DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
October 26, 2023

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

RE: CCN: 245342
Cycle Start Date: September 7, 2023

Dear Administrator:

On October 23, 2023, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 20, 2023

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

RE: CCN: 245342
Cycle Start Date: September 7, 2023

Dear Administrator:

On September 7, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Renee McClellan, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by December 7, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by March 7, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
travis.ahrens@state.mn.us
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	09/07/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 9/5/23 through 9/7/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 9/5/23 through 9/7/23, 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 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 regulations has been attained.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights.	F 550		10/13/23

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

Electronically Signed | 10/01/2023

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

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F 550	Continued From page 1 The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.	F 550		

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F 550	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure dignity was maintained for 1 of 2 residents (R24) reviewed who had not been shaved. Findings include: R24's annual Minimum Data Set (MDS) dated 7/5/23, identified severely impaired cognition and a diagnosis of dementia. R24 required extensive assist from staff with hygiene, and total assistance with transfers. R24 had not rejected care. R24's care plan dated 9/7/23, identified a self-care deficit related to right lower leg amputation and mild cognitive impairment. R24's goal was to be dressed groomed and bathed per preferences and accept assistance. The care plan lacked interventions specific for shaving but identified R24 required assist of one for personal hygiene. R24's progress notes (nurses charting) and point of care (POC) (nursing assistant charting) dated 7/9/23 through 9/7/23, lacked documentation of attempts, or refusals of shaving. R24's POC charting had one instance of refusing care documented on 8/2/23, which improved with reassurance from the nursing assistant. During an observation on 9/5/23 at 1:58 p.m., R24 was in bed and had approximately 10 noticeable gray and white hairs on her chin about half of an inch long. R24 was unable to answer questions about her preferences for shaving.	F 550	F550: Resident Rights, SS: D ¿ How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Care plan has been updated with ADL assistance and routine grooming has been offered to resident. ¿ How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. ¿ What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. Nursing staff educated on the need to ensure grooming is offered to all residents per facilities policy titled "Activities of Daily Living (ADLs)/Maintain Abilities Policy". Education was provided on dignity with policy titled "Dignity" ¿ How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Weekly audits will be done for 1 month on 10 residents to ensure grooming is offered and completed as needed. Audit results will be reviewed at QAPI. The facility will determine the need and frequency of additional audits based on the results.	

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F 550	Continued From page 3 During an observation and interview on 9/6/23 at 9:10 a.m., nursing assistant (NA)-B entered R24's room to complete morning cares. R24 was in a gown. NA-B changed R24's brief and exited the room. NA-B was asked if any further cares were to be done and stated have to talk to the other aide. NA-B left and returned with NA-A and entered R24's room. NA-B and NA-A assisted R24 with dressing and transfer out of bed. NA-B completed other hygiene tasks but had not shaved R24. When asked, NA-B acknowledged R24's chin hairs and said they were "long" but stated was not sure where shaving supplies were, and R24 would be shaved on her shower day. NA-B left the room and had not attempted to shave R24. R24 had been cooperative with all other cares provided. During an observation on 9/6/23 at 12:03 p.m., R24 was in the dining room with several other residents. R24 had not been shaved yet. During an observation on 9/6/23 at 1:04 p.m., NA-A observed R24's chin hairs and stated R24 should have been shaved and was not. NA-A agreed there were no care planned interventions specific to shaving. NA-A stated an unshaved face could reasonably be a dignity issue. During an observation on 9/6/23 at 2:40 p.m., R24 was in the lounge area with other residents and had not been shaved. During an observation and interview on 9/7/23 at 9:30 a.m., NA-A and NA-C assisted R24 with morning cares and transfer out of bed. R24's chin was shaved and the NA's were unsure who had completed the task. NA-A and NA-C stated R24 was cooperative with cares.	F 550	LNHA/designee is responsible for completing these audits	

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F 550	Continued From page 4 During an interview on 9/7/23 at 9:53 a.m., registered nurse (RN)-A stated residents should be shaved routinely to maintain dignity. If a personal preference to not be shaved was shared, then it would be added to the care plan. If refusals were consistent, then interventions would be added to the care plan. RN-A stated R24 should have been shaved. During an interview on 9/7/23 at 10:43 a.m., the director of nursing (DON) stated residents should be shaved routinely for dignity and personal preference. If a resident refused consistently then there should be documentation of the efforts and care planned interventions would be implemented. The facility policy titled Shaving dated 2/2018, identified the purpose of shaving was to promote cleanliness and provide skin care. If the resident refused the treatment, the supervisor would be updated and the reasons why and intervention taken would be documented.	F 550		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.	F 583		10/13/23

