation was also completed at the time of the licensing survey.<br><br>An investigation of complaint H#5337029 was completed. The complaint was not substantiated.   | 2 000         |   |                    |
| 2 830              | MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General<br><br>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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure visits by a hospice provider were coordinated with the facility to promote communication and appropriate enhanced care for 1 of 1 residents (R6) reviewed for hospice services. | 2 830         |   |                    |



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| 2 830              | <p>Continued From page 3</p> <p>Findings include:</p> <p>During an observation on 4/24/17, at 6:15 p.m., R6 was sitting in a specialty wheel chair at the dining room table and was able to feed self food and fluids and was communicating with the staff present. During an observation on 4/25/17, at 7:23 a.m., R6 was observed in the dining room feeding self and was able to pick up a glass of fluids without assistance.</p> <p>Document review of R6's plan of care indicated being on hospice services but the plan of care did not indicate what those services were.</p> <p>When interviewed on 4/26/17, at 1:07 p.m., licensed practical nurse (LPN)-B did not know what day of the week or what time hospice services were expected. There was no calendar for dates or times to expect hospice services. Furthermore, LPN-B verified did not know where to find the hospice notes for services provided for R6.</p> <p>When interviewed on 4/26/17, at 1:22 p.m. nursing assistants (NA)-D and NA-E indicated the hospice aide was in to see R6 today but they did not know beforehand when the hospice aide or nurse were coming to see R6 and expressed dissatisfaction that the hospice agency were not providing enhanced services for R6, and expressed today as an example. NA-D and NA-E asked the hospice aide to be sure that R6 was clean and dry yet just after the hospice aide left NA-D and NA-E discovered R6 was saturated with a large amount of urine, and both aides indicated the hospice aide could not have performed the expected cares. NA-D and NA-E expressed the hospice aide does not ask them for help and observed at other times the hospice</p> | 2 830         |   |                    |

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| 2 830              | <p>Continued From page 4</p> <p>aide sitting in the dining room working on a personal electronic device while R6 was self feeding. NA-D and NA-E expressed the hospice aide should perform services above and beyond what services the facility was providing and they did not observe enhanced services with R6 from the hospice provider.</p> <p>When interviewed on 4/27/17, at 10:09 a.m. LPN-C and registered nurse (RN)-A verified they did not know what day of the week or what time hospice services were expected. There was no calendar for date or times to expect hospice services. Furthermore, LPN-C and RN-A verified they did not know where to find the hospice notes or services provided for R6. LPN-C and RN-A knew that hospice had a separate book in another cupboard at the nurses station but hospice did not coordinate the plan of care with the facility plan of care.</p> <p>When interviewed on 4/27/17, at 10:15 a.m., NA-C verified the facility did not have a system for the staff to know when hospice services would be provided for R6. For example, NA-C expressed frustration that the hospice aide comes in at meal times when R6 is able to feed self and then NA-C has observed the hospice aide working on a electronic device. Furthermore, NA-C had expected the hospice aide to do a bed bath only to discover R6 did not appear to have been bathed that day.</p> <p>When interviewed on 4/27/17, at 11:46 a.m. NA-B and NA-G verified not knowing when the hospice aide or nurse would be in to care for R6, or what services would be provided. Both nursing assistants expressed frustration because the hospice could be enhancing R6's care and they did not feel that was happening currently.</p> | 2 830         |   |                    |

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| 2 830              | <p>Continued From page 5</p> <p>Document review of the facility 9/05 policy titled, Hospice, indicated the facility would coordinate care with the hospice provider.</p> <p>When interviewed on 4/27/17, at 1:35 p.m., the director of nursing (DON) verified the facility expectation from the hospice provider was to be informed of the date and time hospice would be providing services for R6 to enhance the quality of care and the plan of care should be integrated for hospice into the facility plan of care.</p> <p><b>SUGGESTED METHOD OF CORRECTION:</b><br/>The director of nursing (DON) could work with hospice staff to develop a system to ensure coordination of care is maintained between the facility and all hospice staff who provide services in the facility. The DON or designee could educate all appropriate staff on the policies/procedures, and could develop monitoring systems to ensure ongoing compliance.</p> <p><b>TIME PERIOD FOR CORRECTION:</b> Twenty One (21) Days</p> | 2 830         |   |                    |
| 21695              | <p>MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, &amp; Maintenance</p> <p>Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings.</p> <p>This MN Requirement is not met as evidenced</p>   | 21695         |   |                    |