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F 583	Continued From page 5 §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure privacy during personal cares for 1 of 2 residents (R27) reviewed for personal cares. Findings include: R27's quarterly Minimum Data Set (MDS) dated 6/13/23, indicated R27 had intact cognition, required extensive assist for transfers, dressing, toileting, personal hygiene, and was frequently incontinent of bowel and bladder. R27's Medical Diagnosis form undated, indicated R27 had the following diagnosis: major	F 583	F583: Personal Privacy/Confidentiality of Records " How corrective action will be accomplished for those residents found to have been affected by the deficient practice. R27□s privacy curtain will be utilized when the resident has the potential to have a breach in privacy. Compliance and incident policy was reviewed by the Administrator and remains current. NA-F was educated on Privacy Policy and procedure.	

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F 583	Continued From page 6 depressive disorder, abnormalities of gait, and muscle weakness. R27's care plan dated 12/22/22, indicated R27 had an alteration in elimination and interventions included: R27 was independent with a rolling walker to and from the bathroom, required assistance with perineal (cleaning private areas) cares in the a.m., bedtime, and as needed; staff were to provide incontinent products and assist to change as needed. R27's care plan also identified R27 required assist of one with personal hygiene, dressing, and bathing. R27's IDT (interdisciplinary team) Care Conference form dated 6/23/23, indicated R27 expressed desire for a single unshared room and did not like having a roommate. Further, the note indicated it was explained multiple times to R27 there were no private rooms for residents in long term care. During interview and observation on 9/5/23 between 3:48 p.m. and 3:55 p.m., nursing assistant, (NA)-F was assisting R27 in the bathroom. R27's pants were pulled down and the bathroom door was opened. R27's roommate was sitting directly across from the bathroom entrance. The privacy curtain in the room was not pulled to allow for privacy. NA-F stated could not fit in the bathroom with R27 when the door was opened. NA-F stated should use the privacy curtain, but stated the curtain did not cover between the bathroom and the door. NA-F viewed the curtain and verified the curtain would have covered the resident while in the bathroom and further stated should have used the privacy curtain.	F 583	" How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents residing at The Estates at Greeley have the potential to be affected. " What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. Staff will be educated on the following: - Facility□s policy on resident privacy, titled Confidentiality of Information and Personal Privacy - Facility□s policy on resident dignity, titled Quality of Life □ Dignity - Facility□s policy on resident rights, titled Resident Rights Residents□ rights related to dignity has been reviewed to include resident privacy. Weekly observation audits of 4 rooms per week to ensure privacy curtains and drapes are operational. Audit staff to ensure they know to provide privacy and honor resident preferences during cares. " How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Facility will conduct audits on staff using resident□s privacy curtain. Audits will be done on multiple shifts once per day for the first week and 3 times per week for 1 month thereafter. Audit results will be reviewed at the facility QAPI meeting. Scope and frequency may be adjusted based on the results. LNHA/designee is responsible for completing these audits.	

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F 583	Continued From page 7 During interview on 9/5/23 at 3:57 p.m., R27 stated he did not feel he had his own privacy and had been begging for a private room. During interview on 9/6/23 at 1:22 p.m., licensed practical nurse (LPN)-C stated the curtain divider was supposed to be used for privacy and staff should know better. During interview on 9/6/23 at 1:38 p.m., the director of nursing (DON) stated staff were supposed to respect resident's privacy. A policy, Quality of Life-Dignity dated 2009, indicated staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.	F 583		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure grooming was offered and/or provided for 1 of 2 residents (R32) reviewed for shaving. Findings include: R32's quarterly Minimum Data Set (MDS) dated 6/13/23, indicated intact cognition, did not reject cares, and required extensive assistance with dressing and personal hygiene which included	F 677	F677: ADL Care Provided for Dependent Residents, SS: D How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Care plan has been updated with ADL assistance and grooming has been offered to affected resident.	10/13/23