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| 21695              | <p>Continued From page 6</p> <p>by:<br/>Based on observation and interview, facility failed to ensure 1 of 2 floor's (lower level) carpet was maintained and free of odor, this had the potential to affect 10 of 10 residents who resided on the lower level, visitors, and staff.</p> <p>Findings include:</p> <p>During observation of the lower level resident hallway on 4/24/17, at 4:24 p.m., the carpet was damp because housekeeping staff had just shampooed it. The hallway, consisting of resident rooms and a shower room, smelled wet and musty.</p> <p>During an interview on 4/24/17, at 4:24 p.m. a housekeeper (H)-A working in the hallway said "I know it doesn't smell that clean, but we clean all the time." H-A was sure the smell came from the carpet, and explained every time housekeeping staff shampooed the carpet, it pulled up the musty smell. On 4/25/17, at 10:10 a.m. H-A again mentioned the smell in the lower level. H-A thought the building's lower level might have had a water leak in the past, but did not think the carpet had been replaced after the leak.</p> <p>During an interview on 4/24/17, at 5:27 p.m. family member (FM)-A thought there was mold under the carpet in the lower level hallway that was shared by resident rooms and the shower room. FM-A said the water from the shower room leaked under the wall and into the hallway carpet, adding "It smells like mildew down there, especially when wet."</p> <p>Observation on 4/26/17, at 10:43 a.m. revealed a wet spot on the lower level carpet. The wet spot came out from the wall in the shape of a half</p> | 21695         |   |                    |

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| 21695              | <p>Continued From page 7</p> <p>circle, with an approximate two foot radius. Directly on the other side of the wall was the shower.</p> <p>During an interview on 4/26/17, at 11:54 a.m. the maintenance director said he noticed the wet spot on the carpet today. He explained that water from the shower used to leak, so he put down a barrier to try and stop the leak. The maintenance director pointed to a layer of caulk he placed along the edges of the shower stall, where the floor tile met the wall tile. He said the leak stopped for about three weeks after caulking the shower, but now he noticed it was leaking again. He said he was not sure if the shower drain was backing up to cause standing water, or if the shower needed a new floor, or what exactly caused the leak. When asked about the general musty smell in the hallway, the maintenance director said housekeeping staff shampooed the carpet often, and wondered whether the shampoo machine was not fully sucking the water back out of the carpet.</p> <p>During an interview on 4/26/17, at 2:08 p.m. nursing assistant (NA)-H said water leaked under the wall and into the carpet after every shower. NA-H explained that housekeeping cleaned the hallway carpet often because a resident occasionally urinated on it, but thought the carpet was "just old," and some of "that stuff" had just soaked underneath the carpet. When the carpet gets wet, you can smell it, NA-H explained.</p> <p>On 4/27/17, at 1:38 p.m. a small damp spot of approximately two inches was observed on the hallway carpet on the other side of the shower wall. NA-I was asked about the wet spot. NA-I confirmed that the water leaked into the carpet when residents showered. NA-I was not sure how</p> | 21695         |   |                    |

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| 21695              | Continued From page 8<br><br>long water had been leaking under the wall.<br><br>SUGGESTED METHOD OF CORRECTION: The maintenance director or his designee could develop a system to ensure the environment was clean, comfortable and checked on a routine basis. The maintenance director or his designee could develop a system for staff to report any concerns with the physical plant. All facility staff could be educated on these systems. The maintenance director or his designee could develop a monitoring system to ensure ongoing compliance.<br><br>Time Period for Correction: Twenty-one (21) days   | 21695         |   |                    |
| 21880              | MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights<br><br>Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place.<br><br>Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every | 21880         |   |                    |

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| 21880              | <p>Continued From page 9</p> <p>facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview and document review, the facility failed to ensure that prompt efforts were made to resolve resident grievances for 3 of 3 residents (R7, R20 &amp; R39) reviewed who expressed a grievance to facility staff.</p> <p>Findings include:</p> <p>R20 expressed concerns to facility staff that were not addressed to R20's satisfaction.</p> <p>During an observation on 4/24/17, at 6:30 p.m. licensed practical nurse (LPN)-A handed medication to R20 seated at a dining room table. R20 stated, "Is that my diuretic, why am I taking</p> | 21880         |   |                    |

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| 21880              | <p>Continued From page 10</p> <p>that at night, it makes me go to the bathroom all night long. Why can't someone answer me?" LPN-A responded with, "I don't know."</p> <p>During an interview on 4/24/17, at 7:00 p.m. R20 expressed being up all night long to the bathroom and no one is listening and working out a better schedule for the diuretic medication. R20 agreed it was difficult to come up with a time because of sleeping in late, then, afternoon activities, and then, supper meal but is frustrated that someone has not tried to work with R20 for a better solution to 6:30 p.m. for a diuretic. R20 complained that the tubroom is cold, and they don't have a hair dryer here and stated, "Why can't they have a hair dryer here, I need my hair washed but I don't want to get cold and get sick again, I keep asking and no one will help me." Other concerns expressed by R20 during this interview included difficulty with the resident next door and sharing the bathroom. R20 expressed, "I'm angry [R7] is in that bathroom so long and then I can't get in there especially after the diuretic." R20 expressed frustration because had a commode at the bedside but the facility took the commode away and there has not been a resolution that R20 is satisfied with and again expressed, "Do they think I am stupid? Why can't anyone here help me?"</p> <p>Document review of the 2/15/17 facility care area assessment (CAA) indicated R20 was assessed as cognitively intact.</p> <p>Document review of the bathing schedule verified R20 last bathed 4/20/17. Documentation of the diuretic on the medication sheet indicated R20 began taking the diuretic medication March 9, 2017. Document review of the facility concern/grievance log did not indicate any concerns written for R20.</p> | 21880         |   |                    |



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| NAME OF PROVIDER OR SUPPLIER<br><br><b>THE ESTATES AT LINDEN LLC</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>105 WEST LINDEN STREET</b><br><b>STILLWATER, MN 55082</b> |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| 21880              | <p>Continued From page 11</p> <p>During an interview on 4/25/17, at 3:42 p.m. licensed practical nurse (LPN)-A and registered nurse (RN)-A verified being aware of multiple concerns expressed by R20 but that no concern/grievance form had been completed regarding the unresolved issues.</p> <p>R7 did not feel the facility was taking care of concerns expressed</p> <p>During an interview on 4/25/17, at 10:00 a.m., R7 expressed concern about other residents coming to R7 with complaints that the facility does not follow through with specific concerns. R7 says staff are informed, but there does not seem to be a resolution. For example, R7 discussed R20 and R39 not getting along over the use of the bathroom. R7 stated, "It makes me mad that I am the go between for [R20] &amp; [R39] complaining about each other and the staff know about it."</p> <p>Document review of the 1/9/17, facility CAA indicated R7 was assessed as cognitively intact.</p> <p>During an interview on 4/26/17, at 12:53 p.m. R7 expressed, "I'm angry about the noise outside my room at night. I have been complaining a long time and I get tired of telling them, they don't think it is true, but it is true. They are not here at night and they have no idea what is going on at night. They should sneak in and see what is going on here after hours." R7 indicated the noise outside the room in the hallway has been going on for months and that R7 has reported on numerous occasions to the facility staff. R7 indicated not being aware of the facility concern grievance process. Furthermore, R7 said ask the other residents around the nurses station about the noise at night because they will tell you it is a</p> | 21880         |   |                    |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>00948</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>C</b><br><b>04/27/2017</b> |
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| 21880              | <p>Continued From page 12</p> <p>problem.</p> <p>Document review of the facility concern/grievances did not reveal any concerns regarding noise in the hallway</p> <p>R39 expressed the facility did not satisfy the concern with a bathroom issue</p> <p>Document review of the 2/20/17, facility CAA indicated R39 was assessed as cognitively intact.</p> <p>During an interview on 4/25/17, at 11:00 a.m. R39 expressed being very upset and stated "[R20] is banging on the bathroom door when I am in there, and she makes a terrible mess and [R20] is the one who takes too long, I tell the staff but no one takes care of the problem." R39 stated, "I wish there was a solution to this ongoing problem in the bathroom."</p> <p>R39 did not know about the facility concern. grievance process.</p> <p>Document review of the facility concern/grievance log did not reveal any concerns regarding roommate/bathroom.</p> <p>Document review of the facility 9/01 policy titled, Complaint and Grievance Procedure, indicated a grievance form should be completed when the verbal complaint had been voiced to each of the above individuals (charge nurse, director of nursing, department head, administrator) and the grievance remains unresolved. The administrator shall issue a written summary to the complainant of proposed action on the grievance no later than 7 days after receipt of the grievance.</p> <p>When interviewed on 4/27/17, at 2:00 p.m. the</p> | 21880         |   |                    |

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| 21880              | <p>Continued From page 13</p> <p>director of nursing verified the residents concern/grievances needed to be taken care of and a resolution would be implemented immediately.</p> <p>SUGGESTED METHOD OF CORRECTION:<br/>The director of nursing could in-service staff on the requirement to address resident concerns and make a good faith attempt to resolve the grievances. The director of nursing could develop a monitoring system to ensure ongoing compliance and report the findings to the Quality Assurance Committee.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p> | 21880         |   |                    |