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F 677	Continued From page 8 shaving. R32's Medical Diagnosis form undated, in the electronic medical record (EMR), indicated R32 had the following diagnosis: cerebral infarction (stroke) due to unspecified occlusion or stenosis of unspecified cerebral artery, adjustment disorder with depressed mood and slurred speech. R32's care plan dated 2/5/21, indicated R32 had an alteration in communication due to a cerebral infarction and interventions included allowing R32 time to communicate his wishes, and anticipate needs so they could be met. R32's care plan additionally indicated R32 had an alteration in mood and behaviors and interventions indicated staff were to monitor and document mood state and behaviors upon occurrence. Additionally, R32's care plan indicated R32 had a self care deficit and his goal was to be dressed, groomed, and bathed per preferences. Interventions included a weekly bath, encourage R32 to participate as able, and required assist of one with bathing, dressing, and personal hygiene. R32's Look Back Report Behaviors form for the past 16 days was reviewed on 9/6/23, and indicated there were no documented behaviors. R32's Look Back Report ADL (activities of daily living) form was reviewed from 8/22/23 through 9/6/23, under the heading: Personal Hygiene, indicated the type of assistance R32 required. Under the heading POC Legend Report: the letters "RR" would indicate resident refused, however, there was no documentation with the letters "RR" to indicate R32 refused personal hygiene cares. Additionally, the report indicated	F 677	How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents residing at The Estates at Greeley have the potential to be affected. " What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. Nursing staff educated on the need to ensure grooming and nail care are offered to all residents per facilities policy titled "Activities of Daily Living (ADLs)/Maintain Abilities Policy" How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Weekly audits will be done for 3 months X 10 residents to ensure grooming is offered and completed as needed. Audit results will be reviewed at QAPI. The facility will determine the need and frequency of additional audits based on the results. LNHA/designee is responsible for completing audits.	

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	245342	A. BUILDING _____ B. WING _____	09/07/2023

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F 677	Continued From page 9 R32 had a bath on 8/22/23, 8/29/23, and 9/5/23. The report lacked documentation with the letters "RR" to indicate R32 refused bathing. R32's nursing progress notes were reviewed from 8/2023 through 9/5/23, lacked documentation R32 refused personal hygiene cares. The progress note dated 9/5/23, indicated R32's scheduled shower was given. During interview and observation on 9/5/23 at 12:30 p.m., R32 stated it had been over a week since he had been shaved and preferred to be clean shaven. R32 was observed to have a beard and mustache growth. During interview on 9/6/23 at 7:09 a.m., nursing assistant (NA)-G stated R32 did not refuse cares, and had a shower on Tuesday or Thursday evenings. During interview and observation on 9/6/23 at 12:17 p.m., R32 still had beard and mustache growth on his face. R32 felt his face and stated he wanted to be clean shaven. During interview on 9/6/23 at 12:56 p.m., NA-G stated shaves R32 on his shower day and did not shave R32 today. NA-G stated clean shaved R32 the week prior when NA-G gave him a shower. At 12:58 p.m., NA-G looked in R32's room for his electric shaver, located his shaver in the communal shower room. NA-G added this was definitely R32's shaver and stated it was left it in the shower room the week prior. NA-G verified the electric shaver did not contain R32's name. NA-G further verified R32's shower day was on Tuesday evenings and stated it did not look like R32 had been shaved. At 1:01 p.m., R32 stated	F 677		

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F 677	Continued From page 10 to NA-G he wanted to be clean shaven. NA-G stated R32 did not look clean shaven. At 1:06 p.m., NA-G stated it was not on R32's care plan to shave daily, it was care planned to shave R32 on his bath day. During interview on 9/6/23 at 1:25 p.m., licensed practical nurse (LPN)-C stated R32 used to refuse shaving, but no longer refused and if R32 refused cares, staff were required to document refusals. LPN-C further stated R32 was shaved once a week on bath days and verified it did not look like R32 had been shaved. During interview on 9/6/23 at 1:42 p.m., the director of nursing (DON) stated the NA would document refused in for a task a resident refused, some residents were offered shaving daily, and some residents were shaved on an as needed basis. DON further stated, would have to check with NA-F to see if R32 refused shaving. DON verified there was no documentation R32 refused shaving and would verify with NA-F because he participated in R32's bath. DON stated would follow up with the nurse as well and they didn't just shave on shower days because R32 went back and forth on that. During interview on 9/7/23 at 10:03 a.m., DON stated NA-G informed her R32 was shaved on 9/4/23, but was not able to do a close shave. Furthr, NA-F informed her R32 refused shaving on his shower day and NA-F was going to reapproach R32. DON further stated, she couldn't be quoted on the days because she did not have a calendar. A policy, Shaving the Resident dated February 2018, indicated the following information should	F 677		

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F 677	Continued From page 11 be recorded in the resident's medical record: the date and time that the procedure was performed, the name and title of the individual(s) who performed the procedure, if and how the resident participated in the procedure or any changes in the resident's ability to participate, if the resident refused the treatment, the reason(s) why and the intervention taken. A policy, Activities of Daily Living (ADLs) Maintain abilities dated 3/31/23 indicated care and services provided were person-centered, and honored and supported each resident's preferences, choices, values and beliefs. The policy further indicated a resident who was unable to carry out activities of daily living would receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 677		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 686	F686: Treatment/Svcs to Prevent/Heal	10/13/23

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F 686	Continued From page 12 review the facility failed to ensure interventions were in place for 1 of 2 residents (R52) at risk for pressure ulcers when an air mattress was not functioning properly. Findings include: R52's 30-day Minimum Data Set (MDS) dated 8/10/23, indicated R52 was cognitively intact, required one person extensive assistance for most activities of daily living (ADLs) and was at risk for developing pressure ulcers. R52's diagnosis included chronic obstructive pulmonary disease (COPD), pulmonary fibrosis, open wound of left foot, and type 2 diabetes mellitus. R52's Care Area Assessment (CAA) dated 7/14/23, indicated R52 had an alteration in skin integrity related to stage II left heel wound and required a pressure redistribution mattress on his bed. R52's care plan dated 7/17/23, indicated R52 had alteration in skin integrity related to non-healing left heel wound, abrasion on left lateral foot, and skin tear on left lower shin. Interventions included pressure redistribution mattress. R52's provider note dated 8/31/23, indicated, "Changed to air mattress but doesn't seem to be working properly today." During observation and interview on 9/6/23 at 7:16 a.m., R52 was awake and sitting in recliner. R52 stated did not sleep in the bed due to the mattress not working. The red light on the air mattress control panel was flashing indicating low pressure.	F 686	Pressure Ulcer, SS: D How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Maintenance Director made repair to R52's mattress and is functioning properly. How the facility will identify other residents having the potential to be affected by the same deficient practice. All like residents who have air flow mattresses have been inspected and are in proper working order. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. Staff will be educated on the following: - Facility's policy, titled "Work Orders, Maintenance" Staff will be provided with education on common repairs and air mattress maintenance. Education titled "Air Mattress Maintenance Explained: 5 Common Repairs". Monitoring for compliance will be ensured through weekly audits of residents using an air mattress to ensure proper functioning. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. For the 1 month, the LNHA or designee will complete 3 audits per week on 5 residents to ensure durable medical	

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F 686	Continued From page 13 During observation and interview on 9/7/23 at 8:42 a.m., R52 was sitting in his recliner and stated that was where he slept again last night. The red light on the air mattress control panel was flashing indicating low pressure. R52 stated he slept in the bed one night after the air mattress was installed, but was very uncomfortable and woke up feeling the hard bar across his back. R52 stated told staff who stated the mattress appeared to have a leak up by the head of the bed. R52 stated no one had ever come to fix or replace the mattress and he would sleep in the bed if the mattress worked properly. During interview on 9/7/23 at 8:48 a.m., nursing assistant (NA)-D stated the flashing red light indicated low pressure and the bed did not seem to be working properly. During interview on 9/7/23 at 8:55 a.m., registered nurse (RN)-B stated it appeared the mattress was not working and could not remember the last time R52 slept in the bed. RN-B stated R52 had wounds, was at risk for further skin breakdown and could not reposition self in bed due to a shoulder injury. RN-B stated an air mattress would stimulate blood flow and prevent skin breakdown. During interview on 9/7/23 at 9:02 a.m., maintenance (M)-A stated did not have a work order on R52's bed was not aware it was not functioning properly. M-A stated typically staff would verbally inform him of such issues or enter a work order into the TELS system which would automatically notify him of the request to inspect/repair defective items. During interview on 9/7/23 at 9:17 a.m., director	F 686	equipment is in working order. The facility QA committee will review audit results and make further recommendations as needed.	

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F 686	Continued From page 14 of nursing (DON) stated expectation was for staff to report equipment issues to M-A or enter a work order into the TELS system. During interview on 9/7/23 at 10:42 a.m., family member (FM)-A stated R52 had not been able to sleep in the bed for several weeks. FM-A stated the air mattress was installed on 8/22/23, and it was not working properly since then. FM-A stated visited at least once each day since then and had told staff of the malfunctioning air mattress several times. FM-A stated R52 would sleep in the bed if it worked properly and would possibly alternate between the bed and the recliner due to his lung condition. During interview on 9/7/23, at 11:12 a.m., administrator stated R52's air mattress had been installed several weeks ago and was not aware it had not been working properly. Administrator stated expectation was for staff to report such issues by entering a work order into the TELS system and verified all staff had access to the TELS system. During interview on 9/7/23 at 12:53 p.m., RN-A stated R52's air mattress was installed at FM-A's request and an air mattress was used to promote skin integrity. RN-A's expectation was staff would report when the mattress was not working properly and it would be corrected. During interview on 9/7/23 at 12:57 p.m., DON stated an air mattress was considered a redistribution mattress. DON stated when a resident was admitted with a pressure ulcer or was at risk for developing one, an air mattress was used to promote healing and prevent further skin breakdown.	F 686		

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F 686	Continued From page 15 Facility policy Skin Assessment and Wound Management dated 2/12/23, indicated general guidelines for skin and wound management to include implementation of appropriate preventative skin measures.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide a nursing rehabilitation functional maintenance program (FMP) for 1 of 3 residents (R24) who had limited range of motion. Findings include: R24's annual Minimum Data Set (MDS) dated	F 688	F688: Increase/Prevent Decrease in ROM/Mobility, SS: D " How corrective action will be accomplished for those residents found to have been affected by the deficient practice. R24 has had maintenance program reviewed and care plan revised to meet	10/13/23

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F 688	Continued From page 16 7/5/23, identified severely impaired cognition. R24 required extensive assist of staff for bed mobility, locomotion on and off the unit, toileting and hygiene. R24 required total assistance for transfers. R24 could eat independently after set up. R24's diagnosis included dementia and peripheral vascular disease (impaired blood circulation). R24's care plan dated 9/7/23, identified a self-care deficit related to right lower leg amputation and mild cognitive impairment. Interventions included an FMP where R24 performed seated exercises with the nursing assistant (NA) daily. Cues for correct technique and copies of exercises were identified to be in R24's closet. R24's Restorative Nursing Program form dated 7/23/20, identified R24 would perform seated exercises with NA daily for 15 repetitions and verbal cues for correct technique. A copy of the exercises would be in R24's closet. R24's point of care (POC) (nursing assistant charting) dated 8/9/23 through 9/7/23, identified on 11 out of those 29 days the FMP had not been recorded as attempted or completed. R24's nursing progress notes dated 8/9/23 through 9/7/23, lacked documentation why the FMP had not been completed. During an observation on 9/6/23 at 9:10 a.m., nursing assistant (NA)-B and NA-A completed R24's morning cares and transfer R24 out of bed. R24's FMP was not attempted. During an interview 9/6/23 at 1:04 p.m., NA-A	F 688	current needs " How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents residing at The Estates at Greeley have the potential to be affected. " What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. Residents with active restorative programs have been reviewed for appropriateness. Restorative plans have been adjusted and care planned as needed. Nursing staff and rehabilitation staff will be educated on the initiation and completion of restorative programs and on periodic review of programs. Staff will be required to review and understand the facility's policy titled, "Restorative Nursing Services". " How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Random audits will be done weekly for 1 month on X 5 resident's restorative programs to ensure compliance is achieved. The facility QA&A committee will review audit results and make further recommendations. Director of Nursing/Designee IS responsible for completing the audits.	

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F 688	Continued From page 17 agreed they had not attempted R24's FMP. NA-A stated R24's dementia had advanced and R24 was no longer able to complete the tasks independently. NA-A reviewed R24's POC tasks and agreed it was still an active task. During an observation and interview on 9/7/23 at 9:30 a.m., NA-A and NA-C assisted R24 with morning cares and transfer out of bed. NA-A and NA-C stated R24 was cooperative with cares today. R24's FMP was not attempted. NA-C stated was not aware of an FMP for R24. NA-C reviewed the POC tasks and agreed the program was active, however, no instructions were posted in the closet as identified in the task. NA-A stated the FMP could not be attempted without the instructions. During an interview on 9/7/23 at 8:50 a.m., the certified occupational therapy assistant (COTA) stated they had worked with R24 in the past and R24 had the ability to participate in her FMP. The COTA stated staff should be assisting R24 with the FMP as ordered, R24 would not be able to do this independently. The COTA stated R24 had dementia but was cooperative typically, with the right approach. During an interview on 9/7/23 at 9:53 a.m., registered nurse (RN)-A stated the therapy department initiated FMP's and nursing would enter the program into the POC tasks. If a resident refused or was not able to complete the FMP anymore, therapy should be notified to see if the program could be revised. RN-A stated R24's FMP was an active task and should have been carried out as written. RN-A stated R24 had recently moved to a new room and the instructions may have been left in the closet of	F 688		

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F 688	Continued From page 18 the previous room in the facility. During an interview on 9/7/23 at 10:43 a.m., the director of nursing (DON) stated she would expect staff to carry out FMP's as ordered. If R24 had been refusing or unable, should be documented so care planned interventions could be adjusted. The facility policy titled Restorative Nursing Services dated 7/2017, identified the purpose was to promote optimal safety and independence. Additionally, restorative goals may have included: a. Adjusting or adapting to changing abilities; b. Developing, maintaining or strengthening his/her physiological and psychological resources; c. Maintaining his/her dignity, independence and self-esteem; and d. Participating in the development and implementation of his/her plan of care.	F 688		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure food was palatable for 1 of 2 residents (R207) reviewed.	F 804	F804: Nutritive Value/Appear, Palatable/Prefer Temp, SS: D	10/13/23

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F 804	Continued From page 19 Findings include: R207's Medical Diagnosis form in the electronic medical record (EMR) indicated R207 had the following diagnosis: displaced intertrochanteric fracture of the right femur (broken hip), type two diabetes mellitus, exocrine pancreatic insufficiency (a condition where the small intestine cant digest food), alcohol dependence, Wernicke's encephalopathy (a neurological disorder), major depressive disorder, and general anxiety disorder. R207's Dietary Communication form dated 8/21/23, indicated consistent carbohydrate diet and R207's sodium was not restricted. R207's Clinical Nutrition Evaluation form dated 8/30/23, indicated R207's meal intakes were between 26-50%. R207's physician's orders dated 8/31/23, indicated R207 had an order for a consistent carbohydrate diet, mechanical soft texture, with regular thin consistency, no salads or lettuce, may have popcorn. R207's social services note dated 9/5/23, indicated R207 had intact cognition. R207's care plan dated 8/28/23, indicated R207 had a potential alteration in nutrition and interventions included: a consistent carbohydrate diet, mechanical soft texture, thin liquids, no salads or lettuce, okay to have popcorn, additionally staff were to offer substitutes for dislikes or when not eating.	F 804	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident was provided condiments and water for meal. Resident's food preference form was updated to reflect his preference for salt and pepper each meal. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents residing at The Estates at Greeley have the potential to be affected. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. Condiments and special requests will be added to the resident meal preference form. Any preference or special requests will then be added to the resident's meal ticket by the Culinary Director or designee. LNHA/designee will perform routine auditing on any new or updated preference requests to ensure resident's preference are being met How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. A food preference form audit was created to ensure that all ordered menu items are received by each resident. Random Audits will be completed X 3 a week for X 5 residents for X 1 month. Audit results will be reviewed in QAPI. Ongoing audits and frequency will be adjusted based on the results. The QA Committee will identify	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245342	A. BUILDING _____ B. WING _____	09/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 804	Continued From page 20 R207's meal ticket dated 9/7/23, indicated under allergies: no lettuce/salads and did not indicate any likes or dislikes. During interview on 9/5/23 at 2:17 p.m., R207 stated he had eaten several meals at the facility and the food was terrible. R207 further stated, the facility did not provide any salt and pepper and when he asks for it the staff just walk away. During continuous observation on 9/6/23 from 8:28 a.m. to 9:02 a.m., licensed practical nurse (LPN)-D delivered R207's meal in the south dining room which consisted of eggs and one piece of toast. There was no salt or pepper identified on the tray. LPN-D asked R207 what he wanted to drink and R207 stated he would like ice water. LPN-D left. At 8:33 a.m., R207 took a bite of his eggs and set his fork down. At 8:48 a.m., R207 had hardly eaten and still had one fourth a piece of toast left and the eggs were mostly untouched. At 8:55 a.m., an unidentified staff person asked R207 how it was going and R207 stated he was finished eating. R207 had not received his ice water. At 9:01 a.m., an unidentified staff person took R207's meal and asked if R207 did not like the eggs. R207 stated he liked salt and pepper on them and had asked for salt and pepper every day since he had been at the facility and the staff had not provided salt and pepper since he arrived at the facility. The unidentified staff person stated would try to remember the following day and would check R207's diet regarding salt after providing R207 with pepper packets. At 9:02 a.m., the unidentified staff person told nursing assistant (NA)-H R207 wanted to have salt and pepper. During interview on 9/6/23 at 9:36 a.m., LPN-D	F 804	any trends or patterns and make recommendations to revise the plan of correction as indicated	

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F 804	Continued From page 21	F 804		

verified delivering R207's breakfast and R207 had asked for ice water. LPN-D stated they usually have a pitcher of ice water on the juice cart, but it wasn't there this morning. LPN-D verified did not give R207 the ice water R207 requested.

During observation on 9/7/23 at 8:15 a.m., a staff person delivered R207's meal to his room and left.

During interview on 9/7/23 between 8:25 a.m. and 8:27 a.m., NA-I stated would go get salt and pepper for R207. R207 stated the salt and pepper was not on his meal tray and staff had to go and get it. At 8:27 a.m., NA-I verified R207 did not have salt and pepper on his breakfast tray.

During interview on 9/7/23 at 8:33 a.m., the culinary director (CD) stated food likes and dislikes were added to meal tickets. CD stated residents can let a nurse know and the nurse can relay to me any changes. CD verified R207 had no likes or dislikes identified on his meal ticket. CD further stated, condiments were available upon request, however if a resident consistently wanted something like salt and pepper every day it would be added to the meal ticket. CD verified had not received any requests of R207 wanting salt and pepper.

During interview on 9/7/23 at 9:55 a.m., the director of nursing (DON) stated residents had to ask for condiments and if they tell someone they always want it, it can be added to the meal ticket.

During interview on 9/7/23 at 10:29 a.m., registered nurse (RN)-B stated R207 was alert and able to make his needs known.

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F 804	Continued From page 22 During interview on 9/7/23 at 10:23 a.m., physical therapist (PT)-B stated R207 was alert and able to make his needs known. A policy, Resident Food Preferences dated July 2017, indicated when possible staff will interview the resident directly to determine current food preferences based on history and life patterns related to food and mealtimes. If the resident refuses or is unhappy with his or her diet, the staff will create a care plan that the resident is satisfied with. The facility's Quality Assessment and Performance Improvement (QAPI) committee will periodically review issues related to food preferences and meals to try to identify more widespread concerns about meal offerings, food preparation.	F 804		

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	245342	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/07/2023**

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K 000	INITIAL COMMENTS The Minnesota Department of Public Safety conducted an annual Life Safety recertification survey, State Fire Marshal Division, on Septmeber 7, 2023. At the time of this survey, The Estates at Greeley was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. Greeley Healthcare Center is a 1-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1964 and was determined to be of Type 2(111) construction. In 1988, an addition was constructed to the west side of the building that was determined to be of Type II(111)construction. In 1997, an addition was constructed to the north and south sides of the building that was determined to be of Type V(111)construction. Because the original building and the additions meet the construction type allowed for existing buildings, the facility was surveyed as one building as Type V(111) construction. The facility has a capacity of 64 beds and had a census of 54 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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